APL-2023-00086

To be argued by:
RICHARD DEARING
15 minutes requested

Court of Appeals
State of New York

In the Matter of the Application of

NYC ORGANIZATION OF PUBLIC SERVICE RETIREES, INC., LISA FLANZRAICH, BENAY WAITZMAN, LINDA WOOLVERTON, ED FERINGTON, MERRI TURK LASKY, and PHYLLIS LIPMAN,

Plaintiffs-Respondents,

against

RENEE CAMPION, CITY OF NY OFFICE OF LABOR RELATIONS, and THE CITY OF NEW YORK,

Defendants-Appellants.

REPLY BRIEF

HON. SYLVIA O. HINDS-RADIX
Corporation Counsel
of the City of New York
Attorney for Appellants
100 Church Street
New York, New York 10007
Tel: 212-356-2275 or -2500
Fax: 212-356-2222
jschoepp@law.nyc.gov

RICHARD DEARING
DEVIN SLACK
JONATHAN SCHOEPP-WONG
of Counsel

February 26, 2024

TABLE OF CONTENTS

Page

TABLE OF CONTENTS (cont'd)

Page

TABLE OF AUTHORITIES

Page(s)

CASES

STATUTES

TABLE OF AUTHORITIES (cont'd)

Page(s)

OTHER AUTHORITIES

TABLE OF AUTHORITIES (cont'd)

Page(s)

PRELIMINARY STATEMENT

To sustain the permanent injunction rendered below, petitioners must run the table on two points: (1) Administrative Code § 12-126 not only requires the City to pay for at least one premium-free plan for each insured, but also compels the City to do so for *all* optional plans it makes available; and (2) the law's statutory cap is set so as to be meaningless for Medicare-eligible individuals. Section 12-126 supports neither.

Nothing in the law prevents the City from providing first-rate healthcare to retirees while saving hundreds of millions of dollars by making better use of federal funding. Petitioners' proposed "pay for all plans" obligation is absent from the text of § 12-126, finds no support in the legislative history, and undermines their stated goal of providing retirees a choice of healthcare options. And their view of the statutory cap renders it a nullity for Medicare-eligible individuals, when both statutory text and good sense tell us that the legislature intended a meaningful, apples-to-apples comparison, with the cap for Medicare-eligible retirees tied to an insurance product that is actually available to them.

ARGUMENT

In a statutory interpretation case, it speaks volumes that petitioners do not confront the statutory text until page 35 of their brief. Before then, petitioners (aided by two paid-for amici[1]) go on an extended detour to fearmonger about Medicare Advantage generally as well as a specific Medicare Advantage plan that the City once intended to offer but has since replaced with an even better plan to be offered by Aetna (*see* Brief for Appellants ("City Br.") 25–26 (describing the Aetna plan)).

Those aspersions say nothing about the meaning of Administrative Code § 12-126—the legal question in this appeal. The local law does not dictate the content of the "hospital-surgical-medical benefits" to be offered by the City. Those are arrived at through negotiations with the City's Municipal Labor Committee—a potent and sophisticated group of labor unions that has focused on healthcare matters for decades and supports the City's proposed approach. And the local law certainly does not bar the City from

---

[1] *See* Donald Berwick's Mot. for Leave to File as Amicus Curiae 6 (disclosing petitioners' payment); Physicians for a Nat'l Health Program's Mot. for Leave to File Brief for Amicus Curiae 3 (same).

offering one or more Medicare Advantage plans—as the City has done for decades.

Petitioners' invective is misguided in any event. Consider their criticisms of Medicare Advantage as a concept, a program benefitting more than 30 million Americans—over half the Medicare-eligible population—including nearly two million New York residents. Ctrs. for Medicare & Medicaid Servs. (CMS), *Medicare Monthly Enrollment* (2023), https://perma.cc/4B43-LBGF. Compared with fee-for-service Medicare, Medicare Advantage improves healthcare utilization rates and may also lead to better health outcomes. Christie Teigland et al., *Utilization and Efficiency Under Medicare Advantage vs. Medicare Fee-for-Service* 9, https://perma.cc/8FXU-SXLH (Harvard-Inovalon study).

Medicare Advantage enrollees report at least as much if not more satisfaction with their coverage than those in fee-for-service Medicare. *See* Nancy Ochieng & Jeannie Fuglesten Biniek, KFF, *Beneficiary Experience, Affordability, Utilization, and Quality in Medicare Advantage and Traditional Medicare* (2022), https://perma.cc/FK95-XYWA. And Medicare Advantage enjoys

broad legislative support: Senate majority leader Chuck Schumer and 60 other Senators recently wrote to CMS to underscore that Medicare Advantage is a "critical choice for current and future Medicare beneficiaries." Letter from 61 Senators to CMS (Jan. 26, 2024), https://perma.cc/45HY-AKQV.

The broad-brush criticisms are an especially poor fit here because the City's plan is not just any Medicare Advantage plan, but a specialized, employer-sponsored plan known as an Employer Group Waiver Plan ("EGWP," pronounced "egg-whip"). Over five million retirees are in Medicare Advantage EGWPs, capturing over half of large employers still offering healthcare coverage in retirement—an increasingly rare benefit. Laura Skopec & Stephen Zuckerman, Urban Institute, *Medicare Advantage Employer Group Waiver Plans* 1 (2024), https://perma.cc/Q2TE-8NCC; Meredith Freed et al., KFF, *Medicare Advantage Has Become More Popular Among the Shrinking Share of Employers that Offer Retiree Health Benefits* (2023), https://perma.cc/YPV2-W5R7. That includes New Jersey, Connecticut, Pennsylvania, Illinois, and Michigan, the MTA, healthcare unions like 1199SEIU, and public employee

unions. Skopec & Zuckerman, *supra*, at 8; Nancy Ochieng et al., KFF, *Medicare Advantage in 2023: Enrollment Updates and Key Trends* (2023), https://perma.cc/L7DS-EMY5; Aff. of Richard A. Frommeyer, *Bentkowski v. City of N.Y.*, Index No. 154962/2023 (Sup. Ct. N..Y. Cnty. May 31, 2023), NYSCEF No. 69.

EGWPs are popular in large part because employers can customize them to offer retirees superior benefits. Skopec & Zuckerman, *supra*, at 14. The Aetna plan that the City will offer includes features unheard of in individual plans on the private market, such as an expanded, nationwide service area allowing retirees to see network and out-of-network providers at the same level of benefits and cost share, a dramatic reduction in prior-authorization requirements, lower copays and deductibles, and a lower out-of-pocket maximum.

The City's plan is likely the most generous EGWP in the country. It is thus no surprise that municipal unions—including those associated with larger and on-average older retiree populations—overwhelmingly approved the plan. NYSCEF No. 61 at 9–10; R907–09; *see also* Claudia Irizarry Aponte, *City Union Leaders Approve*

Controversial Medicare Advantage Retiree Health Care, The City, Mar. 9, 2023, https://perma.cc/VAH9-A6W7 (unions representing vast majority of municipal workers and soon-to-be retirees approved transition).

Medicare Advantage plans in general, and EGWPs in particular, are an alternative and often superior means through which Medicare funding addresses the country's healthcare needs. Petitioners and amici are free to press their policy disagreements to lawmakers, but those disagreements have no bearing on the meaning of Administrative Code § 12-126.

POINT I

NOTHING IN § 12-126 COMPELS THE CITY TO PAY FOR ALL PLANS IT MAKES AVAILABLE TO RETIREES

A. Petitioners fail to offer a consistent, coherent, or viable interpretation of § 12-126.

Despite spilling tens of thousands of words in three different courts, petitioners still cannot explain exactly what their interpretation of § 12-126 is. At times, petitioners appear to echo the lower courts' view that the City would satisfy § 12-126 by simply offering one premium-free plan, but that if the City instead allows people to

decline that plan and elect to enroll in optional plans, the law requires it to pay for those too, up to the statutory cap (*see* Brief for Petitioners-Respondents ("Resp. Br.") 27, 33, 36, 39 (suggesting the City must pay for plans that are "offered" or "available")).

At other times, petitioners pivot to what seems to be their preferred position, arguing that § 12-126 requires the City to offer retirees a "choice" among multiple premium-free plans—just how many, petitioners cannot say (*see* Resp. Br. 2, 6, 26, 29–32, 36, 45–46). While that argument is incorrect, it is not even available to petitioners here. After all, they concede that the lower courts' rulings and the permanent injunction *allow* the City to offer only one premium-free plan and cancel all other plans. Though petitioners are mistaken in describing this deliberate outcome as an "unintended loophole" (Resp. Br. 23), that is beside the point.

The fact remains that the lower courts' rulings and the permanent injunction do not require the City to provide retirees with any choice—one premium-free plan will suffice. And because petitioners failed to pursue a cross-appeal at any stage, they are bound by that determination—in this case and in future litigation. *See*

Buechel v. Bain, 97 N.Y.2d 295, 303–04 (2001) (collaterally estopping relitigation of previously decided issue); *Hecht v. City of N.Y.*, 60 N.Y.2d 57, 61–63 (1983) (relief to nonappealing party generally unavailable). So there are really only two options available at this point: (1) affirm a result that satisfies no one, which pushes toward a world where the City stops offering optional plans, even though that was never its preference;[2] or (2) reverse and vacate the permanent injunction, holding that so long as the City offers at least one premium-free plan to retirees, it can also take the further step of making optional plans available to retirees who may prefer them and choose to pay for them.

The first path still leads to the conclusion that the City's current approach is lawful—since not just one, but two, premium-free plans will be offered to retirees (*see* City Br. 25–26 (explaining how

[2] As noted in our opening brief, in a separate litigation, Supreme Court enjoined the City from transitioning to a new retiree plan from Aetna based on the court's view that the City's past descriptions of its existing healthcare offerings constituted perpetual promises not to change them, and because Admin. Code § 12-126 allegedly prohibited direct federal funding to insurers in the City's healthcare offerings, though the City's offerings have included plans receiving direct funding for decades (City Br. 26–27). The City's appeal from that order is fully briefed before the First Department. *Bentkowski v. City of N.Y.*, A.D. No. 2023-04716.

the City will offer an Aetna Medicare Advantage PPO plan and the HIP VIP HMO plan, both premium-free)). But the second path is the vastly preferable one, as it would also enable the City to leverage its substantial bargaining power to offer a suite of optional plans to retirees, who may elect to pay for those plans while continuing to have the City cover their Medicare Part B premiums to the tune of nearly $2000 per person, per year. Only that path leads to more retiree choice, and § 12-126 hardly bars such an approach.

B. The City's reading of the statutory text is the far better one, but the City would prevail even with petitioners' misplaced focus.

As we have shown, the plain text of § 12-126 requires that the City make one premium-free plan available to each category of insured (*see* City Br. 29–36). The term "health insurance coverage" is defined in singular terms as "[a] program of hospital-surgical-medical benefits." When that definition is substituted into the operative sentence, the City must "pay the entire cost of a program of hospital-surgical-medical benefits for city employees, city retirees, and their dependents" (*id.* at 31 (cleaned up)). Providing each insured a

premium-free plan with hospital-surgical-medical benefits satisfies that obligation.

It is as simple as that. No matter how much petitioners may wish it to be so, nothing in § 12-126 requires the City to pay for all the plans it makes available up to the statutory cap. The text pointedly does *not* require the City to pay the entire cost of "all plans" or "every plan" offered or available. Even if the text referred to "plans" in the plural—and it does not even do that—words in the "plural number include the singular," Gen. Constr. Law § 35—meaning that even such hypothetical language could still be satisfied by offering a single plan. Petitioners are trying to conjure an obligation that can be found nowhere in the text.

That may be why petitioners do not get to the statutory text until deep into their brief. Then, they begin by arguing that § 12-126's use of the "the word 'program' … refer[s] to the entire array of health insurance plans by the City" (Resp. Br. 36). But petitioners sprint past the most important point there: nothing in § 12-126 dictates the content of the City's "program," other than requiring it to provide "hospital-surgical-medical benefits." The law

leaves the task of defining the contours of the free program to the City's discretion, subject to collective bargaining.

Imagine a situation where the City offered a total of two premium-free plans—one for Medicare-eligible individuals and a second for everyone else. That would still be a "program" under any reasonable understanding of the term. And even if the term could be twisted to somehow require more than one premium-free plan for *each* category of insured, the City would satisfy that understanding too, because it will offer two premium-free plans to Medicare-eligible retirees, the only category of insured at issue here (*see* City Br. 25–26). Any way you slice it, the law's use of the term "program" gets petitioners nowhere near a mandate that the City must pay for all the plans made available, because nothing in the law dictates that a § 12-126 "program" must include all plans on offer.

Nor can petitioners fill the gap by observing that § 12-126 requires the City to offer insurance benefits through "contracts" with "companies" (Resp. Br. 38–39). Those plural terms are perfectly compatible with the City offering a single premium-free plan to each category of insured. While petitioners try to deny it, the record

is clear that the City has repeatedly established a *single* "hospital-surgical-medical" plan through *multiple* contracts with *multiple* companies—one a medical-benefits insurer and the other a hospitalization insurer (*see* City Br. 35; *see, e.g.*, R1342, 1347, 1350–51, 1360–61, 1366–67, 1369 (noting separate contracts with separate insurers to provide single plan)). In any case, retirees are not the only category of insured: the City offers multiple plans—secured through "contracts" with "companies"—to active employees, retirees, and their dependents. And again, even if this language could be twisted to require more than one premium-free plan for each category of insured, the City would still satisfy it.

C. Petitioners' distortions of the legislative history and past practice cannot create an obligation that appears nowhere in § 12-126.

Petitioners cannot rewrite § 12-126 through their misguided—and at times outright misleading—gloss on the legislative history (Resp. Br. 29–32, 39). Their argument openly foregrounds supposed legislative "intent" and relegates text (Resp. Br. 29–35). But it is a case study in how malleable and misdirected that approach can sometimes be. As we have explained (*see* City Br. 36–

38), petitioners rely almost entirely on language that the City Council chose *not* to incorporate in the law, as if "adding words that are not there" were a valid means of determining legislative intent. *Aybar v. Aybar*, 37 N.Y.3d 274, 283 (2021).

For instance, petitioners attempt to import language from a 1965 Board of Estimate resolution ("Resolution 292") into the later-enacted § 12-126 (Resp. Br. 39–40). But while § 12-126 did borrow some language from Resolution 292, the City Council pointedly did not adopt the language that petitioners cite. Resolution 292 expressly referenced the City's then-existing decision to pay for retirees' "*choice* of health and hospital insurance" and described the specific contents of that choice (R1344 (emphasis added)). But no such language can be found in § 12-126, and so the relevance of Resolution 292 is the exact opposite of what petitioners claim. By eschewing the language about "choice," the City Council rejected the kind of obligation that petitioners now contend § 12-126 imposes via breadcrumb trail.

Indeed, proposed bill language that would have required the City to pay for "the entire cost of *any* basic health insurance plan"

(R1324, 1326) was scrapped following Mayor Lindsay's veto. The removal of that language in response to the Mayor's financial concerns is compelling evidence that the City Council did so intentionally. *Chem. Specialties Mfrs. Ass'n v. Jorling*, 85 N.Y.2d 382, 394 (1995).

Petitioners also continue to rely heavily on a "zombie" committee report that addressed outdated bill text bearing no resemblance to the enacted law (Resp. Br. 34). As detailed in our opening brief (City Br. 37–38), even after the bill's language was overhauled from top to bottom following the Mayor's veto, the committee report remained verbatim unchanged—every jot and every tittle. For example, the report makes no mention of the statutory cap added to the revised bill, rendering its description of the City's payment obligation plainly inaccurate (R1327). Nor does the report mention the significant changes to the bill's scope in response to the Mayor's veto (City Br. 37–38 & n.5). Petitioners have no answer for this—they do not even attempt one.

With nothing of significance to say about § 12-126's legislative history, petitioners observe in passing that the City Council

recently declined to amend § 12-126 (Resp. Br. 23). But legislative inaction "affords the most dubious foundation" for statutory interpretation. *Clark v. Cuomo*, 66 N.Y.2d 185, 190–91 (1985). The Council's non-action has no bearing on the meaning of § 12-126—and indeed, petitioners do not argue otherwise.

Petitioners also misconstrue the City's past practice of paying for their preferred plan, Senior Care (Resp. Br. 40–41). The record demonstrates that the City has paid for Senior Care as a result of collective bargaining, even when the cost of doing so exceeded § 12-126's statutory cap (City Br. 14–16). And petitioners similarly mischaracterize the City's past statements on this topic: the City's pleading in *City of New York v. Group Health Inc.*, No. 06-cv-13122 (S.D.N.Y. Nov. 13, 2006), did not endorse petitioners' view of § 12-126 and instead confirmed that the City has paid for multiple plans "through its collective bargaining agreements." Compl. ¶¶ 30–31, *Grp. Health Inc.*, No. 06-cv-13122. Nor can petitioners elevate a passing statement in a letter from city attorneys, which overall emphasized the City's ability to adapt to industry conditions under

§ 12-126, as proof of the law's meaning. What the law says—and does not say—speaks for itself.

D. The extra-textual obligation that petitioners try to manufacture would undermine retiree choice for no good reason.

Petitioners openly argue that, under their understanding of § 12-126, the City would have "no incentive" to adjust its healthcare offerings as the market and regulatory landscape evolve—even over decades—because "its payment obligation would remain the same regardless" (Resp. Br. 46). But petitioners never grapple with how odd it would be for the City Council to require the City to pay the same amount for any healthcare offering, leaving no space for market competition or other developments to achieve taxpayer savings.

Forcing the City to pay for all healthcare plans—not just a premium-free offering—up to the price of the applicable HIP-HMO plan would mean that a competitor who might otherwise offer premiums lower than HIP would have little incentive to do so knowing that the City's payment mandate was tied to HIP's rates. It would likewise blunt the incentive for *HIP* to ensure competitive rates. As pertinent here, petitioners' fiscally indifferent interpretation would

deny City taxpayers the full benefit of Medicare funding that they already pay federal taxes to provide—giving insurance companies a financial windfall instead.

Ironically, petitioners' understanding of § 12-126 would not even deliver on retiree choice. If their understanding were adopted, the City's obligation could still be satisfied by offering *two* premium-free plans, rather than one. And § 12-126 would still have nothing to say about the content of those plans, other than requiring that they provide "hospital-surgical-medical benefits." So in times of financial stress, petitioners' reading would leave the City little alternative but to remove retiree options—rather than simply allow competition on price—thus limiting the very "choice" that petitioners claim to protect (Resp. Br. 46–47). The City Council could not have intended such a self-defeating design.

Petitioners are thus left to suggest that the City should simply deplete its fiscal reserves (Resp. Br. 9–10 & n.10). But stakeholders from all quarters have called on the City to build those reserves, which the City already relies on to bridge shortfalls and which are critical to weathering financial crises. *See, e.g.*, Brad Lander, N.Y.C.

Comptroller, *Preparing for the Next Fiscal Storm* (2022), https://perma.cc/M687-HVJC; Ana Champeny, *The Record on Reserves*, Citizens Budget Comm'n (Feb. 28, 2022), https://perma.cc/PB8X-RQKD. And there is no doubt that closing the City's yearly budget gaps requires finding billions of dollars in savings—including by reducing healthcare costs. *See, e.g.*, Ana Champeny & Julia Nagle, Citizens Budget Comm'n, *Don't Step Off the Cliff: Fiscal Cliffs and Budget Gaps in New York City's Fiscal Year 2025 Preliminary Budget* (2024), https://perma.cc/JLE7-H4K5 (noting $3.6 billion deficit for 2025 and projecting $9.7 billion shortfall in 2028).

Petitioners also mischaracterize the Health Stabilization Fund (Resp. Br. 8), which funds a variety of critical benefits for both employees and retirees (City Br. 20). Yet petitioners ignore that in less than five years, the fund's short-term assets have dwindled from $1 billion to just $69 million. Thomas P. DiNapoli, Office of the N.Y. State Comptroller, *Review of the Financial Plan of the City of New York* 31 (2023), https://perma.cc/8MHA-YQ9G. That shortfall forced the City to sharply increase healthcare expenditures in

2023 to over $7 billion, a cost that is expected to rise to over $8 billion by 2027 if the Stabilization Fund is not replenished—outpacing all other City spending in the same period. *Id.* at 32. Petitioners' reading of the local law would thus leave the City no choice but to limit the options available to retirees, an outcome that the City Council could not have intended.[3]

POINT II

PETITIONERS' VIEW OF THE STATUTORY CAP RENDERS IT MEANINGLESS AND UNPRINCIPLED

After arguing that § 12-126 is designed to ensure that the City will never pay below the statutory cap—turning the cap into a floor as well as a ceiling—petitioners proceed to advance an interpretation of the cap that makes it all but meaningless for Medicare-eligible retirees. By that two-step, petitioners would have the Court thoroughly delete fiscal prudence from the equation.

Fortunately, the text of the actual law does not. As we have noted, nothing in the law bars the City from offering optional plans

---

[3] As noted above, *supra* 8 n.2, the City has appealed the injunction barring the transition to a new Aetna plan, which is based on legal theories that are not at issue in this appeal.

to retirees who choose to pay for them. But even if that were not so, any obligation to subsidize additional plans would be capped at the "full cost of H.I.P.-H.M.O. on a category basis." § 12-126(b)(1). When HIP-HMO products became the statutory cap in 1984, the only HMO from HIP offered to Medicare-eligible retirees was a Medicare-funded plan—in 1984, a Medicare Advantage precursor—that is enormously less expensive than an active-employee plan because the federal government subsidizes it (R1414). Petitioners want to force the City to pay up to the higher rate for the active-employee HIP-HMO, yet offer not one valid reason that the City Council would have enacted a bill that ignores the core reality that insurance coverage for Medicare-eligible retirees is *dramatically* less expensive because it is heavily subsidized by the federal government.

A. Petitioners' misguided preservation objection ignores that the issue was reached and resolved in Supreme Court.

While petitioners spill a lot of words on their preservation objection (Resp. Br. 48–55)—a sure sign they would rather not talk about the merits—the issue could not be simpler. Before Supreme Court, the City (and an amicus) argued that the statutory cap for

Medicare-eligible retirees is the HIP-HMO plan available to them; petitioners responded to that argument; the court resolved the question on the merits over petitioners' objection that it was raised too late; and in so doing, the court confirmed that it had considered all the submissions addressing the question (R7–9, 1970–71; NYSCEF No. 205 at 15–16; NYSCEF Nos. 208, 213). Petitioners' preservation objection is meritless.

To be sure, petitioners *claim* that the City never made the cap argument in Supreme Court (Resp. Br. 48). But their own brief—buried in two footnotes—puts the lie to that claim (Resp. Br 21 n.20, 49 n.35).[4] Petitioners' real complaint is that the City should have raised the argument *earlier* before Supreme Court. But that is not a preservation problem where Supreme Court reached the point.

Perhaps Supreme Court could have declined to reach it on the basis that the City should have raised it sooner (*see* Resp. Br. 50

[4] It is likewise false that the City "affirmatively conceded" their view of the statutory cap (Resp. Br. 48–49). That argument mischaracterizes the City's papers (Resp. Br. 49 & n.35), which at times described *petitioners'* view of the statutory cap and otherwise posed arguments in the alternative without adopting petitioners' position (*see* NYSCEF No. 201 at 2, 5). In any event, the City's later letter made clear it was not conceding the point and Supreme Court entertained it.

(citing cases to this effect)), but the court did not do so. Instead, it heard petitioners' objection to that effect and nonetheless resolved the question on the merits—the critical point that the Appellate Division failed to acknowledge and petitioners do their best to ignore (R1998). The bottom line is that the issue was raised and resolved in Supreme Court, and it is undisputed that the City raised the argument before the Appellate Division. That is the end of any preservation objection.

Regardless, the meaning of § 12-126 is a purely legal question. Whether the cap "on a category basis" refers to the HIP-HMO plan that's available to Medicare-eligible retirees or to a plan that's irrelevant for them is a question of statutory interpretation, and § 12-126's meaning on this point can be discerned from the plain text. *See Am. Sugar Refining Co. v. Waterfront Comm'n*, 55 N.Y.2d 11, 25 (1982) (statutory interpretation is not susceptible to factual rebuttal). Like the Appellate Division (R1998), petitioners suggest that determining the "current cost" of the applicable HIP-HMO plan is a factual issue (Resp. Br. 53), but they have already conceded that HIP VIP HMO costs $7.50 per person per month. *See* Aff.

of Marianne Pizzitola ¶ 34, *Bentkowski v. City of N.Y.*, Index No. 154962/2023 (Sup. Ct. N..Y. Cnty. May 31, 2023), NYSCEF No. 5. And even if a live dispute still existed on that issue, this Court need not determine the current cost to resolve the law's meaning. The question is simply whether § 12-126's language capping expenditures for Medicare-eligible retirees at "the full cost of H.I.P.-H.M.O. on a category basis" refers to the Medicare-dependent HIP-HMO available to those retirees, or the far more expensive HIP-HMO available to everyone else.

And because this is an issue of statutory interpretation, any further factual development is irrelevant. *Am. Sugar Refining*, 55 N.Y.2d at 25. There is no dispute that HIP has offered different HMO plans for Medicare-eligible retirees and those ineligible for Medicare since the local law's enactment, that the latter plans cost far more than plans for those eligible for Medicare, and that the City has historically paid for both the HIP offerings and Senior Care. Additional information about HIP's contracts and the City's past payment practices thus have no bearing on the City Council's meaning when it adopted the statutory cap. Nor does this result

change because petitioners hope to find additional legislative history supporting their view, as nothing prevented them from offering that history, if any, on appeal. *See State v. Green*, 96 N.Y.2d 403, 408 n.2 (2001) (allowing judicial notice of legislative history).

And the issue calls out for resolution. The Appellate Division acknowledged that the first issue in this appeal, whether § 12-126 requires the City to pay for all plans offered, was an issue of "pure statutory interpretation" (R1997–98). Yet at the same time, the court concluded that the statutory cap appearing in the very same sentence imposing the City's payment obligation somehow raised "factual issues" that required further record development (R1998). That incomplete and incoherent disposition—concluding that the City had an obligation to pay for all plans offered but declining to say how much—is an interpretive issue dependent on the law's plain text that this Court should address.

B. Petitioners' interpretation of the statutory cap ignores the text, as well as Medicare's wide-ranging impact on retiree healthcare.

Turning to the merits, this Court should reject petitioners' claim that the relevant HIP-HMO plan for Medicare-eligible

retirees is a plan that is available only to people who are not eligible for Medicare. Because of Medicare's availability, the cost to the City of insuring Medicare-eligible retirees is *dramatically* lower than the cost for those ineligible for Medicare. A cap that fails to recognize that basic reality renders the cap a nullity for the category of Medicare-eligible individuals. For instance, petitioners openly argue that the current $776 cap for Medicare-ineligible enrollees also applies to Medicare-eligible ones (Resp. Br. 56), even though the $776 amount is four times greater than the premiums for their current Medigap plan. Only the clearest expression of legislative intention should suffice to support such a radical outcome.

Petitioners muster nothing close. The text of § 12-126 confirms the City Council intended a meaningful apples-to-apples comparison. The relevant comparison for Medicare-eligible retirees is the HIP-HMO available to those individuals—known as HIP VIP HMO—not the radically more expensive HIP-HMO that is only available to people ineligible for Medicare (R1293). *See* N.Y.C. Office of the Actuary, *Fiscal Year 2019 GASB 74/75 Report* 126 (2019), https://perma.cc/Q9R3-GEMQ (identifying the substantial

gap in premiums between the "HIP HMO" plan for Medicare-eligible retirees and the "HIP HMO" plan for others).

Petitioners cannot dispute that—both at the time of the relevant enactment and now—two HIP HMO products were and are offered: one for those eligible for Medicare and another for those who are not.[5] The unavoidable question is therefore *which* of those HIP HMO products sets the cap for Medicare-eligible persons. And that question answers itself. Even absent specific text, the City Council must be presumed to have established a cap that is meaningful rather than arbitrary—to have intended that the comparison for Medicare-eligible individuals be based on a plan that is available to them, is actuarially relevant to them, and accounts for the dramatic effect of federal funding on premiums, rather than a plan

---

[5] There is no relevance to petitioners' observation that HIP has at times offered more than one HMO to Medicare-eligible retirees, especially where only one such HMO existed when the statute was amended to refer to HIP, just as is true today (R1411, 1414). *See* N.Y.C. Office of Labor Relations, *New York City Employee Benefits Program* 4, 26 (1986), https://perma.cc/L9NX-Y3Y8 ("1986 SPD") (describing HIP/Medicare Supplemental Program). Equally irrelevant is petitioners' claim that the City intended to discontinue HIP VIP HMO (Resp. Br. 64 & n.45), where even the cited document confirms that the plan would have continued indefinitely and it is undisputed that the City's current proposal ensures that HIP VIP HMO remains an option. See City of N.Y., *Mayor Adams, OLR Commissioner Campion Announce Signing of Medicare Advantage Contract*, Mar. 30, 2023, https://perma.cc/AFZ5-U5AB.

that fits none of those bills. *See Bank of Am. N.A. v. Kessler*, 39 N.Y.3d 317, 324–25 (2023) (courts must interpret statute "to avoid an unreasonable or absurd application of the law").

But the matter becomes only clearer when one considers the full sweep of the law's text. The understanding that the cap for Medicare-eligible individuals should be based on a plan for Medicare-eligible individuals was expressly built into the law through (a) the text setting the cap at "the full cost of H.I.P.-H.M.O. *on a category basis*," and (b) the law's consistent and explicit recognition that healthcare coverage "predicated on the insured's enrollment in [Medicare]" is its own distinct category of coverage. § 12-126(b)(1), (b)(2)(i)–(iv) (emphasis added).[6]

On the first point, petitioners contend that "category basis" refers only to individual versus family coverage (Resp. Br. 58). But while it certainly does refer to individual versus family—a category the law alludes to with its reference to "dependents"—there is no reason to conclude that those are the only categories relevant to

[6] Section 12-126 refers to Medicare as "the hospital and medical program for the aged and disabled under the Social Security Act." § 12-126(b)(1). *See* Social Security Amendments of 1965, Pub. L. 89-97, 79 Stat. 286 (creating Medicare).

§ 12-126. That is especially when the cost disparities between individual versus family coverage and Medicare-eligible versus Medicare-ineligible coverage are at the very least comparable. And stepping back, the reference to "category basis" confirms what common sense would suggest: that the legislature intended the comparison to be an apples-to-apples one. Nor can petitioners point to anything in the local law or even the Board of Estimate resolutions that excludes Medicare eligibility as a relevant category (Resp. Br. 58–59).

In any event, the second textual point seals the deal. Section 12-126 expressly and repeatedly distinguishes between healthcare coverage for (a) those eligible for Medicare and (b) those who are not. Section 12-126 thus itself recognizes that coverage between those two categories is *different*: those ineligible for Medicare get full coverage, while those who are eligible receive "health insurance coverage … predicated on the insured's enrollment in [Medicare]." In at least five different places, the local law distinguishes in close succession between (a) "health insurance coverage" *simpliciter* and (b) "health insurance coverage which is predicated on the insured's enrollment in [Medicare]." § 12-126(b)(1), (b)(2)(i)–(iv). The text

thus expressly confirms that Medicare-eligible individuals constitute their own category, distinct from others. Indeed, the obvious reason that the law envisions coverage requiring Medicare enrollment is that doing so helps control costs—the same objective served by the cap.

Petitioners argue that "there is and always has been one single insurance plan that sets the statutory cap," which they claim is the plan for active employees (Resp. Br. 57). But that is simply false: the City does not pay up to the "active" HIP HMO price for Medicare-eligible enrollees—and indeed the City has paid far less than that amount towards expensive "deluxe" plans that have been made available to Medicare-eligible persons over the years, where enrollees were required to pay hundreds in monthly premiums. And, contrary to petitioners' suggestion that the cap has always been meaningless because the City Council always chose "the most expensive healthcare plan" for it (Resp. Br. 33, 61), several plans from the period of § 12-126's 1984 amendment demonstrate that HIP HMO for active employees was far from the most expensive

option. *See, e.g.*, 1986 SPD at 30–31 (listing non-HIP plans requiring employee contributions).[7]

Petitioners' contention also simply ignores that the offering identified in § 12-126, including upon its original enactment, has always distinguished between those eligible for Medicare and those who were not. Since 1966, those ineligible for federal benefits were entitled to complete coverage through the City, while Medicare-eligible retirees received less expensive coverage that Medicare subsidized (*see* R1339 (noting that Medicare-eligible retirees were required to enroll in Medicare to receive full benefits upon § 12-126's enactment); R1414–17 (HIP-HMO offered "primary" coverage to those under 65 but did not "duplicate" federal benefits for Medicare-eligible retirees)).[8]

---

[7] The same publication demonstrates the falsity of petitioners' claim that all plans were free up to at least 2004 (Resp. Br. 62 & n.42). Since at least 1986, soon after the local law was amended to refer to HIP HMO, the City has offered "deluxe" plans to Medicare-eligible retirees requiring them to make additional premium payments. *See* 1986 SPD at 30 (noting plan imposing additional retiree premiums).

[8] Here too, petitioners falsely claim that the City conceded their argument (Resp. Br. 57), but the City's brief cited for that proposition never identified the "particular plan" that applied to petitioners (NYSCEF No. 201 at 2–3). Nor does *New York 10-13 Ass'n v. City of New York*, No. 98 Civ. 1425 (JGK), 1999 U.S. Dist. LEXIS 3733, at *36 (S.D.N.Y. Mar. 30, 1999).

The practical effect of petitioners' shortsighted reading confirms its flaws. As noted, the City currently offers many plans to Medicare-eligible retirees other than petitioners' chosen plan, including some "deluxe" plans that require enrollees to pay hundreds of dollars per month. *See, e.g.*, N.Y.C. Office of Labor Relations, *Retiree Health Plan Rates as of Jan. 1, 2022* (2021), https://perma.cc/HFM8-8463. If § 12-126 forced the City to ignore the role that Medicare plays and pay up to the $776 active-employee rate for every retiree, even those who seek the most expensive insurance, the City's taxpayers would realize little to none of the benefits of Medicare's funding. Instead, those select retirees would reap a windfall in the form of free "deluxe" insurance on top of the benefits that the federal government already provides. The City Council, which specifically provided that some retirees would receive insurance "predicated on" enrollment in Medicare, could not have intended that result.

Petitioners' remaining efforts to rewrite § 12-126 also fail. That the City has historically paid for Senior Care is irrelevant (Resp. Br. 63), given that the City did so pursuant to its collective

bargaining agreements, not § 12-126 (City Br. 14–15). Contrary to petitioners' claims (Resp. Br. 62 n.43), that practice is also apparent from the record (R1282–83, 1294 (noting that Senior Care was designated as a "benchmark" plan by agreement with municipal unions); NYSCEF No. 61 at 3–5 (same)). The more telling fact is that the City long has *not* paid the full premium for the "deluxe" Medigap plans, as petitioners' position would seemingly require.

Finally, petitioners also contend that even if they are wrong about the statutory cap, this Court should still affirm because HIP VIP HMO is funded directly by the federal government, and including those subsidies in the cost of the plan would make the cap exceed the cost of Senior Care. But § 12-126's mandate to pay for "the entire cost of healthcare coverage" does not include federal subsidies—which of course reduce the costs of *all* plans for Medicare-eligible persons. § 12-126(b)(1). Instead, the City is obliged only to pay for the cost of the "insurance contracts entered into between the city and [insurance] companies," *i.e.*, plan premiums. § 12-126(b)(1), (a)(iv). The state-level enabling statutes likewise confirm that the City's payment obligation is tied to "the sum to be paid under such

contract[s]" with insurers. Gen. City Law § 20(29), (29-a); *see* Gen. Mun. Law § 92-a(2) (authorizing City to pay amount "under such contract" with insurers). Here again, petitioners' approach is contrary not just to the governing text, but to good sense, as it would operate to nullify the benefit of federal Medicare funding for the City's taxpayers, all for no discernible benefit to retirees beyond serving petitioners' particular preferences.

CONCLUSION

The Court should reverse and deny the petition.

Dated: New York, NY
February 26, 2024

Respectfully submitted,

HON. SYLVIA O. HINDS-RADIX
Corporation Counsel
of the City of New York
Attorney for Appellants

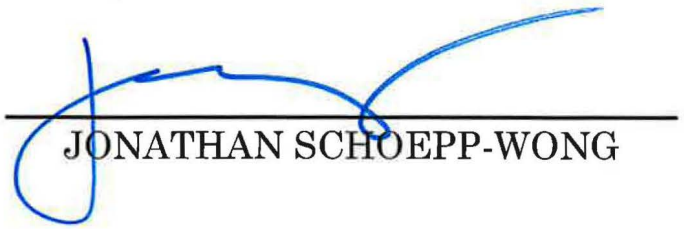
By: _____
JONATHAN SCHOEPP-WONG
Assistant Corporation Counsel

100 Church Street
New York, NY 10007
212-356-2275
jschoepp@law.nyc.gov

RICHARD DEARING
DEVIN SLACK
JONATHAN SCHOEPP-WONG
of Counsel

CERTIFICATE OF COMPLIANCE

I hereby certify that this brief was prepared using Microsoft Word, and according to that software, it contains 6,351 words, not including the table of contents, the table of cases and authorities, the statement of questions presented, this certificate, and the cover.



JONATHAN SCHOEPP-WONG

APL-2023-00086

Court of Appeals
State of New York

In the Matter of the Application of

NYC ORGANIZATION OF PUBLIC SERVICE RETIREES, INC., LISA FLANZRAICH, BENAY WAITZMAN, LINDA WOOLVERTON, ED FERINGTON, MERRI TURK LASKY, and PHYLLIS LIPMAN,

Plaintiffs-Respondents,

against

RENEE CAMPION, CITY OF NY OFFICE OF LABOR RELATIONS, and THE CITY OF NEW YORK,

Defendants-Appellants.

AFFIRMATION OF SERVICE BY MAIL

JONATHAN SCHOEPP-WONG, affirms under the penalties of perjury under the laws of New York, which may include a fine or imprisonment, that the following is true and that this document may be filed in an action or proceeding in a court of law: on February 26, 2024, I served three copies of the accompanying reply brief on all parties by regular U.S. mail, depositing the same in an official depository of the U.S. Postal Service within the state, with first-class postage prepaid, addressed to the following:

Steve Cohen
POLLOCK COHEN LLP
111 Broadway, Suite 1804
New York, New York 10006
212-337-5361
scohen@pollockcohen.com
Attorney for Respondents

Jacob S. Gardener
WALDEN MACHT & HARAN LLP
250 Vesey Street, 27th Floor
New York, New York 10281
212-335-2030
jgardener@wmhlaw.com
Attorney for Respondents

Dated: New York, New York
February 26, 2024

JONATHAN SCHOEPP-WONG
Assistant Corporation Counsel

100 Church Street
New York, New York 10007
212-356-2275
jschoepp@law.nyc.gov