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Court of Appeals

STATE OF NEW YORK

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.

OPPOSITION TO MOTION FOR LEAVE TO APPEAL

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Rule 500.1(f) Corporate Disclosure Statement

Petitioner-Respondent NYC Organization of Public Service Retirees, Inc is not a publicly held corporation. It has no subsidiaries or affiliates that are publicly traded.

Petitioners-Respondents the NYC Organization of Public Service Retirees, Inc., Lisa Flanzraich, Benay Waitzman, Linda Woolverton, Ed Ferington, Merri Turk Lasky, and Phyllis Lipman (together, "Petitioners") respectfully submit this opposition to the motion of Defendants-Appellants Renee Campion, the New York City Office of Labor Relations ("OLR"), and the City of New York (together, "the City") for leave to appeal to this Court from the Appellate Division, First Department's unanimous affirmance of the order of the Supreme Court, New York County granting in part Petitioners' Article 78 Petition.

PRELIMINARY STATEMENT

It is hard to imagine a case less deserving of this Court's discretionary review than this one. At issue here is a two-page opinion by a unanimous First Department affirming a Supreme Court order requiring the City of New York to continue its 55-year compliance with a single provision of its administrative code. This ruling does not conflict in any way with any decision by this Court or any other Appellate Division department, nor does the City contend otherwise. Further, the ruling does not implicate any general legal principles that might impact future litigants. The courts below merely confirmed a simple obligation

imposed on the City by local law, an obligation that the drafters of the legislation and the City itself have explicitly acknowledged. And the City does not, and cannot, identify any scenario in which the discrete, self-contained issue in this case will ever arise again. Thus, there is no need for this Court to step in to ensure a consistent body of decisional law to guide lower courts and the public—the primary consideration on a motion for leave to appeal.

This Court's intervention is also unnecessary because the conclusion reached by all six Supreme Court justices below is unquestionably correct. They held that N.Y.C. Administrative Code § 12-126(b)(1) ("Section 12-126") requires the City to pay up to the statute's monetary cap for *any* health insurance plan a retired City worker selects, not just one plan of the City's choosing (as the City argued).

This was not a difficult or controversial decision. Indeed, it was compelled by the plain text and legislative history of the statute. In fact, prior to this litigation, the City *itself* explicitly and repeatedly acknowledged that Section 12-126 requires it to pay up to the statutory cap for any available health insurance plan, not just one plan. And, since

Section 12-126 was enacted in 1967, the City has always provided the statutory subsidy for every plan, not just one plan.

The City's abrupt change of position in this case has no principled legal basis. It simply reflects the City's current desire to save money by forcing Medicare-eligible retirees to either pay for their existing health insurance or enroll in a new federally funded Medicare Advantage plan that is far inferior. These elderly and disabled retirees are easy targets: not only do the City's powerful labor unions not represent them (they only represent current employees), the unions have actively conspired with the City against these retirees in order to split the cost savings that would accrue from the City's withdrawal of funding for their healthcare.[1]

If the City wishes to escape its financial obligations under Section 12-126, it can simply lobby the City Council to amend the law. In fact, that is exactly what the City is doing right now. If the City Council refuses to pass the City's proposed amendment, the City will just have to

[1] *See Testimony of Jonathan Rosenberg to the New York City Council Committee on Civil Service and Labor Regarding Changes to Municipal Retirees' Healthcare Plan*, October 28, 2021, https://ibo.nyc.ny.us/iboreports/medicare-advantage-testimony-october-2021.pdf ("Testimony of Jonathan Rosenberg") at 1 (explaining that the cost savings would be split between "the administration and the unions"). Indeed, because of the millions of dollars that would flow to the unions, the Municipal Labor Committee—an umbrella organization for the City's labor unions—supported the City below as *amicus curiae*.

comply with the existing statute, just as it has done since 1967. Contrary to the City's fearmongering, it can easily continue offering and paying for retirees' current health insurance. The money the City had hoped to save will merely have to come from somewhere else (or not at all). Although the City might prefer to achieve millions of dollars in savings on the backs of elderly and disabled retired civil servants, that is a political problem, not a legal one for this Court.

Because this case does not present a leave-worthy issue, this Court should deny the City's motion for leave to appeal.

NATURE OF THE ACTION

Retired New York City firefighters, paramedics, cops, teachers, and other civil servants dedicated their lives to—and in many cases risked their lives for—the City. They did not do so for the money. Indeed, most would have made a better living, and enjoyed a safer and healthier existence, in the private sector. They sacrificed their bank accounts and their physical well-being in order to serve their fellow New Yorkers and secure the retirement benefits guaranteed by the City. Chief among those benefits is a choice of health insurance paid for by the City, for life. Given that many elderly and disabled retirees live on small, fixed

incomes with debilitating health issues, the right to receive continued care from their doctors, funded by the City, is essential.

The primary source of this health insurance guarantee is N.Y.C. Administrative Code § 12-126 ("Section 12-126"), which requires the City to provide and pay up to a specified amount (the "statutory cap") for any health insurance plan a retiree chooses. That includes plans specifically designed for Medicare-eligible retirees like Petitioners. Although these elderly and disabled individuals are enrolled in Medicare, the City provides supplemental coverage through various "Medigap" plans, which pay for the substantial portion of healthcare costs that Medicare does not cover. (R29). For decades, the overwhelming majority of Medicare-eligible retirees have enrolled in a Medigap plan known as "Senior Care," which has always been fully paid for by the City pursuant to Section 12-126.

In 2021, in a callous attempt to cut costs (despite a historic multi-billion-dollar budget surplus), the City announced that it would cease funding Medicare-eligible retirees' existing health insurance even though such insurance costs less than the statutory cap. (R29). This withdrawal of funding was part of the City's effort to force these elderly and disabled

individuals into a significantly worse type of health insurance—called "Medicare Advantage"—that is paid for by the federal government.[2] (*Id.*). The City declared that if retirees refused to accept the City's new Medicare Advantage plan, they would be charged thousands of dollars a year—a prohibitive expense for most—to retain their existing health insurance and the doctors, timely care, and superior benefits that come with it, which many desperately need. (R30-31).

In an attempt to justify this unprecedented withdrawal of funding for retiree healthcare, the City argued that Section 12-126 does not require it to pay up to the statutory cap for *every* health insurance plan. Rather, according to the City, it is statutorily obligated to pay for only *one* plan, and the plan it decided to pay for was its new Medicare

[2] The Medicare Advantage plan that the City tried to force on retirees had serious flaws that are common to Medicare Advantage. Most notably, unlike a Medigap plan, it had a limited network of healthcare providers, and it would have prevented retirees from receiving treatments ordered by their doctors unless and until those treatments were deemed "medically necessary" by the insurance company. (R843-74, 914-17, 923-69, 1434-82). It is well-documented that Medicare Advantage's prior authorization requirements cause rampant, life-threatening denials of and delays in medical care. *See, e.g.*, 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*, April 2022, https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.

Advantage plan (which was entirely federally funded, so there was nothing for the City to actually pay).

Inconveniently for the City, this argument contradicted its own longstanding interpretation of Section 12-126 as well as over half a century of past practice. Indeed, before the present litigation, the City had explicitly and consistently stated that Section 12-126 requires it to pay up to the statutory cap for any and all plans, not just one.[3] And the City has always paid for all plans (including Senior Care) that cost below the statutory cap.[4] This was not benevolence – the City simply recognized that Section 12-126 clearly required it.

Due to the mounting cost of healthcare and the allure of federal funds, the City took a gamble and hoped that either (i) retirees would not mobilize and file a lawsuit within the 4-month statute of limitations or (ii) a court would accept its new—and entirely meritless—interpretation of Section 12-126.[5] Neither happened.

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[3] *See, e.g.*, *City of New York v. Grp. Health Inc.*, No. 06-CV-13122 (S.D.N.Y. Nov. 13, 2006), ECF No. 1 ¶ 30 (City acknowledgment that Section 12-126 requires it to pay up to the statutory cap "[n]o matter which plan" is selected); NYSCEF No. 227 at 3 (New York City Law Department letter stating that Section 12-126 "requir[es] that the City, with respect to any offered plan, pay up to the [statutory cap]").

[4] *See, e.g.*, R1283, 1294, 1411, 1733.

[5] Importantly, the City's planned healthcare overhaul would not have actually reduced costs; it would have merely shifted them onto retirees and the federal

Shortly after the City announced its unlawful healthcare overhaul in 2021, thousands of elderly and disabled retirees from across city agencies came together (despite innumerable obstacles presented by the pandemic), formed a non-profit called the NYC Organization of Public Service Retirees, and brought an Article 78 proceeding challenging the City's assault on their healthcare rights. (NYSCEF Nos. 1-23).[6] The trial court granted their Article 78 Petition in relevant part, holding that the City was required by Section 12-126 to continue paying up to the statutory cap for all available health insurance plans, including Senior Care, which cost below the cap. In doing so, the court rejected the City's sole argument regarding Section 12-126 that it need only pay for one plan of its choosing.[7]

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government. Moreover, as the Director of Budget Review for the New York City Independent Budget Office testified, the City's plan to withdraw funding for retiree healthcare would not have even saved New York City taxpayers any money. That is because all cost savings were slated to go to "the administration and the unions" (with no "accountability or direct oversight"), not the City budget. *Testimony of Jonathan Rosenberg*, at 1 (explaining how the City's plan would "provide[] the city with no actual budgetary savings").

[6] All citations to NYSCEF refer to the trial court docket.

[7] A thorough recitation of the procedural history is set forth in Petitioners' First Department brief. As that history makes clear, in none of the City's memoranda of law or oral arguments did it 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).

On November 22, 2022, the First Department unanimously affirmed.

ARGUMENT

Although the City never actually sets forth any question of law presented (as required by 22 N.Y.C.R.R. 500.22(b)(4)), its proposed appeal to this Court, like its appeal below, raises a simple legal issue: whether Section 12-126 requires the City to pay up to the statute's monetary cap for *any* healthcare plan a retiree selects or only *one* plan of the City's choosing. The City argues it is the latter (one plan). Petitioners argue it is the former (any plan). The statute's text and legislative history, both of which the City distorts in its motion papers, overwhelmingly support Petitioners' position. In fact, when enacting Section 12-126, the City Council explicitly stated that the law required the City to pay for "any health insurance plan" a retiree chooses, just as the City was required to do under the Board of Estimate resolution codified by Section 12-126. (R1327).

In light of the unambiguous statutory text and legislative history, the trial court and all five First Department justices below easily

concluded that Section 12-126 requires the City to pay up to the statutory cap for any available health insurance plan.

Importantly, prior to this litigation, the City *itself* had always acknowledged this fact. In 2006, the City conceded in unrelated litigation 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 statutory cap, and that this obligation applies "*[n]o matter which plan*" is selected. Compl., ECF No. 1 ¶ 30, *City of New York v. Grp. Health Inc.*, No. 06-CV-13122 (S.D.N.Y. Nov. 13, 2006).[8] Similarly, in a 2016 letter to the City's Office of Labor Relations, 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). Moreover, throughout the 55-year history of Section 12-126, the City has always complied with its obligation to subsidize all available health insurance plans. The City suddenly changed its position in this litigation for the simple—and unprincipled—reason that it no longer wishes to pay for retiree healthcare.

[8] Unless otherwise indicated, all emphasis in this brief has been added, and all internal quotations, citations, and alterations have been omitted.

In sum, the City asks this Court to hear its appeal in order to decide a question that everyone that has ever considered it—including the City itself for over half a century, the City Council, and all six Supreme Court justices below—has answered the same way: Section 12-126 requires the City to pay up to the statutory cap for any plan a retiree chooses.

As explained below, this question does not merit additional review by this Court.

I. THE FIRST DEPARTMENT'S UNANIMOUS DECISION DOES NOT CONFLICT WITH ANY DECISION BY THIS COURT OR ANY OTHER DEPARTMENT, NOR WOULD SUCH A CONFLICT ARISE IN THE FUTURE.

The "primary function" of this Court has been described as "declaring and developing an authoritative body of decisional law for the guidance of the lower courts, the bar and the public, rather than merely correcting errors committed by the courts below." Cohen & Karger, *The Powers of the NY Court of Appeals*, Chapter 10:3 (citations omitted). To that end, when deciding whether to grant leave to appeal, this Court considers the case's broader impact on the law, including whether the issues raised "present a conflict with prior decisions of this Court, or involve a conflict among the departments of the Appellate Division." 22 N.Y.C.R.R. 500.22(b)(4). This case presents no such issues.

Indeed, the City does not, and cannot, identify any decision by this Court or any Appellate Division department that even remotely conflicts with the unanimous decision below. Thus, review by this Court would not help ensure a consistent body of decisional law to guide lower courts, the bar, or the public.

This case involves a narrow issue regarding the meaning of a single sentence in one municipality's administrative code. No other laws or broader legal principles are at stake. Moreover, the sole issue in this case—whether Section 12-126 requires the City to subsidize all available healthcare plans—is now firmly settled and will remain so. The First Department ruled that the City must continue to subsidize all available plans, just as the City has done for over half a century pursuant to its acknowledged statutory obligation. There is no realistic scenario in which this issue would ever be litigated again, nor does the City identify any such scenario. Thus, there is no reason for this Court to weigh in.

II. THE CITY'S INTERPRETATION OF SECTION 12-126 IS MERITLESS.

The Court should deny the City's motion for leave to appeal for the additional reason that the requested appeal lacks merit. As explained below, the trial court and the First Department correctly concluded that

Section 12-126 requires the City to pay up to the statutory cap for any available health insurance plan, not just one plan of the City's choosing.

A. The relevant language of Section 12-126.

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." N.Y.C. Admin. Code § 12-126(b)(1).

"Health insurance coverage" is defined to encompass all of the plans offered by the various health insurance "companies" participating in the City's health benefits "program." *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 any health insurance plan offered through the City's Health Benefits Program, not just one plan of the City's choosing. The City's argument is decisively refuted by the plain text of the statute, the City Council's statement of legislative intent, the legislative history, and past practice. Each of these tools of statutory construction is addressed below.

B. 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 offered through 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 health insurance plans, all of which were paid for by the City up to a predetermined amount. 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). The legislation, which amended General Municipal Law § 92-a, 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, with the balance, if any, to be paid by the

employees." (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 amended General Municipal Law § 92-a so that it could offer and pay for a variety of health insurance plans.

Immediately after § 92-a was amended in 1965, the City promptly took full advantage of 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 Board of Estimate resolution announcing these benefits used language nearly identical to that of Section 12-126, which was passed shortly thereafter.[9] The 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

[9] The now-defunct Board of Estimate possessed various administrative powers and comprised the Mayor, Comptroller, the City Council president, and the five borough Presidents. (R1348).

> 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)).[10] Notably, the term "such health and hospital insurance" referred to *all three* of the health insurance plans offered by the City, and the HIP-based dollar 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.

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

C. Section 12-126 codified the City's obligation to provide and pay for a choice of 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 any health insurance plan offered to City employees, retirees, or their dependents. (*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 v. City of New York*, No. 98-CV-1425, 1999 WL 177442, at *12 (S.D.N.Y. Mar. 30, 1999) (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, these statutory cap plans—the H.I.P.-Blue Cross (21-day plan)

in 1967, and the HIP-HMO plan in 1984—were the most expensive plans offered at the time, meaning the City had to pay the entire cost of those plans as well as all of the other (less expensive) plans.

There is no question that the intent behind Local Law No. 120 was for the City to pay up to the statutory cap for *any* health insurance plan offered through the City's Health Benefits Program, not just one such plan. 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 law. 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].*" (R1327).[11] The City's only response to this clear articulation of legislative intent (which it relegates to a footnote) is

[11] 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).

to claim, preposterously, that the Committee did not mean what it said. City's Br. 24 n.9.

D. The plain text of Section 12-126 makes clear that the City must fund any health insurance plan offered through the City's Health Benefits Program.

The statute's plain text confirms the City's obligation to fund all available health insurance plans, not just one. The statute requires the City to pay for "health insurance coverage," and not, as the City claims, merely one health insurance plan. When the drafters of the statute wanted to refer to a single health insurance plan, they did so expressly. *See* N.Y.C. Admin. Code § 12-126(b)(2)(ii) and (iii) (referring to a deceased retiree's "health insurance plan"). By describing the City's healthcare payment obligation in the broadest possible terms ("health insurance coverage"), the City Council clearly meant more than just one "health insurance plan." *See Rangolan v. Cty. of Nassau*, 96 N.Y.2d 42, 47 (2001) ("[W]here, as here, the Legislature uses different terms in various parts of a statute, courts may reasonably infer that different concepts are intended.").

Indeed, the statutory definition of "health insurance coverage" proves this. Section 12-126 defines that term 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." N.Y.C. Admin. Code § 12-126(a)(iv). As explained below, these underlined words refer to the multiple health insurance plans offered through 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 multiple 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)). The state statute that authorized Section 12-126 likewise uses the term "program" to encompass all offered plans. *See* N.Y. State General City Law § 20(29-b) (empowering cities to pay certain costs for "any retired officer or employee who . . . is enrolled in a choice of *health plans program* offered by the city"). Further, as explained in every healthcare-related document published by the City, all of the health insurance plans available to City employees, retirees, and their dependents are offered through the City's Health Benefits "Program."

(*See, e.g.*, R83, 87, 100, 110, 113, 330, 391, 1162, 1409). Thus, contrary to the City's contention (City's Br. 23), 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 health insurance plans offered through 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 single health insurance plan to be offered by multiple insurance companies pursuant to different contracts with the City, the City has never identified any evidence of a multi-company/multi-contract plan.[12]

Comparative statutory analysis supports Petitioners' interpretation. When General Municipal Law § 92-a was amended 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.

[12] The only contract documentation in the record relates to the Medicare Advantage plan that the City unsuccessfully tried to force on retirees. Although that plan involved two separate insurance companies, it was governed by a single contract. (R1419).

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 Municipal Law § 92-a, which was designed to give the City 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 obligations. 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 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 available health insurance plans, not just one plan.[13]

E. The City's prior statements and uninterrupted past practice support the trial court's holding.

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 any and all health insurance plans, not just one plan.

In fact, the City has explicitly said so. As noted above, the City conceded in a 2006 federal lawsuit 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*" is selected. Compl., ECF No. 1 ¶ 30, *City of New York v. Grp. Health Inc.*, No. 06-CV-13122 (S.D.N.Y. Nov. 13, 2006). And in 2016, the New York City Law Department wrote that Section 12-126 "requir[es] that the City, with

[13] A former State Supreme Court justice and City Councilmember—who sat on the City Council right 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 any and all health insurance plans. (R1967).

respect to *any offered plan*, pay up to the [statutory cap]." (NYSCEF No. 227 at 3).

Decades of past practice confirm the City's obligation to pay up to the statutory cap for any and all health insurance plans. From 1967 (when Section 12-126 was originally enacted) to the present, 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.[14] Indeed, this fact is so widely recognized the Second Circuit Court of Appeals has taken note of it. *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"). The City does not, and cannot, point to any contrary evidence.

[14] *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 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 the HIP-HMO plan).

This longstanding and uninterrupted past practice by the City constitutes an additional binding concession regarding the meaning of Section 12-126. *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); *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 past practice regarding provision of disability benefits).

F. The City's arguments are meritless.

As demonstrated above, the plain text, legislative history, past practice, and prior City concessions all compel the conclusion reached by the trial court: Section 12-126 requires the City to pay up to the statutory cap for any available health insurance plan, not just the City's preferred plan. In the face of this overwhelming evidence regarding the meaning of Section 12-126, the City resorts to making meritless arguments based on (i) distortions of the historical record and (ii) flawed policy analysis. Each of these erroneous arguments is addressed below.

First, the City contends that then-Mayor Lindsay's objections to, and the City Council's subsequent revision of, an early draft of Local Law

No. 120, which included a reference to "any basic health insurance plan," shows that the statute was meant to require payment of only one plan, not any plan. City's Br. 23-24. 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 a definitions section. 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 early version of the bill that would eventually become Local Law No. 120 (which was later codified at Section 12-126). (R1323-24). It differed from the final version in several respects. Most notably, it lacked a statutory cap and defined terms. It also used the phrase "any basic health insurance plan" instead of "health insurance coverage."

In September 1967, Mayor Lindsay returned the bill with his disapproval because of four "technical defects." (R1326). Only the second one is relevant here: Mayor Lindsay complained that "[t]he phrase 'basic health insurance plan' is nowhere defined," which would mean the City

would face an "open-ended" financial obligation that it "cannot now possibly anticipate." (*Id.*). Importantly, although the mayor 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 on Health and Education presented a revised bill that adequately addressed Mayor Lindsay's concerns and was promptly passed into law. It solved the second "technical defect" by defining, and setting 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 term defined to include the benefits offered by the various health insurance "companies" participating in the City's health benefits "program"—up to a generous limit set at the cost of a specific HIP plan (which was the costliest plan available at the time). In its report accompanying the final version of the bill, the Committee on Health and Education noted that although certain language had changed, the City's obligation to fund all available 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 signed the bill into law.

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 to be offered, but compels the City to pay for them if they are offered, subject only to the law's monetary cap." City's Br. 20. There is nothing confusing or illogical about the City Council's intent: it sought to protect those who served the City—many of whom sacrificed their health, safety, and potential for higher earnings—by paying for their chosen health insurance plan up to a generous amount. Section 12-126 reflected a collective desire for the City to "assume" payment for a "choice 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 not have predicted that the City might someday seek 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.[15] And, regardless, such a maneuver would violate the clear purpose of the statute, which was for the City to fund a choice of health insurance options.

III. THIS COURT LACKS JURISDICTION TO REVIEW THE CITY'S UNPRESERVED FACTUAL ARGUMENT REGARDING THE STATUTORY CAP AMOUNT.

In a last-ditch effort to identify some leave-worthy issue, the City also asks this Court to weigh in on an unpreserved factual argument regarding the statutory cap amount. City's Br. 27-30. Specifically, the City argues that the trial court should not have ordered it to continue paying for Senior Care since that plan costs more than the HIP VIP Premier Medicare Plan. *Id.* According to the City, the HIP VIP Premier Medicare Plan (R148) (which is commonly known as the "HIP-VIP plan"

[15] Medicare Advantage plans first appeared in the late 1990s.

(R1733)) sets the statutory cap for Medicare-eligible retirees, while the HIP HMO Preferred Plan (R113) (which is known as the "HIP-HMO plan" (R1733)) sets the statutory cap for everyone else. *Id*.

The City is wrong: the HIP-HMO plan sets the statutory cap for everyone, including Medicare-eligible retirees. But that is irrelevant here. Because the City failed to preserve its statutory cap argument, this Court lacks jurisdiction to review it.

A. The City failed to preserve its statutory cap argument, thereby depriving this Court of jurisdiction.

As the First Department correctly held, the City failed to preserve its statutory cap argument. Indeed, the City never disputed the statutory cap in any of its trial court briefs or during any of the trial court hearings or oral arguments. It had ample opportunity to do so.

The trial court proceedings featured nearly six months of briefing and hearings on the legality of the City's overhaul of retiree healthcare benefits. 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 ($776 per person per month, which was the cost of individual coverage under the HIP-

HMO plan). (*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. *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").

Moreover, after raising no objections to Petitioners' statutory cap analysis, the City urged the trial 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.[16] (NYSCEF No. 198). And that is exactly what the trial court announced it would do—and ultimately did—given the lack of any factual dispute.[17] (SR 1, 11).

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[16] *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").

[17] The night before the trial court issued its ruling on the Petition, 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 the statutory cap for Medicare-eligible retirees was somehow only $7.50. (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

Because the City failed to preserve its statutory cap argument, this Court lacks jurisdiction to hear it. *Bingham v. New York City Transit Auth.*, 99 N.Y.2d 355, 359 (2003) (Court of Appeals "lack[s] jurisdiction to review unpreserved issues"); *Merrill by Merrill v. Albany Med. Cntr. Hosp.*, 71 N.Y.2d 990, 991 (1988) (dismissing appeal because "the Court of Appeals may not address [unpreserved] issues"); *Brown v. City of New York*, 60 N.Y.2d 893, 894 (1983) (unpreserved error "on the law" was "beyond this court's power to review").[18]

This preservation rule not only protects the Court's institutional interests,[19] it ensures that parties have a full and fair opportunity to

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that after oral argument (during which the City conceded that Senior Care costs 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. The trial court correctly rejected this meritless and procedurally 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 raised for the first time in a letter of counsel presented after the motion had been orally argued and submitted").

[18] The two preservation-related cases cited by the City do not help it. *See* City's Br. 27. In *U.S. Bank N.A. v. DLJ Mortg. Capital, Inc.*, 33 N.Y.3d 84 (2019), 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. And in *Geraci v. Probst*, 15 N.Y.3d 336 (2010), 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 at 342.

[19] *See Bingham*, 99 N.Y.2d at 359 ("[I]n making and shaping the common law—having in mind the doctrine of stare decisis and the value of stability in the law—this Court best serves the litigants and the law by limiting its review to issues that have first been presented to and carefully considered by the trial and intermediate appellate courts.").

develop the 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." *Bingham*, 99 N.Y.2d at 359. So too here. Had the City properly raised its statutory cap argument in the trial court, Petitioners would have refuted it with additional 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 and non-Medicare-eligible, 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. An appeal based on such a deficient record also risks creating bad law.

B. The City's unpreserved statutory cap argument is also meritless.

The City's unpreserved statutory cap argument is also meritless, which is likely why the City did not press this argument in the trial court.[20]

The City argues that the HIP-VIP plan sets the statutory cap for Medicare-eligible retirees while the HIP-HMO plan sets the cap for everyone else. City's Br. 28-30. That is not how Section 12-126 works.

As the City conceded below, the statutory cap is pegged to "the cost of *a particular plan*," specifically the "HIP-HMO" plan, 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

[20] The City notes in passing that the trial court ruled on the Petition before "any answer had been filed." City's Br. 12. Importantly, however, the City does not claim that this was procedurally improper. That is because it was not. Not only did the City take full advantage of its ample opportunity to present its arguments and defenses, it affirmatively asked the trial court to rule on the merits of the Petition based on the existing undisputed record. *See Hawkins v. New York City Transit Auth.*, 26 A.D.3d 169, 170 (1st Dep't 2006) ("It was not necessary for the court to grant respondents leave to serve an answer under CPLR 7804(f) before ruling on the merits, since they had already clearly stated their relevant arguments, leaving no material facts in dispute."); *cf. Wein v. City of New York*, 36 N.Y.2d 610, 620-21 (1975) (party who specifically asked for judgment pursuant to statute converting dismissal motion into summary judgment motion could not be heard to complain that court treated motion in that fashion).

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 the HIP-HMO plan. (*See* NYSCEF No. 227 at 1 (stating that cost of the "H.I.P. H.M.O. Preferred Plan . . . constitute[s] the maximum City cost established by the law")).

The City attempts to circumvent this problem by claiming that "Medicare-eligible" is actually a "category" for purposes of Section 12-126. City's Br. 28-30. That is incorrect. A "category" has always referred to types of coverage within the same plan, not to different plans. And, as stated in the City's own documents, "category basis" refers to the two types of coverage that exist within the HIP-HMO plan: individual and family. (*See, e.g.*, R606 (stating that the City must pay for health insurance coverage up to "100% of the full cost of HIP-HMO on a category basis," and explaining that "category basis" refers to "individual or family")). The legislative history reveals that HIP has always based its health insurance costs on the categories of individual and family coverage. (*See, e.g.*, R1375).

Tellingly, the City cannot point to anything in the text or 55-year history of Section 12-126 stating that "Medicare-eligible" is a recognized "category" for purposes of the statute. That is because it is not.

The legislative history of Section 12-126 confirms that "Medicare-eligible" is 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 (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*"); R1344 (same); R1345 (same); R1346 (same); R1347 (same)). An earlier related resolution—Resolution Cal. No. 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 verbatim, in Section 12-126. By doing so, the City Council

clearly meant to import the same meaning of "category basis."[21] Indeed, nothing in the legislative history suggests that the City Council meant "category basis" to mean something different in Section 12-126 than in the resolutions it codified. And because those resolutions were passed before Medicare even existed, "Medicare-eligible" could not possibly have constituted a recognized "category basis."

Had the City Council wanted different statutory caps to apply to Medicare-eligible retirees and non-Medicare-eligible individuals (as the City contends), it could have easily said so. Instead, the Council used the phrase "category basis," a term of art taken from Board of Estimate resolutions that referred to individual and family coverage, not Medicare eligibility.

There are several additional reasons why the City's unpreserved statutory cap argument fails, which are laid out in Petitioners' First

[21] *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).

Department brief. For the sake of brevity, we mention only one of them here.

As the City acknowledged below, it has always paid the full cost of Senior Care even though such insurance has historically cost more than the HIP-VIP plan. Thus, by paying for Senior Care, which is costlier than the HIP-VIP plan, the City has implicitly conceded that the HIP-VIP plan does *not* set the statutory cap for Medicare-eligible retirees, since the cap is the *maximum* the City is allowed to pay for health insurance coverage. *See* N.Y.C. Admin. Code § 12-126(b)(1) (stating that the City's payment for the "cost of health 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").

IV. THIS COURT'S REVIEW IS UNNECESSARY.

Finally, the City claims—perversely—that its requested appeal is necessary to help the very retirees who oppose it. According to the City, unless this Court grants leave and rules that Section 12-126 allows it to cease funding retirees' existing health insurance, the City will be compelled by an arbitrator to cease offering such insurance and only offer

a single federally funded Medicare Advantage plan. City's Br. 16-18, 21. That is false.

What the City claims is an arbitrator's binding order is in fact just a "Recommendation" (Schoepp-Wong Aff., Ex. B at 31) by one of the three chairs of a healthcare policy committee formed in 2018 to "study" and "make recommendations to be considered by the MLC and the City." (*Id.*, at Attachment A at 3). The City is not required to adopt this Recommendation. At most, it need only consider it.[22]

Although the chair at issue, Martin Scheinman, was also authorized to arbitrate disputes between the City and the MLC during fiscal years 2019-2021 (*id.* at 1, 3), Mr. Scheinman was not operating in his capacity as arbitrator when he issued his Recommendation, as his affirmation makes clear. (*See* Schoepp-Wong Aff., Ex. B at 31 (affirming that "this instrument" is Mr. Scheinman's "Recommendation" as chair of the "Tripartite Committee")).[23] That is because there was no dispute between the City and MLC—both parties eagerly agreed to cease funding

[22] In fact, the City's obligation to consider such recommendations expired on June 30, 2020. (*Id.*).

[23] By contrast, when Mr. Scheinman issued decisions in his role as arbitrator, he stated so explicitly in his affirmation.

retiree healthcare and to split the savings—and because Mr. Scheinman's authority to serve as arbitrator expired in fiscal year 2021. (*Id*., at Attachment A at 1, 3).

Thus, this Court does not need to intervene in order for the City to be able to offer retirees a choice of healthcare options. The City can simply continue to offer and subsidize those options, just as it has done for over half a century. Or it can persuade the City Council to amend Section 12-126, which the City is currently trying to do. In short, to the extent the City wishes to escape its financial obligations under Section 12-126, that is a political problem, not a legal problem for this Court.

Lastly, even if this Court were to grant leave and rule in favor of the City (thereby allowing it to offer, but not fund, Medigap plans like Senior Care), that would not in fact protect retiree healthcare choice. Many municipal retirees live on fixed monthly incomes of less than $1,500 and cannot afford to pay thousands of dollars a year for a Medigap plan. An unaffordable plan is not a real choice. Moreover, retirees can already purchase Medigap plans on the open market outside of the NYC Health Benefits Program. Thus, "offering" retirees unsubsidized plans is not meaningfully different from not offering them at all.

CONCLUSION

For the reasons set forth above, the Court should deny the City's motion for leave to appeal.

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