To Be Argued By:
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Time Requested: 15 Minutes

APL-2023-00086

New York County Clerk's Index No. 158815/2021
Appellate Division, First Department Case No. 2022-01006

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,

Petitioners-Respondents,

against

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

Respondents-Appellants.

BRIEF FOR PETITIONERS-RESPONDENTS

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Date Completed: January 23, 2024

DISCLOSURE STATEMENT

Petitioner-Respondent NYC Organization of Public Service Retirees, Inc. is a New York not-for-profit corporation with no parent companies and no subsidiaries or affiliates.

STATEMENT OF THE STATUS OF RELATED LITIGATION

A related case is *Bentkowski, et al. v. City of N.Y., et al.* (N.Y. Cnty. Index No. 154962/2023), which is currently on appeal before the Appellate Division, First Department (Case No. 2023-04716). Like the present litigation, *Bentkowski* involves the healthcare rights of Medicare-eligible retired New York City workers. Retirees brought that case after the City of New York altered its retiree healthcare policy in response to the present litigation.

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PRELIMINARY STATEMENT

This case is about the healthcare rights of Medicare-eligible (*i.e.*, elderly and/or disabled) retired New York City municipal workers and their Medicare-eligible dependents (collectively, "Retirees"). The statutory source of those rights is New York City Administrative Code § 12-126 ("Section 12-126"). Section 12-126 requires the City to provide health insurance coverage to Retirees, among others, and to pay for such insurance up to a maximum amount (the "statutory cap"). The statute states, in relevant part: "The city will pay the entire cost of health insurance coverage for city employees, city retirees, and their dependents, not to exceed one hundred percent of the full cost of H.I.P.-H.M.O. on a category basis." Admin. Code § 12-126(b)(1). "Health insurance coverage" is defined to mean the City's entire "program of [health] benefits." *Id.* § 12-126(a)(iv).

The City's Health Benefits Program has always offered Retirees a selection of health insurance plans (usually around a dozen). Since Section 12-126 was passed in 1967, the City has consistently—and correctly—interpreted the law to mean that it must pay up to the statutory cap for *all* of these plans. Thus, for the past 56 years, the City

has funded whichever plan a Retiree has chosen for herself. That is an essential benefit for these senior citizens and disabled first responders, many of whom live pension-check-to-pension-check with serious health problems. Indeed, the right to lifelong City-funded health insurance of one's choice is a main reason Retirees worked—and in many cases risked their lives—for the City.

After more than half a century of honoring and explicitly acknowledging this statutory right, the City has decided to violate it. In 2021, the City announced that it would stop funding Retirees' health insurance. Retirees were given a choice: either pay thousands of dollars a year to keep their preferred health insurance plan or enroll for free in a new, federally funded (and far inferior) plan called the NYC Medicare Advantage Plus Plan ("MAPP").

For decades, the vast majority of Retirees have chosen to enroll in a plan called Senior Care, which offers virtually unrestricted access to medical providers and full coverage for whatever services those providers prescribe. By contrast, the now-defunct MAPP would have offered limited access to providers and coverage only for services the insurer deemed necessary. Because most Retirees cannot afford to pay

thousands of dollars a year for health insurance, the City's new healthcare policy would have forced them to enroll in the MAPP. As a result, many would have lost access to their doctors and all would have been subject to routine denials of coverage.

Despite the significant problems with the MAPP, the City claims that forcing this federally funded plan on Retirees was necessary to address rising healthcare costs. However, as the Director of Budget Review for the New York City Independent Budget Office ("IBO") testified, the City's plan to cease funding Retiree healthcare would "provide[] the city with *no actual budgetary savings*."[1] That is because the money saved would go not to the City budget, but rather to a special fund controlled by "the [mayor's] administration and the unions," which do not represent retirees.[2] Mayor Adams's Administration and the union

[1] *Testimony of Jonathan Rosenberg to the New York City Council Committee on Civil Service and Labor Regarding Changes to Municipal Retirees' Healthcare Plan* ("Rosenberg Testimony"), October 28, 2021, https://perma.cc/4WYB-F8Y6 at 1. Unless otherwise indicated, all emphasis in this brief has been added, and all internal quotations, citations, and alterations have been omitted.

[2] *Id.* It is black-letter law that unions do not represent retirees. *Kolbe v. Tibbetts*, 22 N.Y.3d 344, 354 (2013) (stating that "once employees retire, they are no longer represented by the union").

umbrella organization (the Municipal Labor Committee ("MLC")) are seeking to defund Retiree healthcare in order to benefit themselves.

Regardless, if actual budget needs conflicted with the City's statutory obligation to pay for Retirees' chosen health insurance, the proper response would be for the City Council to amend Section 12-126—which Mayor Adams recently requested and the City Council refused.[3] The Adams Administration cannot disregard a statutory mandate by citing supposed financial concerns.[4]

In its eagerness to defund Retiree healthcare, the City resorts to making baseless legal arguments that contradict its own decades-long interpretation of Section 12-126.

First, the City contends that Section 12-126 only requires it to pay up to the statutory cap for *one* of the plans in its Health Benefits Program (which the City decided would be the federally funded MAPP). However, the statutory text, legislative history, and 56 years of past practice

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[3] *See* Chris Sommerfeldt, *NYC Council has no plan to pass bill that would let Mayor Adams charge retired city workers for healthcare: 'It's dead'*, NEW YORK DAILY NEWS, Jan. 19, 2023, https://perma.cc/96L7-L6P6 ("Daily News Article").

[4] That is especially so here where the Adams Administration has exaggerated those concerns. The IBO recently concluded that "the city will end 2024 with an additional $3.6 billion in surplus above the Mayor's Office of Management and Budget (OMB) estimate." IBO Report, December 2023, https://perma.cc/H5XF-MET9 at I.

decisively refute that argument. Section 12-126 clearly requires the City to pay up to the statutory cap for *any* health insurance plan a Retiree selects. In fact, the City Council said so when it passed the statute. And the City itself has explicitly and repeatedly acknowledged this statutory obligation in the past, an inconvenient fact the City neglects to mention in its brief. As explained below, the City omits and distorts conclusive proof of the statute's meaning, including the very words of the statute, which require the City to subsidize all of the plans comprising its health benefits "program." Admin. Code § 12-126(a)(iv).

Second, the City contends that Retirees have their own unique statutory cap that is pegged to a plan that costs $7.50 per month (a fraction of the cost of their existing health insurance). Because the City failed to make this argument in any of its briefs or oral arguments in Supreme Court, it is not preserved for this Court's review.[5] Regardless,

[5] The City's failure to preserve this argument may explain why its brief (i) makes so many unsupported factual assertions, (ii) relies on 25 documents outside the record, and (iii) includes numerous record citations that do not actually support the propositions for which they are cited. *See, e.g.*, City's Br. 16 (claiming that the most expensive Retiree plan costs $789, and citing documents in and outside the record, none of which says that), 50 (claiming, without evidence, that "the City has never paid for those more expensive plans").

the argument is wrong, as it is contradicted by undisputed evidence, legislative history, basic logic, and past practice.

In short, the City's arguments regarding Section 12-126 are meritless, as both Supreme Court and the Appellate Division correctly held. Accordingly, this Court should affirm the order below requiring the City to continue paying for Retirees' health insurance regardless of which plan they select.

QUESTIONS PRESENTED

1. Does Section 12-126 require the City to pay up to the statutory cap for Retirees' health insurance coverage regardless of which plan they select?

2. Is the City's statutory cap argument—that Retirees are subject to a unique cap pegged to the $7.50-per-month cost of the HIP VIP Premier Medicare Plan—both preserved and meritorious?

STATEMENT OF THE CASE

A. Background

1. The City attempts to shift the cost of healthcare onto elderly and disabled Retirees.

Through its Health Benefits Program, the City has always offered Retirees a choice of several City-funded health insurance plans. (R148,

913, 1344, 1411, 1733). For decades, the overwhelming majority of Retirees (including all of the Petitioners) have chosen to enroll in a plan called Senior Care, which is administered by the non-profit Group Health Incorporated ("GHI"). (R29, 913). Senior Care is a Medicare supplemental plan, which means it covers the substantial portion of healthcare costs that Medicare does not cover. (R29, 151). With Medicare and Medicare supplemental insurance, there are no provider networks (meaning Retirees can go to any doctor) and essentially no prior authorization requirements (meaning Retirees cannot be denied coverage for medical care ordered by their doctors). (R111, 148, 151).

In 2021, the cost of Senior Care was approximately $192 per person per month ($2,300 per year).[6] (R1998). Without funding from the City, few Retirees could afford this. Indeed, most live on small, fixed incomes: over 70,000 Retirees survive on pensions of less than $1,500 a month; nearly 100,000 survive on less than $2,000; and over 150,000 survive on less than $3,000. *Bentkowski v. City of N.Y.*, Index No. 154962/2023 (Sup.

[6] Senior Care, like other healthcare plans, also offers family coverage for approximately twice the cost of individual coverage.

Ct. N.Y. Cnty.) ("*Bentkowski*"), NYSCEF Nos. 5, 39.[7] Their finances are so strained that Supreme Court and the Appellate Division recently concluded that most cannot even afford $15 copays. *Bianculli v. City of New York Off. of Lab. Rels.*, 216 A.D.3d 560, 561 (1st Dep't 2023).

Despite Retirees' precarious health and finances, the City and the MLC (a union organization that represents only active employees) have teamed up to eliminate City funding for Retiree health insurance. (R29-30). These Retirees are easy targets: they are no longer represented by their former unions, and the savings achieved by defunding their healthcare will go to a special fund controlled by Mayor Adams and unions leaders, with no "accountability or direct oversight." Rosenberg Testimony at 1. In other words, the Adams Administration and the MLC will reap enormous financial benefits if they defund Retiree healthcare, which explains their unusual partnership here.[8]

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[7] *Bentkowski* is a related Retiree healthcare case. We use "*Bentkowski* NYSCEF No." to refer to the Supreme Court docket in that case. We use "NYSCEF No." to refer to the Supreme Court docket in the present case (N.Y. Cty. Index No. 158815/2021).

[8] Many unions opposed the idea of defunding Retiree healthcare. However, the leaders of the most powerful unions in the MLC decided that the immediate financial benefit to their members (active employees who are mostly in their 20s, 30s, or 40s) outweighed inferior health insurance in their distant future.

In July 2021, the City announced that, for the first time in history, it would cease funding Retiree health insurance plans. Retirees were informed that, starting on January 1, 2022, they could either: (1) keep their Medicare supplemental insurance, provided they pay for it themselves; or (2) enroll for free in the inferior new MAPP, which was to be funded entirely by the federal government.[9] (R30-31, 36, 841, 1642). The MAPP, whose inferior features are discussed in the next section, was to be jointly administered by two insurance companies, collectively referred to as the "Alliance." (R30-31).

Because Retirees generally cannot afford to pay thousands of dollars a year for health insurance (and they never budgeted for this unexpected expense), the City's scheme would have forced most of them off of Senior Care and into the materially worse MAPP.

Contrary to the City's suggestion, there was no budgetary justification for this healthcare overhaul. As the IBO's Director of Budget Review testified, the City's plan to stop funding Retiree health insurance would "provide[] the city with no actual budgetary savings." Rosenberg

[9] Under either option, the City would avoid financial responsibility. However, the City would continue to pay for Retirees' Medicare Part B premium, which is a separate (and undisputed) statutory obligation that is not at issue in this case.

Testimony at 1; *see also id*. (stating that "none of this savings will accrue to the city"). That is because all cost savings have been slated to go to "the [mayor's] administration and the unions," not the City budget. Moreover, when the City announced its planned healthcare overhaul, there was no budget crisis. In fact, there was a historic budget *surplus*.[10]

2. The MAPP offered inferior benefits.

Although the City claims that the MAPP would have provided benefits "equal to or better than Senior Care," City Br. 19, the facts belie that boast.

As noted above, the MAPP was a Medicare Advantage plan. Despite the name, Medicare Advantage is completely different from—and far worse than—Medicare plus supplemental insurance. *See RiseDelaware Inc. v. DeMatteis*, 2022 WL 11121549, at *2, 4 (Del. Super. Ct. Oct. 19, 2022) (explaining that a "Medicare Advantage plan is substantially different" from Medicare plus supplemental insurance, and

[10] In 2022, the City had the highest cash reserves in its history, including a $3.7 billion surplus on a nearly $100 billion budget. *See Review of the Financial Plan of the City of New York* (March 2022), https://perma.cc/M7V9-HDPR, at 12; *The City of New York Preliminary Budget Fiscal Year 2023*, https://perma.cc/XKL5-3QMJ, at 4. That has grown to a $5.5 billion surplus on a $113 billion budget. Office of the New York State Comptroller, *DiNapoli: NYC's 2024 Budget Balanced, but Risks Loom* (Aug. 10, 2023), https://perma.cc/8G4B-HW6B.

enjoining implementation of Medicare Advantage plan based on those harmful differences).

Medicare Advantage is a privatized, for-profit alternative to Medicare that emerged in the 1990s. Under Medicare Advantage, insurance companies receive a fixed amount of money from the federal government to provide health insurance to elderly and disabled individuals. 42 U.S.C. § 1395w-23. These companies maximize profits for their shareholders by minimizing their expenditure of those federal funds. In order to minimize spending, Medicare Advantage plans: (1) limit enrollees to a network of low-cost providers; and (2) deny coverage for services they deem unnecessary. (*Bentkowski* NYSCEF Nos. 38, 40, 42-43). That is exactly what the MAPP would have done.

First, the number of medical providers that would have accepted the MAPP was limited. Although virtually all doctors and hospitals accept Medicare and Medicare supplemental insurance, many refuse to accept Medicare Advantage plans. (R111, 913-14, 1109; *Bentkowski* NYSCEF Nos. 5, 38, 40, 42-43). The City and the Alliance admitted that at least nine percent of Retirees' existing medical providers were not going to accept the MAPP. (R1958; NYSCEF No. 148 at 13). Affidavits

from Retirees and doctors revealed that the actual percentage was likely much higher. (R843-74, 914-17, 923-69, 1109; NYSCEF No. 124). Thus, had Retirees been forced into the MAPP, countless senior citizens with life-threatening illnesses would have had to switch doctors mid-treatment and many others would have had to leave facilities where they were receiving end-of-life care.

Second, unlike Senior Care and other Medicare supplemental plans, the MAPP would have imposed dangerous "prior authorization" requirements on scores of life-saving medical procedures and diagnostic tests. (R696, 913, 1434-82; NYSCEF No. 149). Prior authorization is a process whereby Medicare Advantage plans refuse to cover medical care they deem unnecessary. (R696).

Given the powerful financial incentive for Medicare Advantage plans to conclude that care is unnecessary (which allows them to avoid paying and thereby maximize profits), it is not surprising that they regularly do so, thus creating life-threatening risks for patients. In April 2022, the U.S. Department of Health and Human Services ("HHS") released a damning report revealing "widespread and persistent problems related to inappropriate denials of services and payment"

caused by Medicare Advantage prior authorization requirements.[11] The report noted "millions of denials each year," which are so routine and unwarranted that 75% of denials that are appealed eventually get reversed (but only after causing dangerous delays in care).[12]

In a recent physician survey conducted by the American Medical Association, 94% of respondents reported that prior authorization requirements caused delays in necessary treatment, and, as a result, 30% reported "serious adverse events" that required medical intervention, 18% reported a life-threatening event, and 9% reported a serious disability or permanent bodily damage. (R1104). The problems with prior authorization have become so extreme that Congress recently proposed bipartisan bills to address it and to prevent Retirees from being forced into Medicare Advantage.[13]

While the numbers alone tell a distressing story, the HHS report also described the harrowing human impact of Medicare Advantage's

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[11] U.S. Dep't of Health and Human Services, Office of Inspector General, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care* ("HHS Report"), April 2022, https://perma.cc/WXP6-P7PM at PDF p.2.

[12] *Id*. at PDF pp. 2, 9.

[13] *See* Improving Seniors' Timely Access to Care Act, https://perma.cc/R689-42JZ; Right to Medicare Act, https://perma.cc/4H2C-YB27.

prior authorization requirements. Three examples from the report—all of which occurred in a single week during a random sampling exercise—illustrate this impact:

- A Medicare Advantage plan denied coverage for surgery needed by a 72-year-old woman battling breast cancer.[14] That decision was reversed only after HHS happened to intervene.
- An 81-year-old with uterine cancer was improperly denied a CT scan that was "needed to determine the stage of the cancer, whether it had spread, and to determine the appropriate course of treatment."[15]
- A Medicare Advantage plan refused to admit a 67-year-old stroke victim to an inpatient rehabilitation facility even though he presented with an "acute ... stroke and [was] seen at the emergency department with new onset slurred speech."[16] According to the Medicare Benefit Policy Manual, he "should have been under the frequent supervision of a rehabilitation physician."[17]

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[14] HHS Report, Appendix B, Example D385.

[15] *Id.*, Example D421.

[16] *Id.*, Example D270.

[17] *Id.*

In sum, with its limited network of doctors and dangerous prior authorization requirements (among other negative features), the MAPP would have subjected Retirees to far worse healthcare than they had received for over half a century. Indeed, under the MAPP, countless Retirees would have lost access to their doctors and would have experienced routine denials of coverage and delays in care. For a city that has always led the nation in protecting the health of its elderly and disabled Retirees, such an outcome is deeply disturbing.

B. Procedural History

1. Supreme Court grants the Petition.

On September 26, 2021, Petitioners—a representative group of Retirees and a Retiree organization with tens of thousands of members—filed this Article 78 proceeding in New York County Supreme Court. (NYSCEF No. 1). Petitioners argued that the City's attempt to withdraw funding for Retiree health insurance violates Section 12-126.[18] (*Id.*).

On October 3, 2021, Petitioners filed an amended petition (the "Petition") that included new allegations regarding the inadequate and

[18] Petitioners also alleged that the City's actions violated other rights of Retirees. (*Id.*). Those rights are not at issue on this appeal.

misleading information being provided about the MAPP. (R26-82). Simultaneously, Petitioners moved for a preliminary injunction to prevent the City from imposing an October 31, 2021 deadline for Retirees to decide whether to opt out of the MAPP. (R13-16).

On October 15, the City opposed the preliminary injunction motion, and on October 19—one day before the scheduled hearing on the motion—it cross-moved to dismiss the Petition. (R1121; NYSCEF Nos. 66-76). Petitioners filed a reply in support of their preliminary injunction motion on October 19 but did not have an opportunity to respond to the City's cross-motion before the next day's hearing. (NYSCEF No. 97).

On October 20, Supreme Court heard argument on the preliminary injunction motion, which it granted the following day.[19] (NYSCEF No. 112). The preliminary injunction order focused on the lack of accurate information about the MAPP. (*Id*. at 3). Because it would have been impossible for Retirees to make an informed healthcare enrollment decision without such information, the court concluded that "the implementation of [the MAPP] is irrational and if the petitioners and

[19] The court did not address the City's cross-motion to dismiss, which it noted in a subsequent email to the parties was procedurally defective.

similarly situated individuals are required to opt-in or out ... by the October 31, 2021 deadline there would certainly be irreparable harm." (*Id.* at 3-4). The court did not address the merits of the Petition—*i.e.*, whether the City could cease funding Retirees' health insurance plans—although the parties had briefed that issue. (NYSCEF Nos. 63, 72, 79, 97).

On December 14, 2021—following additional hearings regarding the City's flawed implementation of the MAPP—Supreme Court extended the preliminary injunction to April 1, 2022 and ordered the City to submit biweekly reports on the progress of its curative measures. (NYSCEF No. 166 at 2). The court stated that it would rule on the merits of the Petition once the MAPP misinformation problems were resolved. (*Id.*).

A few weeks later, Supreme Court scheduled a hearing for late February 2022 to address the merits of the Petition. Specifically, the court wrote:

> I ask for the parties to be prepared to discuss the overall Article 78 issue on that date aside from the roll out. There has been some argument on this, but as I will look to make an ultimate decision on this sooner rather than later, I would appreciate it if all sides were ready to discuss this issue.

(R1988).

In order to assist the court—particularly in light of the avalanche of evidence and arguments submitted by the parties over the previous four months—Petitioners promptly filed a memorandum of law, which they styled as a "motion for summary judgment," that succinctly distilled the issues remaining in the case along with the relevant facts and legal authorities. (R1127-29; NYSCEF Nos. 185-97). *See Gerardi v. Vill. of Scarsdale*, 26 Misc. 3d 1239(A) n.1 (Sup. Ct. Westchester Cnty. 2009), *aff'd*, 71 A.D.3d 895 (2d Dep't 2010) (permitting petitioner to submit a "'motion for summary judgment' as a further elucidation of his argument under Article 78"). Petitioners' submission also responded to the arguments raised in the City's cross-motion to dismiss, which had been filed months earlier without a valid return date.

On February 1, the City asked Supreme Court to issue a final ruling on the merits of the Petition based on the existing record, and it requested that oral argument be held at the next scheduled conference (February 7) rather than at the end of the month (as originally planned). (NYSCEF No. 198). The City wrote: "We believe that it is in the best interest of the parties for the conference on February 7, 2022 to include

oral argument on the merits of the Petition. Respondents respectfully reassert their strong desire for a determinative ruling as soon as possible ...." (*Id.*). Petitioners were similarly eager for the court to conduct "a full and fair hearing on the merits" of the Petition but asked that the hearing remain calendared for late February. (NYSCEF No. 199). The court notified the parties by email that it would "set a definitive date to discuss the merits" at the February 7 status conference. (R1978). At that conference, the court informed the parties that oral argument on the merits of the Petition would be held on February 28 and that a final ruling would follow promptly thereafter.

On February 4, the City submitted a memorandum of law in response to Petitioners' submission. (NYSCEF No. 201). On February 15, both the MLC and the Alliance—the two non-parties with significant financial interests in the MAPP's implementation—filed *amicus curiae* briefs in support of the City, to which Petitioners responded a week later. (NYSCEF Nos. 205, 206, 208).

On February 28, Supreme Court heard argument on the merits of the Petition. As the court had warned in advance, the exclusive focus of the hearing was on Section 12-126.

At the February 28 hearing, the City did not argue (as it does here on appeal) that Section 12-126's monetary cap was lower than what Petitioners had alleged—and proven—in their Petition. Likewise, not once in the nearly six months of motion practice and court conferences leading up to the hearing did the City contest the statutory cap amount or dispute that this amount exceeded the cost of the health insurance plans the City had always paid for (including Senior Care). Nor did the City argue (as it does here on appeal) that there was a reduced statutory cap unique to Medicare-eligible Retirees, much less that this cap was a mere $7.50 (as it argues on appeal).

The City's silence is all the more deafening given Petitioners' repeated statements in their filings and at oral argument that the statutory cap amount was undisputed. (*See, e.g.*, R1955; NYSCEF No. 189 at 8, 14; NYSCEF No. 208 at 1, 7, 14). In fact, not only did the City not dispute the statutory cap, it affirmatively *conceded* that Senior Care and other plans cost less than the cap. (*See, e.g.*, NYSCEF No. 201 at 2 (referring to "health insurance plans that fall below [the] statutory cap, including GHI-Senior Care"); *id*. at 5 (arguing that the City need not pay

for Senior Care "[s]imply because the cost of GHI-Senior Care premiums may fall below the statutory cap")).[20]

The City's *sole* argument with respect to Section 12-126 was that the law only requires it to pay up to the statutory cap for *one* of the health insurance plans in the City's Health Benefits Program, and that it could satisfy this obligation by offering the federally funded MAPP to Retirees for free. (*See* NYSCEF No. 79 at 3; NYSCEF No. 201 at 2-6). According to the City, "[s]imply because the cost of [Retirees' existing health insurance] may fall below the statutory cap does not shift the obligation to the City." (NYSCEF No. 201 at 5).

On March 3, 2022, Supreme Court granted the Petition in relevant part. (R7-10). Rejecting the City's sole argument regarding Section 12-126, the court held that the City must continue to pay up to the statutory cap for whichever plan a Retiree chooses. (R9-10).

[20] The only time the City raised any issue regarding the statutory cap was on March 2, 2022, *after* briefing and oral argument on the Petition. (R1970-71). In a frantic, one-and-a-half-page letter filed at the close of business the day before Supreme Court had announced it would issue its ruling, the City claimed for the first time, and without citation to any evidence, that the statutory cap for Medicare-eligible Retirees was $7.50, drastically below the cost of Senior Care. (*Id.*). The City offered no explanation for why it had never raised this issue before or how the statutory cap could be so low.

2. The Appellate Division affirms.

On November 22, 2022, the Appellate Division, First Department unanimously affirmed. It held that "Administrative Code § 12-126(b)(1) requires [the City] to pay the entire cost, up to the statutory cap, of any health insurance plan a retiree selects." (R1998). The court added: "This interpretation comports with the plain language of the provision as well as its legislative history. Nothing in the statutory text or history supports [the City's] interpretation that the provision is satisfied so long as they pay for the costs of one of the health insurance plans offered to retirees …." *Id*.

The Appellate Division refused to consider the argument raised by the City for the first time on appeal regarding the statutory cap amount. Specifically, the City argued that Retirees have their own unique statutory cap that is $7.50 per person per month, which is a fraction of the cost of Senior Care. (1st Dep't Case No. 2022-01006, NYSCEF No. 10 at 35). The Appellate Division dispatched that argument as follows:

> Respondents' contention that they are not required to pay the full cost of $192 per month for the retiree petitioners' current plan, Senior Care, because that cost exceeds the full cost of H.I.P.-H.M.O. "on a category basis" is improperly raised for the first time on appeal. This argument does

> not raise solely a question of statutory interpretation that may still be addressed, but involves factual issues that cannot be determined on this record. Further evidence is necessary to determine, for example, the meaning of the phrase "on a category basis" and whether, as argued by respondents, coverage for Medicare-eligible individuals constitutes a "category" and costs only $7.50 per month.

(R1998).

3. The City Council refuses to amend Section 12-126.

In January 2023, after losing in court, Mayor Adams lobbied the City Council to amend Section 12-126 so that the City could cease funding Retirees' health insurance.[21] The City Council, which is responsible for balancing the City's budget, rejected that proposed amendment, explaining that Retirees need City-funded Medicare supplemental insurance.[22]

The City then decided to exploit an unintended loophole in the Appellate Division's ruling. Because the court had held that the City must continue to pay up to the statutory cap for all of the healthcare plans that comprise the City's Health Benefits Program, the City

[21] *See* Int. No. 874-2023, https://perma.cc/QF56-E3S8.

[22] *See* Daily News Article.

announced that, starting on September 1, 2023, the Program would no longer include City-funded (*i.e.*, Medicare supplemental) plans, and that Retirees would only have access to federally funded (*i.e.*, Medicare Advantage) plans. In May 2023, the Retirees filed an Article 78 petition challenging this new attempt to defund their healthcare. In August 2023, Supreme Court granted the petition on multiple grounds. *See Bentkowski* NYSCEF No. 102. That ruling is now on appeal before the Appellate Division, First Department.

SUMMARY OF ARGUMENT

With respect to the first question presented, Section 12-126 requires the City to pay up to the statutory cap for *all* of the health insurance plans that comprise the City's Health Benefits Program, not just one plan of the City's choosing. As summarized below, the statutory text, legislative history, and past practice compel that conclusion.

Statutory text. Section 12-126 states that "the city will pay the entire cost of health insurance coverage [up to the statutory cap] for city employees, city retirees, and their dependents." Admin. Code § 12-126(b)(1). "Health insurance coverage" is defined in the statute to mean the City's entire health benefits "program," not just one of the plans

within that program. *Id.* § 12-126(a)(iv). When the drafters of the statute wanted to refer to a single health insurance plan, they did so explicitly. *See id.* § 12-126(b)(2)(ii)-(iii); R1327. "Program" is a term of art used throughout the legislative record to refer to the full bundle of City health insurance plans. (*See, e.g.*, R1339, 1347, 1354). The term is used the same way in the state statute that authorized Section 12-126. *See* General City Law § 20(29-b) (empowering cities to pay certain costs of their "health *plans* program"). Further confirming the City's obligation to fund more than just one plan, the statutory definition of "health insurance coverage" refers to "companies" (plural) providing health insurance through "insurance contracts" (plural) with the City. Admin. Code § 12-126(a)(iv).

Legislative history. When passing Section 12-126, the City Council clearly meant for the City to pay for *any* health insurance plan an individual selected, not just one plan of the City's choosing. Indeed, the City Council explicitly said so. When publishing the final version of the bill that would become Section 12-126, the City Council explained: "*This bill would provide that The City of New York pay for the entire cost of <u>any</u> health insurance plan providing for medical and hospitalization*

coverage of employees and [retirees]." (R1327). That same legislative report also noted that the statute was codifying a 1965 resolution that required the City to pay for all of the plans in the City's Health Benefits Program. (R1327 (noting the codification of Resolution Cal. No. 292); R1344 (Resolution Cal. No. 292)); *see also New York 10-13 Ass'n v. City of New York*, 1999 WL 177442, at *12 (S.D.N.Y. Mar. 30, 1999) (stating that "the statute was enacted pursuant to Resolution Cal. No. 292"). Moreover, Section 12-126 was the product of a years-long effort by the City to provide a "choice of coverage … for which the City pays," thus "permit[ting] each [person] to obtain the form of insurance most advantageous to himself in the light of his personal circumstances." (R1396).

Past practice. For over half a century, up until this litigation, the City had always acknowledged that Section 12-126 requires it to subsidize all of its health insurance plans. In prior litigation, the City stated that its statutory obligation to pay for health insurance coverage applies "[n]o matter which plan" an individual selects. Compl., ECF No. 1 ¶ 30, *City of New York v. Grp. Health Inc.*, No. 06-CV-13122 (S.D.N.Y. Nov. 13, 2006). The New York City Law Department reiterated this

position a few years ago, explaining that Section 12-126 "requir[es] that the City, with respect to *any offered plan*, pay up to the [statutory cap]." (NYSCEF No. 227 at 3). And since Section 12-126 was enacted in 1967, the City has always provided the statutory subsidy for all health insurance plans, resulting in a wide selection of premium-free healthcare options, including Senior Care.

Accordingly, Supreme Court and the Appellate Division correctly concluded that Section 12-126 requires the City to continue paying up to the statutory cap for whichever plan a Retiree chooses.

The City's attempt to litigate the statutory cap for the first time on appeal (which is the subject of the second question presented) should be rejected, as it is both procedurally improper and meritless. Contrary to the City's contention, Retirees are subject to the same statutory cap as everyone else: the cost of the HIP-HMO plan on a category basis of individual or family coverage. They are not subject to a unique $7.50 per-person-per-month cap. All of the legislative history and evidence in the record support this conclusion.

ARGUMENT

I. SUPREME COURT AND THE APPELLATE DIVISION CORRECTLY HELD THAT THE CITY MUST CONTINUE PAYING UP TO THE STATUTORY CAP FOR WHICHEVER HEALTHCARE PLAN A RETIREE SELECTS.

The City provides its employees, retirees, and their dependents a choice of health insurance plans, all of which are offered through the City's Health Benefits Program. (R83-166). Section 12-126 requires the City to pay for such health insurance coverage up to a maximum amount, specifically the cost of the HIP-HMO plan based on its two categories of coverage: individual and family. In other words, if an employee or retiree seeks coverage for herself individually, the City must pay for her chosen health insurance up to the cost of individual coverage under the HIP-HMO plan. If, however, the employee or retiree seeks coverage for herself *and* her dependents, the City must pay for their chosen health insurance up to the cost of family coverage under the HIP-HMO plan.

Section 12-126 states in relevant part: "The city will pay the entire cost of health insurance coverage for city employees, city retirees, and their dependents, not to exceed one hundred percent of the full cost of H.I.P.-H.M.O. on a category basis." Admin. Code § 12-126(b)(1). "Health

insurance coverage" is defined to mean the City's entire "program of [health] benefits." *Id*. § 12-126(a)(iv).

The City argues that the courts below erred by interpreting Section 12-126 to mean that the City must pay up to the statutory cap for every health insurance plan in the City's Health Benefits Program. According to the City, Section 12-126 only requires it to pay up to the statutory cap for one of those plans (which the City decided would be the federally funded MAPP).

The City's argument is decisively refuted by the plain text of the statute, the City Council's clear statement of legislative intent, the legislative history, and 56 years of past practice. Each of these tools of statutory construction is addressed below.

A. Section 12-126 was the product of a years-long movement to provide municipal employees and retirees a choice of City-funded health insurance.

When interpreting statutes, this Court has "repeatedly recognized that legislative intent is the great and controlling principle, and the proper judicial function is to discern and apply the will of the enactors." *ATM One, LLC v. Landaverde*, 2 N.Y.3d 472, 476-77 (2004). Accordingly, "inquiry must be made of the spirit and purpose of the legislation, which

requires examination of the statutory context of the provision as well as its legislative history." *Id.* at 477.

To that end, before delving into the statutory text, it is helpful to first place Section 12-126 in its historical context. That context demonstrates that Section 12-126 was meant to codify the City's contemporaneous practice of paying up to a generous amount for any and all health insurance plans in the City's Health Benefits Program.

Section 12-126 was originally enacted in 1967 through Local Law No. 120. (R1319-21). It was the product of a years-long movement to provide City employees, retirees, and their dependents a choice of City-funded health insurance plans. In fact, the desire to offer a selection of City-funded plans was so great that in 1965, the City, through home rule request, pushed through state legislation removing then-existing limits to the plans the City could offer and the percentage of funding it could provide. (R1378-1407). That legislation, which amended General City Law § 20, allowed the City to "contract for and administer health insurance contracts and plans for active and retired city officers and employees and their families," and to "assume all or any part of the cost of such insurance." (R1389-90; *see also* R1393, 1395 (noting that the state

law amendment would finally allow the City "to offer a wider choice of health insurance plans" and "to assume as an employer expense, all or part of the cost of such plans")). In short, the City successfully amended state law so that it could offer a wide variety of City-funded health insurance plans to its employees, retirees, and their dependents. (*See* R1399 (stating that the amendment would allow the City to provide a "free choice of plans" that was "much wider" than before)).

After the General City Law was amended in 1965, the City immediately exercised its new powers: it offered all City employees, retirees, and their dependents a "program" (R1354) of health insurance plans and paid for all of them up to the cost of a specific plan administered by the insurance company HIP. (R1341-48). Importantly, the 1965 City resolution announcing these benefits used language nearly identical to that of Section 12-126, which was passed shortly thereafter. That resolution—Resolution Calendar No. 292 ("Resolution 292")—stated in pertinent part:

> Whereas, it is the desire and intent of The City of New York to grant to all of its retired employees ... a choice of health plans consisting of H.I.P.-Blue Cross, G.H.I.-Blue Cross and Blue Cross-Blue Shield-Major Medical (Metropolitan Life Insurance Company), ... and *the City shall assume*

> *full payment for such health and hospital insurance, not to exceed 100% of the full cost of H.I.P.-Blue Cross (21-day Plan) on a category basis*, effective April 1, 1967.

(R1344; *see also* R1343-44 (stating the same with respect to City employees and the dependents of City employees and retirees)).[23] Notably, the term "such health and hospital insurance" referred to *all three* of the health insurance plans that comprised the City's Health Benefits Program, and the HIP-based cap represented the amount the City was required to pay for *all* of those plans.

By passing Resolution 292, the City recognized that what people needed was an opportunity to choose a health insurance plan that was right for them and City funding to enable that choice. The goal was to "permit each [person] to obtain the form of insurance most advantageous to himself in the light of his personal circumstances" and "insure that the protection for which the City pays is not wasted by disuse." (R1396). The goal was decidedly not for the City to select one lone health insurance plan to fund.

[23] Resolution 292 continued and extended the healthcare benefits addressed in an earlier resolution (Resolution Calendar No. 155), which used nearly identical language. (R1350-52).

B. Section 12-126 codified the City's obligation to provide and pay for all health insurance plans.

Section 12-126 was enacted through Local Law No. 120 in 1967 to codify the essential protections of Resolution 292 by requiring the City to fund all of the health insurance plans in its Health Benefits Program. (*See* R1327 (noting the codification in the bill)); NYSCEF No. 227 at 2 (City acknowledgment that Section 12-126 "was based" on Resolution 292); *New York 10-13 Ass'n*, 1999 WL 177442, at *12 (stating that "the statute was enacted pursuant to Resolution Cal. No. 292")).

Echoing Resolution 292, Local Law No. 120 stated in relevant part: "The city of New York will pay the entire cost of health insurance coverage for city employees, city retirees, and their dependents, not to exceed one hundred percent of the full cost of H.I.P.-Blue Cross (21-day plan) on a category basis." (R1321). This statutory mandate remains in effect today, with one minor tweak: in 1984, the HIP-Blue Cross 21-day plan became defunct and was replaced by the HIP-HMO plan. (R1141). When the law was originally enacted in 1967 and when it was amended in 1984, the statutory cap was pegged to these plans because they were the most expensive ones offered at the time, meaning the City had to pay the entire cost of those plans as well as all of the other plans it offered.

There is no question that the legislative intent was for the City to pay up to the statutory cap for any plan selected. Indeed, the City Council explicitly said so.

On November 21, 1967, the City Council's Committee on Health and Education published the final version of Local Law No. 120 along with a report summarizing the legislation. In a definitive answer to the exact question before this Court, the Committee announced: "*This bill would provide that The City of New York pay for the entire cost of* <u>*any*</u> *health insurance plan providing for medical and hospitalization coverage of employees and [retirees].*"[24] (R1327). The City's only response to this clear articulation of legislative intent is to claim, preposterously, that the Committee did not mean what it said. City's Br. 37.

The City erroneously argues that a committee report does not merit consideration. City's Br. 38. However, this Court routinely relies on such reports. *See, e.g., Zakrzewska v. New Sch.*, 14 N.Y.3d 469, 480 (2010) (relying on City Council committee report to interpret statute);

[24] This Court has "repeatedly held that the word '*any*' means 'all' or 'every.'" *People v. Silburn*, 31 N.Y.3d 144, 155 (2018) (emphasis in original). These "repeated" holdings began well before Local Law No. 120 was enacted in 1967. *See, e.g., Randall v. Bailey*, 288 N.Y. 280, 285 (1942). "[T]he [City Council] must be presumed to have been aware of the long-standing judicial construction of that language." *Sheehy v. Big Flats Cmty. Day, Inc.*, 73 N.Y.2d 629, 635 (1989).

Hernandez v. Barrios-Paoli, 93 N.Y.2d 781, 789 (1999) (same); *cf. Lightbody v. Russell*, 293 N.Y. 492, 496 (1944) (holding that "Committee Reports … are relevant and open for use in the aid of construction and a determination of [legislative] intent").[25] In this case, the Committee's report provides the only summary in the legislative record of the statute's meaning, thus elevating its importance.

C. The plain text of Section 12-126 clearly requires the City to fund all of the plans in the City's Health Benefits Program.

The statute's plain text confirms the City's obligation to fund all of its health insurance plans.

Section 12-126 requires the City to pay up to the statutory cap for "health insurance coverage." That term is defined as the entire "program of hospital-surgical-medical benefits to be provided by health and hospitalization insurance contracts entered into between the city and companies providing such health and hospitalization insurance." Admin. Code § 12-126(a)(iv). As explained below, these underlined words refer

[25] The City's reliance on *Fletcher v. Kidder, Peabody & Co.* is misplaced. In that case, unlike here, the Court concluded that a congressional committee's reports were not helpful because "they merely set forth the committees' *understanding* of … then-existing Supreme Court precedent." 81 N.Y.2d 623, 634 (1993) (emphasis in original).

to the multiple health insurance plans that comprise the City's Health Benefits Program.

First, the word "program" is used throughout the legislative record to refer to the entire array of health insurance plans offered by the City. (*See, e.g.*, R1354 (repeatedly referring to the "program" of health insurance plans offered by the City, and using the term "health insurance coverage" in connection with the City's obligation to pay for all of these plans); R1339 (stating that "the city's health insurance *program* offer[s] a choice of *three plans*"). Indeed, when the City Council was drafting the bill that would become Section 12-126, then-Mayor Lindsay issued a statement regarding the legislation and explained that "[t]he City's health insurance *program* offers … a choice of *three different health insurance plans*."[26] The state statute that authorized Section 12-126 likewise uses the term "program" to encompass all of the City's multiple health insurance plans. *See* General City Law § 20(29-b) (empowering the City to pay certain costs for its "health *plans* program"). Further, as explained in every healthcare-related document published by the City, all of the health insurance plans available to City employees, retirees,

[26] *Bentkowski* NYSCEF No. 4 at PDF p.518.

and their dependents are offered through the City's Health Benefits "Program." (*See, e.g.*, R83, 87, 100, 110, 113, 330, 391, 1162, 1409).

When the drafters of Section 12-126 wanted to refer to a single health insurance plan, they did so expressly. *See* Admin. Code § 12-126(b)(2)(ii) and (iii) (referring to a deceased retiree's "health insurance plan"); R1327 (referring to a "health insurance plan"); *id.* (identifying the "plan" that set the original statute cap). "[W]here, as here, the Legislature uses different terms in various parts of a statute, courts may reasonably infer that different concepts are intended." *Rangolan v. Cnty. of Nassau*, 96 N.Y.2d 42, 47 (2001); *see also* N.Y. Stat. § 236. By using the term "program," the City Council clearly meant something other than just a single "health insurance plan."

Thus, contrary to the City's contention (City's Br. 31), the use of the singular term "program" does not suggest that the City's payment obligation is limited to one health insurance plan. Just the opposite: it confirms that the City must fund all of the plans in its Health Benefits Program.

Second, the two words in the definition that relate to the number of health insurance plans—"contracts" and "companies"—are both plural.

Although the City claims it is possible for a health insurance plan to be administered by multiple insurers pursuant to *different* contracts with the City, the City could not produce any evidence below of a multi-company/multi-contract plan. That is because a single health insurance plan is generally governed by a single contract, even if that contract is between the City and multiple insurers. Indeed, the only contract documentation in the record relates to the MAPP, which was to be administered by two insurance companies pursuant to a *single* contract with the City.[27] (R1419).

Comparative statutory analysis supports Petitioners' interpretation. When General City Law § 20 was amended at the City's behest in order to lift state restrictions on the plans the City could offer and the level of funding it could provide, noticeably different language was used. The amendment referred to a "contract or contracts" with "one or more insurance companies." (R1407). The use of both the singular and plural in General City Law § 20, which was designed to give the City

[27] The City claims that "*all* of the City's offerings as of [Section 12-126's] enactment involved multiple contracts with multiple companies." City's Br. 35 (emphasis in original). That is incorrect, and the lone document cited by the City (R1350-51) does not support that assertion. Although the cited document states that insurance companies all signed contracts with the City, nowhere does it say that any single healthcare plan was governed by multiple contracts.

maximum contracting flexibility, stands in stark contrast to the exclusive use of the plural ("contracts" and "companies") in Section 12-126, which defines the City's payment obligation. This contemporaneous difference in terminology indicates that the City Council's choice of the plural in Section 12-126 was deliberate, confirming that it intended to pay for multiple health insurance plans, not just one.

Finally, the phrase "such health and hospitalization insurance" is virtually identical to the phrase used in Resolution 292 to refer to all of the health insurance plans offered by the City. (R1344 (referring to the various plans offered and paid for by the City as "such health and hospital insurance")). By citing and mirroring the language of Resolution 292—which took effect just months before Section 12-126 was enacted—the City Council clearly sought to invoke its requirements. (R1327).

In addition to the statutory definition of "health insurance coverage," Section 12-126's inclusion of a monetary cap is further textual evidence in Petitioners' favor. The City Council could have required the City to pay for just HIP-HMO or for a single "health insurance plan." Instead, it required the City to pay for "health insurance coverage" up to

the full cost of HIP-HMO. That naturally suggests that the City must pay for HIP-HMO as well as all other plans up to the cost of HIP-HMO.

In sum, the statutory text and legislative history compel the conclusion reached by the courts below: Section 12-126 requires the City to pay up to the statutory cap for all—and not just one—of the health insurance plans that comprise the City's Health Benefits Program.

Testimonial evidence corroborates this conclusion. Former City Councilmember Barry Salmon, who sat on the City Council shortly after Section 12-126 was enacted and who voted on various amendments to the statute, submitted a sworn affidavit stating that the City Council intended the City to pay up to the statutory cap for all health insurance plans, not just one. (R1967).

D. The City's prior statements and 56 years of uninterrupted past practice support Petitioners' interpretation.

For over half a century—since Section 12-126 was enacted in 1967—the City itself has consistently construed the law as requiring it to pay up to the statutory cap for all health insurance plans, not just one.

In fact, the City has repeatedly said so. In a 2006 federal lawsuit, the City stated that under "local law, N.Y.C. Admin. Code § 12-126," it is

"required" to pay for health insurance coverage "up to, but not more than, the rate set by HIP for its HMO plan" and that this obligation applies "*[n]o matter which plan*" an individual selects. Compl., ECF No. 1 ¶ 30, *City of New York v. Grp. Health Inc.*, No. 06-CV-13122 (S.D.N.Y. Nov. 13, 2006). The Second Circuit adopted this position in its summary judgment affirmance a few years later. *See City of New York v. Grp. Health Inc.*, 649 F.3d 151, 154 (2d Cir. 2011) (stating that "[u]nder municipal law, ... the City pays the entire premium" for the statutory cap "HIP plan" as well as all other plans up to "the cost of the HIP plan"). And in 2016, the New York City Law Department wrote that Section 12-126 "requir[es] that the City, with respect to *any offered plan*, pay up to the [statutory cap]." (NYSCEF No. 227 at 3).

The City has also acknowledged through 56 years of uninterrupted past practice that it must pay up to the statutory cap for all of its health insurance plans. Since Section 12-126 took effect in 1968, the City has always fully paid for plans that cost below the statutory cap, including Senior Care. The record is replete with uncontested evidence of this.[28]

[28] *See, e.g.*, R1411 (1983 Health Benefits Handbook listing the various health insurance plans available to Retirees and explaining that all such health insurance "is paid in full by the City of New York"); R1733 (2004 United Federation of Teachers Pension Handbook noting that health insurance coverage under HIP, GHI, and

In fact, a City healthcare document published shortly after the passage of Section 12-126 listed all of the health insurance plans in the City's Health Benefits Program and noted that "[t]he City pays the full cost of *whichever* plan you choose for yourself and your eligible dependents."[29] The City does not, and cannot, point to any contrary past practice.

This longstanding past practice is powerful, if not conclusive, proof that Section 12-126 requires the City to pay up to the statutory cap for all of its health insurance plans. *See Kolb v. Holling*, 285 N.Y. 104, 113 (1941) (assigning "controlling" weight to the city of Buffalo's past payment practice and requiring it to continue making payments pursuant to that practice); *id*. at 112 ("The practical construction put upon a ... statute ... is entitled to great weight, if not controlling influence, when such practical construction has continued in operation over a long period of time."); *Ferraiolo v. O'Dwyer*, 302 N.Y. 371, 376 (1951) (stating that "practical construction by an officer or agency charged with the

various other plans is fully paid for by the City); R1283, 1294 (2021 New York City Office of the Actuary Report noting the multiple health insurance plans (including Senior Care) paid for by the City, and explaining that individuals must pay for health insurance coverage only if, and to the extent, the plan they select is more expensive than the statutory cap set by HIP-HMO).

[29] *Bentkowski* NYSCEF No. 7 at 3.

administration of a statute, especially when followed by a long period of time, is entitled to great weight and may not be ignored"); *cf. Polan v. State of N.Y. Ins. Dep't*, 3 N.Y.3d 54, 63 (2004) (refusing "to infer a legislative intent" that "would upset longstanding" practice regarding provision of disability benefits).

E. The City's arguments are meritless.

In the face of overwhelming evidence regarding the meaning of Section 12-126, the City resorts to making meritless arguments based on distortions of the historical record and flawed policy analysis.

First, the City contends that then-Mayor Lindsay's objections to, and the City Council's subsequent revision of, an early draft of Section 12-126, which included a reference to "any basic health insurance plan," show that the statute was meant to require payment of only one plan, not any plan. City's Br. 36. But Mayor Lindsay's concern was simply that there was no predictable limit to what the City might be required to pay under the statute, and that concern was fully resolved through the addition of a statutory cap and defined terms. As detailed below, Mayor Lindsay never objected to the City's obligation to fund all health insurance plans, and the City Council never altered that obligation.

In July 1967, the City Council's Committee on Health and Education presented an initial version of the bill that would eventually become Section 12-126. (R1323-24). It differed from the final version in several notable respects: it lacked a statutory cap and defined terms, and it used the phrase "any basic health insurance plan" instead of "health insurance coverage."

Mayor Lindsay vetoed the initial version because, among other reasons, "[t]he phrase 'basic health insurance plan' [wa]s nowhere defined," which would mean the City would face an "open-ended" financial obligation that it could not "anticipate." (R1326). Importantly, although Mayor Lindsay objected to the absence of a definition and to the unpredictable financial exposure, he took no issue with the term "any," nor with the City's obligation to subsidize all available plans.

In November 1967, the Committee presented a revised bill that adequately addressed Mayor Lindsay's concerns. It defined, and set a predictable cap on, the City's financial obligation. Under the revised bill, the City would have to pay the entire cost of "health insurance coverage"—a defined term that encompassed the City's entire health benefits "program"—up to a generous limit set at the cost of the most

expensive plan offered at the time.[30] (R1327). In its report accompanying the final version of the bill, the Committee noted that although certain statutory language had changed, the City's obligation to fund all plans had not. Like the original version (R1324), the enacted bill "would provide that The City of New York pay for the entire cost of *any* health insurance plan providing for medical and hospitalization coverage of employees and [retirees]." (R1327). Mayor Lindsay approved and promptly signed the bill into law. (R1321).

Second, the City claims that "[i]t is hard to see why the City Council would create a regime that does not require any alternative plans, but then compels the City to pay for any optional plans it makes available, subject only to the law's monetary cap." City's Br. 38-39. There is nothing confusing or illogical about the City Council's intent: it sought to protect those who served the City—all of whom sacrificed their health, safety, and/or potential for higher earnings—by paying for their preferred health insurance up to a generous amount. Section 12-126 reflected a collective desire for the City to "assume" payment for a "choice

[30] The rate structure of the City's Health Benefits Program was originally designed to hold the cost of all plans below or at the cost of this statutory cap plan.

of health plans," with the goal being to "permit each [current and retired municipal worker] to obtain the form of insurance most advantageous to himself in the light of his personal circumstances" and "insure that the protection for which the City pays is not wasted by disuse." (R1344, 1396). Given the diverse healthcare needs and personal circumstances of the municipal employee and retiree community, the wisdom of such a policy is plain.

The City Council had no reason to require the City to offer a specific number of health insurance plans because the City had no incentive to unduly limit that number: its payment obligation would remain the same regardless. When Section 12-126 was enacted in 1967, its drafters could hardly have predicted that the City might someday try to limit Retirees' healthcare options in order to force them into a federally funded Medicare Advantage plan. Such plans did not exist at the time.[31] And, regardless,

[31] *See Parra v. PacifiCare of Arizona, Inc.*, 715 F.3d 1146, 1152 (9th Cir. 2013) ("In 1997, Congress enacted Medicare Part C, providing for private Medicare Advantage plans."); *see also* Jonathan Oberlander, *The Politics of Medicare Reform*, 60 WASH. & LEE L. REV. 1095, 1114-15 (2003) (explaining that Congress did not authorize federal funding of private Medicare plans until the 1970s); Government Accountability Office, *Statements of Kathleen M. King and James Cosgrove*, March 4, 2014, https://perma.cc/WU7F-QDAW, PDF p.2 ("The [federal] government first began contracting with private plans in 1973.").

such a maneuver would violate the clear intent of the statute, which was for the City to fund a choice of health insurance options.[32]

II. THE CITY'S STATUTORY CAP ARGUMENT IS BOTH UNPRESERVED AND MERITLESS.

In addition to its flawed statutory interpretation argument (addressed above), the City also raises an unpreserved factual argument regarding the statutory cap amount. City's Br. 41-52.

Petitioners established in Supreme Court that the statutory cap is pegged to the cost of the HIP HMO Preferred Plan (R113), commonly known as "HIP-HMO" (*see, e.g.*, R1733), and that, in 2021, this amount was well above the $192-per-person-per-month cost of Senior Care (R28, 69). The City did not dispute this fact in Supreme Court, much less submit any evidence to rebut it. However, on appeal to the Appellate Division, the City argued that the statutory cap for Retirees is actually $7.50 per person per month, which is what the City pays for the HIP VIP

[32] The City disputes this intent based on the fact that the word "choice" appears in Resolution 292 (which is 5,660 words long) but not in Section 12-126 (which is, in relevant part, a single sentence). City's Br. 36-37. However, "choice" appears in Resolution 292 to describe the "choice" of three specific healthcare plans offered by the City at the time. Section 12-126, by contrast, was not meant to identify a specific "choice" of plans offered at a given time. Regardless, the notion of choice is implied in Section 12-126 through its authorizing statute, General City Law § 20(29-b), which empowers the City to pay certain costs for its "health *plans* program." Choice is also implied in Section 12-126 by its (i) reference to a "program" of plans and (ii) legislative history, including the explicit codification of Resolution 292.

Premier Medicare Plan, commonly known as "HIP-VIP" (*see, e.g.*, R148, 1733). (1st Dep't Case No. 2022-01006, NYSCEF No. 10 at 35). Although the Appellate Division refused to consider this unpreserved argument, the City repeats it here.

The City is wrong: HIP-HMO (with its two categories of coverage, individual and family) sets the statutory cap for everyone, including Medicare-eligible Retirees; HIP-VIP does not, and never has, set the statutory cap for anyone. This Court, however, need not even reach this issue because the City failed to preserve it.

A. The City did not preserve its statutory cap argument.

The City did not once argue in any of its trial court briefs or during any of the trial court hearings that HIP-VIP sets the statutory cap for Medicare-eligible Retirees, nor did it argue that this cap was below the cost of Senior Care. It had ample opportunity to do so.

The Supreme Court proceedings featured nearly six months of briefing and hearings on the legality of the City's Retiree healthcare overhaul. During that time, Petitioners repeatedly and accurately reported to the court (verbally and in writing) that there was no dispute between the parties regarding the statutory cap amount. (*See, e.g.*,

NYSCEF No. 189 at 8, 14; NYSCEF No. 208 at 1, 7, 14; R1955). Despite Petitioners' clearly stated position regarding the statutory cap amount and its undisputed status, the City not only failed to object, but affirmatively conceded the point.[33]

Moreover, after raising no objections to Petitioners' statutory cap analysis, the City urged Supreme Court to issue a final ruling "on the merits" of the Petition based on the arguments and undisputed facts presented in the parties' dispositive motion papers.[34] (NYSCEF No. 198). And that is exactly what Supreme Court announced it would do—and ultimately did—given the lack of any factual dispute.[35] (R1978, 1988).

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[33] *See, e.g.*, NYSCEF No. 201 at 2 (referring to "health insurance plans that fall below [the] statutory cap, including GHI-Senior Care"); *id*. at 5 (arguing that the City need not pay for Senior Care "[s]imply because the cost of GHI-Senior Care premiums may fall below the statutory cap").

[34] *See* Black's Law Dictionary (11th ed. 2019) (defining "on the merits" as "delivered after the court has heard and evaluated the evidence and the parties' substantive arguments," and "hearing on the merits" as "a formal proceeding before a judge" who "makes a final decision in the case").

[35] The night before Supreme Court issued its decision in this case, the City filed a one-and-a-half-page letter claiming, for the first time, that it had no duty to continue paying for Senior Care because that plan was somehow 25 times more expensive than the statutory cap. (R1970-71). The City offered no explanation as to how that could be or why it had never raised this issue before, and it cited no evidence or authority to support this inaccurate assertion. What appears to have happened is that after oral argument (during which the City again conceded that Senior Care cost less than the statutory cap), the City saw the writing on the wall and sought to stave off defeat by creating a last-minute factual dispute. Supreme Court correctly rejected this improper tactic. *See Metropolitan Transp. Auth. v. 2 Broadway LLC*, 279 A.D.2d 315, 315 (1st Dep't 2001) (holding that it was error to consider an argument "improperly

The City's failure to dispute the statutory cap in its Supreme Court papers prevents it from doing so here. It is well settled that where, as here, a party fails to raise an argument in its trial court briefs—in fact, in its *opening* trial court brief—it has both waived that argument below and failed to preserve it for appeal. *See, e.g.*, *Residential Bd. of Managers of Platinum v. 46th St. Dev., LLC*, 154 A.D.3d 422, 423 (1st Dep't 2017) (arguments not raised in trial court opening brief could not be considered below or on appeal); *RSB Bedford Assocs., LLC v. Ricky's Williamsburg, Inc.*, 91 A.D.3d 16, 23 n.1 (1st Dep't 2011) (argument waived if not raised in dispositive motion brief).[36]

This Court has held that it "lack[s] jurisdiction" to consider unpreserved arguments. *Bingham v. New York City Transit Auth.*, 99 N.Y.2d 355, 359 (2003). *See also Henry v. New Jersey Transit Corp.*, 39 N.Y.3d 361, 367 (2023) ("To demonstrate that a question of law is preserved for this Court's review, a party must show that it raised the

raised for the first time in a letter of counsel presented after the motion had been orally argued and submitted").

[36] The two preservation-related cases cited by the City do not help it. *See* City's Br. 43. In *U.S. Bank N.A. v. DLJ Mortgage Capital, Inc.*, this Court refused to consider an issue that a party failed to properly raise in its trial court briefs, which is precisely what happened here. 33 N.Y.3d 84, 89-90 (2019). And in *Geraci v. Probst*, unlike here, the relevant issue "was placed squarely before the court" because defendants argued it "on more than one occasion" during trial. 15 N.Y.3d 336, 342 (2010).

specific argument in Supreme Court and asked the court to conduct that analysis in the first instance.").[37]

This preservation requirement serves at least two important purposes. First, it protects this Court's role in "making and shaping the common law ... by limiting its review to issues that have first been presented to and carefully considered by the trial and intermediate appellate courts." *Bingham*, 99 N.Y.2d at 359. The City's statutory cap argument was not "presented to and carefully considered by" the courts below.

Second, the preservation requirement ensures that parties have a full and fair opportunity to develop the factual and legal record at the trial court level. As this Court stated in *Bingham*, "[h]ad defendants' new argument been presented below, plaintiff would have had the opportunity to make a factual showing or legal argument that might have undermined defendants' position." *Id.* at 359. So too here. Had the City properly raised its statutory cap argument in Supreme Court, Petitioners

[37] The MLC claims that it preserved the argument by briefly disputing the statutory cap in an *amicus* brief. The MLC, however, is not a "party" and therefore cannot preserve anything. *Id. See also People v. Talluto*, 39 N.Y.3d 306, 310 (2022) (refusing to consider argument made by *amici* because defendant failed to preserve it); 4 Am. Jur. 2d Amicus Curiae § 7 ("[A]n amicus curiae generally cannot raise issues that have not been preserved by the parties.").

would have refuted it with evidence and counterarguments demonstrating that there has always been one universal statutory cap plan and that the only relevant cost "categories" for that plan are individual and family (not Medicare-eligible Retirees and everyone else, as the City incorrectly contends here). Forcing Petitioners to litigate this issue in this Court based on the current undeveloped record would be grossly unfair, particularly given the grave healthcare consequences for hundreds of thousands of elderly and disabled Retirees.

B. The City's statutory cap argument does not fit within the narrow exception to the preservation requirement.

To overcome this Court's prohibition on unpreserved arguments, the City asks the Court to apply the "rarely invoked exception" for pure and "decisive" "point[s] of law" that "could not have been obviated by factual showings or legal countersteps [had they] been raised below." *Misicki v. Caradonna*, 12 N.Y.3d 511, 519 (2009). The City's argument does not fit within this narrow exception.

First, the statutory cap amount is not "solely" a question of law, as it must be for the exception to apply. *Richardson v. Fiedler Roofing, Inc.*, 67 N.Y.2d 246, 250 (1986). *See also Howell v. City of New York*, 39 N.Y.3d

1006, 1020, n.6 (2022) (Wilson, J., dissenting) (noting that exception requires a "pure question of law"). Indeed, it cannot be determined from the face of the statute. That is because the cap is a fluctuating amount that is pegged to the current cost of a specific plan (HIP-HMO) based on its "categor[ies]" of coverage. Admin. Code § 12-126(b)(1). Thus, an analysis of the statutory cap requires a factual understanding of HIP-HMO, how it categorizes enrollees, and how much it charges for those categories of coverage. As the Appellate Division correctly concluded, the City's argument "does not raise solely a question of statutory interpretation …, but involves factual issues that cannot be determined on this record." (R1998).

Second, had the City properly disputed the statutory cap amount in Supreme Court, Petitioners could have dismantled that argument through "factual showings" and "legal countersteps." *Misicki*, 12 N.Y.3d at 519. *See Bingham*, 99 N.Y.2d at 359 (refusing to reach defendants' unpreserved argument because, had it been made below, plaintiff might have "ma[d]e a factual showing or legal argument that might have undermined" it). Most notably, Petitioners would have introduced: (1) City contracts and healthcare materials describing HIP-HMO, its

official "categories" of coverage for purposes of Section 12-126, and the cost of those categories as compared to Senior Care; (2) documents from the City, unions, and HIP from the 1960s to the present confirming that there has always been one universal statutory cap plan with two categories of coverage (individual and family), and that HIP-VIP has never set the statutory cap for anyone; (3) testimony from current and former City and HIP officials stating that the City's new statutory cap argument is inconsistent with past practice; and (4) additional legislative history from 1967 (when Section 12-126 was enacted) and 1984 (when HIP-HMO became the statutory cap plan) undermining the City's flawed interpretation of the term "category basis." It would be deeply unfair to rule on the City's unpreserved statutory cap argument without this dispositive evidence, which supports Petitioners' position.

This Court rarely makes an exception to its preservation requirement. As Chief Judge Wilson recently explained: "[W]e have at times claimed that we could review an unpreserved issue if it could not have been avoided by factual showings or legal countersteps had it been raised below. Although promising in theory, the times when we have actually found that an unpreserved issue met this exception are rare,

rendering it mere milquetoast in application." *People v. Epakchi*, 37 N.Y.3d 39, 62 n.8 (2021) (Wilson, J., dissenting). This Court has never applied the exception to an issue as fact-dependent as Section 12-126's statutory cap. Indeed, this Court routinely rejects far purer questions of law due to lack of preservation.[38]

If the City truly believes that HIP-VIP sets the statutory cap and costs less than Retirees' existing health insurance, it should have made that argument during the six-month proceedings in Supreme Court. Petitioners would have demolished it with documentary evidence, testimony, and legislative history that are not in this record. The City should not be allowed to deny essential healthcare benefits to hundreds of thousands of senior citizens and disabled first responders based on an unpreserved argument and undeveloped record.

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[38] *See, e.g.*, *U.S. Bank*, 33 N.Y.3d at 89 (question regarding interpretation of "plaintiff" under CPLR 205(a)); *Bingham*, 99 N.Y.2d at 359 (question regarding whether the *Schlessinger* rule, a "pure[] issue of law," should be abandoned); *Clement v. Durban*, 32 N.Y.3d 337, 340 n.1 (2018) (question regarding constitutionality of two statutory provisions); *Corrigan v. New York State Off. of Child. & Fam. Servs.*, 28 N.Y.3d 636, 643 (2017) (question regarding whether Social Services Law § 427–a is unconstitutional "because [of] the absence of an early expungement provision"); *Brown v. City of New York*, 60 N.Y.2d 893, 894 (1983) (question regarding error "on the law"); *Henry*, 39 N.Y.3d at 373 (question regarding sovereign immunity); *Freedom Mortg. Corp. v. Engel*, 37 N.Y.3d 1, 28, 36-37 (2021) (question regarding contract interpretation).

C. The City's statutory cap argument is meritless.

The City's unpreserved statutory cap argument is also wrong, which is likely why the City did not advance it below. Indeed, before even delving into the record, one can easily recognize that it lacks merit.

The City is claiming that Section 12-126 requires it to pay $776 per person per month on health insurance for employees and under-65 retirees, but only $7.50 for elderly and disabled Retirees, who have far more expensive healthcare needs. Although Medicare helps defray those costs, it does not cover a significant portion of expenses, which is why Medicare-eligible Retirees need robust health insurance coverage that costs thousands of dollars a year.[39] The City has always paid for this coverage pursuant to Section 12-126. The City's contention that the statutory cap for these Retirees is $7.50—less than 1% of the cap for everyone else—sounds implausible because it is.

The City's argument is based on the misguided belief that HIP-VIP sets the statutory cap for Medicare-eligible Retirees while HIP-HMO sets the cap for everyone else. That is not how Section 12-126 works.

[39] In 2022, Senior Care cost approximately $192/month on an individual basis and $383/month on a family basis. Those costs have increased every year.

As the City conceded in Supreme Court, the statutory cap is pegged to "the cost of *a particular plan*," specifically "HIP-HMO" on a "category basis." (NYSCEF No. 201 at 2-3). *See also New York 10-13 Ass'n v. City of New York*, 1999 WL 177442, at *12 (S.D.N.Y. Mar. 30, 1999) (explaining that "the H.I.P.-H.M.O. plan" is the universal "statutory yardstick"). Although there are two different categories of coverage within that plan (individual and family), there is and always has been one single health insurance plan that sets the statutory cap, not two. And the City has previously acknowledged that this plan is HIP-HMO. (*See* NYSCEF No. 227 at 1-2 (stating that the cost of the "H.I.P. H.M.O. Preferred Plan … constitute[s] the maximum City cost established by the law" and is "the *only* 'H.I.P.-H.M.O.' plan … under § 12-126")).

The City attempts to circumvent this problem by claiming that Medicare-eligible Retirees are actually a "category" for purposes of Section 12-126 and that HIP-VIP (a Medicare plan) therefore sets the statutory cap for them.[40] City's Br. 46-49. That is incorrect, as explained below.

[40] The City contends, without any principled explanation or citation to authority, that Medicare-eligible Retirees are in one "category" while Medicare-eligible employees and non-Medicare-eligible employees and retirees are in another "category."

1. "Category basis" refers to individual and family coverage.

"Category basis" is a term of art that has always referred to the two categories of coverage (individual and family) within a single HIP plan (originally H.I.P.-Blue Cross (21-day plan) and later HIP-HMO). The City's own documents confirm that "category basis" refers to individual and family coverage under HIP-HMO. (*See, e.g.*, R606 (NYC Office of Labor Relations document stating that the City must pay for health insurance coverage up to "100% of the full cost of HIP-HMO ... on a *category basis of individual or family*")). Since at least the 1940s, HIP has always priced insurance based on the "categories" of individual and family coverage. (*See, e.g.*, R1375).

Tellingly, the City cannot point to *anything* in the text or 56-year history of Section 12-126 stating, or even implying, that Medicare-eligible Retirees are a category for purposes of the statute. That is because they are not.

The legislative history of Section 12-126 confirms that Medicare-eligible Retirees are *not* a recognized category. The term "category basis" appears throughout the legislative record prior to the introduction of Medicare in July 1966. For example, Resolution 292, which was passed

in December 1965, used the term "category basis" no less than 13 times to refer to the City's healthcare payment obligations. (*See* R1343-47 (requiring the City to pay for health insurance coverage up to "the full cost of H.I.P.-Blue Cross (21-day plan) on a *category basis*")). An earlier related resolution—Resolution 155, which was passed in February 1965—used the term in the exact same way. (*See* R1350 (requiring the "[a]ssumption by The City of New York of full payment for choice of health and hospital insurance, not to exceed 100 per cent of the full cost of HIP-Blue Cross (21-day plan) on a *category basis*")).

The City Council codified these resolutions, and copied their language nearly verbatim, in Section 12-126. By doing so, the City Council clearly meant to import the same meaning of "category basis."[41] Indeed, nothing in the legislative history suggests that the City Council meant "category basis" to mean something different in Section 12-126

[41] *See People v. Duggins*, 3 N.Y.3d 522, 528 (2004) (holding that "where the same word or group of words is used in different statutes, if the acts are similar in intent and character the same meaning may be attached to them," and "when terms of art or peculiar phrases are used, it is supposed that the Legislature had in view the subject matter about which such terms or phrases are commonly employed"); *Zuni Public Sch. Dist. No. 89 v. Dep't of Educ.*, 550 U.S. 81, 90-91 (2007) (explaining that an interpretation of a prior version of a regulatory definition remained the same where the legislature did not express the view that the new legislation was intended to require a change in the definition).

than in the resolutions it codified. And because those resolutions were passed *before* Medicare even existed, Medicare-eligible Retirees could not possibly have constituted a recognized "category basis."

Had the City Council wanted a unique statutory cap to apply to Medicare-eligible Retirees, as the City contends, it could have easily said so. Instead, the Council used the phrase "category basis," a term of art that had always referred to individual and family coverage.

The context in which the term "category basis" appears further confirms its meaning. The sentence containing this term states: "The city will pay the entire cost of health insurance coverage for city employees, city retirees, and their dependents, not to exceed one hundred percent of the full cost of H.I.P.-H.M.O. on a category basis." Admin. Code § 12-126(b)(1). The relevant "categories" of coverage are referenced in the sentence: either the employee/retiree alone (*i.e.*, individual) or the employee/retiree and her dependent(s) (*i.e.*, family). The fact that Medicare-eligible individuals are referenced in a separate sentence later in the statute (and then only to mention an additional benefit they are entitled to) indicates that they are not part of the "category" analysis.

2. The City Council intended there to be one universal statutory cap plan.

When it enacted Section 12-126, the City Council chose to cap the City's payment obligation for everyone, regardless of Medicare eligibility, at the cost of the most expensive healthcare plan offered at the time. In 1967, that was HIP-Blue Cross (21-day plan). (R1321). In 1984, when that plan ceased to exist, it became HIP-HMO. (R1141). Both were non-Medicare plans. Although much of this historical evidence is outside the present record (because the issue was undisputed below), we offer what we can here.

The early drafts of Section 12-126, from July through September 1967, did not include a statutory cap. Instead, they required the City to pay the full cost, whatever that may be, of any plan offered. (R1324, 1329, 1335). In November 1967, after Mayor Lindsay requested a cap to protect the City against future "coverages which it cannot now possibly anticipate" (R1326), the City Council capped the City's payment obligation at the cost of the most expensive plan offered at the time: HIP-Blue Cross (21-day plan), a non-Medicare plan that had served as the cap under (pre-Medicare) Resolutions 155 and 292. (R1327, 1344, 1350). Because this was the most expensive plan, the City Council noted that

its revised legislation would still require the City to "pay for the entire cost of any health insurance plan." (R1327). And for decades, before plans emerged that were more expensive than the statutory cap, the City "pa[id] the full cost of whichever plan [anyone] cho[]se."[42]

The overwhelming majority of Medicare-eligible Retirees have always chosen Senior Care, and the City has always paid the full cost of that plan because it is below the HIP-HMO cap.[43] Although HIP-HMO is a non-Medicare plan, that does not prevent it from setting the cap for everyone, including Medicare-eligible Retirees. The statutory cap is simply a dollar amount limiting the City's health insurance payment obligation to all employees, retirees, and dependents based on whether they seek coverage on an individual or family basis.

The City argues that the statutory cap for Medicare-eligible Retirees should be pegged to HIP-VIP because that is HIP's Medicare-specific HMO-style plan and, according to the City, the cap must be

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[42] *Bentkowski* NYSCEF No. 7 at 3. *See also* R1411, 1733 (1983 and 2004 healthcare handbooks noting that all plans were free).

[43] The City suggests that it has always paid for Senior Care because of collective bargaining, not Section 12-126. But that is false, and the City does not cite any collective bargaining agreement saying as much. None of the collective bargaining agreements in the record mention the City paying for Senior Care. (R168-330, 443-640, 725-838).

"apples-to-apples." City's Br. 46. However, the City fails to mention that there have been years when HIP has administered *multiple* Medicare-specific HMO-style plans for the City, each costing a *different* amount.[44] (By contrast, there has always been just one plan known as "HIP-HMO," and that has always been a non-Medicare plan.) The City does not, and cannot, explain how the statutory cap could be pegged to HIP's Medicare-specific HMO-style plan when it has offered multiple such plans simultaneously with different costs.

3. Additional reasons why HIP-VIP does not set the statutory cap.

There are at least two additional reasons why HIP-VIP does not set the statutory cap.

First, as the City concedes, it has always paid for Senior Care. City's Br. 23. By paying for Senior Care, which, according to the City, is costlier than HIP-VIP, the City has implicitly conceded that HIP-VIP does not set the statutory cap, since the cap is the *maximum* the City is permitted to pay for health insurance coverage. *See* Admin. Code § 12-126(b)(1) (stating that the City's payment for the "cost of health

[44] *See, e.g., Bentkowski* NYSCEF No. 4 at PDF pp. 340, 342.

insurance coverage" is "not to exceed" the statutory cap); *see also* NYSCEF No. 227 at 1 (City acknowledgment that the statutory cap "constitute[s] the maximum" cost permitted "by the law").

Second, HIP-VIP cannot set the statutory cap because it was supposed to be phased out of existence after the City implemented the MAPP. As part of the City's scheme to force Retirees into the MAPP, it announced that it would no longer be offering HIP-VIP to new Medicare-eligible enrollees, and that HIP-VIP's few existing members would be automatically transferred into the MAPP unless they affirmatively opted out.[45] The statutory cap cannot possibly be pegged to a plan that was going to disappear.

* * *

The City would have this Court deny critical healthcare benefits to hundreds of thousands of senior citizens and disabled first responders based on the unpreserved, unsupported, and erroneous claim that HIP-VIP sets the statutory cap for Retirees. The Court should reject this deeply flawed argument.

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[45] *See Frequently Asked Questions (FAQs) About the NYC Medicare Advantage Plus Plan*, https://perma.cc/MZ6Y-S7QJ at 1, 3.

Yet even if the Court were to accept this argument, it should still affirm the order below. Section 12-126 requires the City to pay for health insurance coverage up to "the full cost" of the statutory cap plan. Admin. Code § 12-126(b)(1). Because HIP-VIP is a Medicare Advantage plan, the vast majority of its cost (around $1,126 per person per month) is paid for by the federal government.[46] Since that is higher than the cost of Senior Care and other Retiree plans, the City would still be required to fully fund those plans even if HIP-VIP set the statutory cap (which it does not).

CONCLUSION

For the reasons set forth above, the Court should affirm the order below.

Dated: January 23, 2024
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[46] *See* 42 U.S.C. § 1395w-23; *CMS Regional Rates and Benchmarks 2023*, https://perma.cc/WV9A-SK7T. $7.50 per person per month is just the *City's* portion of HIP-VIP's cost.

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CERTIFICATE OF COMPLIANCE

I hereby certify that this brief was prepared using Microsoft Word, and according to that software, it contains 13,870 words, not including the corporate disclosure statement, the statement of the status of related litigation, the table of contents, the tables of cases and authorities, the statement of questions presented, this certificate, and the cover.

Jacob Gardener