APL-2023-00086

To be argued by:
RICHARD DEARING
15 minutes requested

Court of Appeals
State of New York

In the Matter of the Application of

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

Plaintiffs-Respondents,

against

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

Defendants-Appellants.

BRIEF FOR APPELLANTS

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October 23, 2023

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PRELIMINARY STATEMENT

This case is about the scope of the City of New York's obligation under Administrative Code § 12-126 to provide premium-free healthcare to its retired workforce. For years, the City has worked with municipal unions to rein in ballooning healthcare costs for both employees and retirees—the costs for retirees having tripled over the past two decades to approach $1 billion annually. To address this fiscal challenge, the City sought to offer a new, union-backed, and premium-free Medicare Advantage insurance plan to retirees, while giving them the option to stay in their old plan and pay the premiums. By taking advantage of untapped federal subsidies, the City would save around $600 million every year.

But the Appellate Division, First Department, held that Administrative Code § 12-126 bars the City from giving retirees such a choice—even though petitioners, a small fraction of retirees, brought this lawsuit to maintain their preferred plan, Senior Care. According to the Appellate Division, the City must either reject over half a billion dollars in annual savings or make a new Medicare Advantage plan the *only* option for Medicare-eligible retirees.

Considering the fiscal environment, that is no choice at all. Indeed, after the Appellate Division's decision, a labor arbitrator ruled that the only prudent path forward was for the City to implement a Medicare Advantage plan and eliminate other plans. The City acted on that ruling by offering a substantially improved Medicare Advantage plan, while discontinuing all other plans except one referenced in § 12-126 itself. But these measures were also derailed by a separate litigation brought by petitioners.

To get to its result satisfying no one, the Appellate Division had to stray far from § 12-126's text and history. The law's command is both significant and defined: by its terms, the City must "pay the entire cost of health insurance coverage" for employees, retirees, and their dependents—with the City's monetary obligation capped at a level tied to the relevant category of insurance provided. And the City would fully satisfy this command as to the one category at issue here, Medicare-eligible retirees, by making available a robust, premium-free Medicare Advantage plan with hospital, surgical, and medical benefits. Yet the Appellate Division required

the City to also pay for *any* plan that the City may make available to retirees, even optional plans like Senior Care.

At the same time, the Appellate Division refused to state *how much* its interpretation of § 12-126 requires the City to pay, leaving in place Supreme Court's permanent injunction without addressing petitioners' claim that the cap falls at a level over four times the actual cost of their preferred plan. Nothing in § 12-126 supports that result. On the contrary, the law caps the City's monetary obligation of insuring Medicare-eligible retirees at the substantially lower cost of a particular plan—referenced in the law itself—that covers Medicare-eligible retirees in New York City and surrounding counties. This Court should reverse and dismiss the petition.

QUESTIONS PRESENTED

1. Did the Appellate Division err in holding that Administrative Code § 12-126 prohibits the City from rolling out and paying for a new healthcare plan for Medicare-eligible retiree unless it either (a) cancels all other optional, more expensive plans currently available to such individuals, or (b) subsidizes those other plans?

2. Did the Appellate Division err in affirming the lower court's ambiguous interpretation of § 12-126's monetary cap?

STATEMENT OF THE CASE

A. The City's historic commitment to providing robust healthcare coverage to its employees, retirees, and their dependents

1. The City's healthcare offerings before the introduction of Medicare

Going back nearly 80 years, long before Administrative Code § 12-126 existed, the City has provided high-quality healthcare coverage to its public servants. In the 1940s, the City offered medical insurance through the then-nonprofit Health Insurance Plan of Greater New York (HIP)—finding the coverage to be "comprehensive and complete"—and offered hospitalization insurance through

Blue Cross (Record on Appeal ("R") 1350, 1357–76). Employees shared the costs of coverage with the City (R1376–77).

In 1965, the City agreed to "provide a choice of health insurance plans for certain employees in the uniformed forces" as a result of collective bargaining (R1342, R1350–51). After a transition period, the City assumed 100% of the cost, not to exceed "the full cost of HIP-Blue Cross (21-day Plan) on a category basis" (R1350). By the end of that year, the City extended those benefits to other employees (R1341–48). Retirees could also choose among "the same, or equivalent" plans, with the City paying for "such choice," with the cost "not to exceed 100% of the full cost of H.I.P.-Blue Cross (21-day Plan) on a category basis" (R1343–45). In recognition of the different healthcare needs of active employees and retirees, the City specifically allowed providers to charge different premiums for those two categories (R1344–45).

2. The City's early response to the introduction of Medicare as the primary insurer of people age 65 and older

Medicare's enactment in 1965—and the federal healthcare benefits it provided to those 65 and older—sparked fundamental

changes in health insurance across the country. The City was no exception: that year, it commissioned a study to examine "the effect of the [M]edicare program" on its offerings and to recommend "adjustments or revisions" to "further the health and welfare of … employees and retirees, and protect the interests of the City" (R1347).

With Medicare, the City's healthcare plans for Medicare-eligible retirees took on a new form, building on, rather than duplicating, Medicare's foundation (R1339). In the decades since, the City has contracted with private insurers to offer at least two kinds of Medicare-based plans: (1) Medigap plans covering charges that Medicare does not (R66, 111, 147–48, 1339); and (2) Medicare-subsidized private plans offering complete coverage (R111, 147–48, 1414); *see, e.g.*, N.Y.C. Office of Labor Relations, *New York City Employee Benefits Program* 26–27 (1986), https://perma.cc/L9NX-Y3Y8 (identifying several Medicare-based private plans); *see also* Yash M. Patel & Stuart Guterman, *The Evolution of Private Plans in Medicare* (2017) (describing Medicare's role in funding private plans offering federally regulated benefits).

Medigap plans pay part of a healthcare provider's Medicare-approved charges (R66, 148). *See* U.S. Ctrs. for Medicare & Medicaid Servs., *Learn What Medigap Covers*, https://perma.cc/44WW-NHW4 (captured Oct. 6, 2023). Medicare often pays 80%, with a Medigap plan covering the remainder, subject to deductibles and copays (R1953). Over the years, the City has offered several Medigap plans, including Senior Care (R148, 151).

Meanwhile, federally regulated, Medicare-subsidized private plans—known today as Medicare Advantage plans, or Medicare Part C—have "been part of Medicare since the program's inception in 1966." Patel & Guterman, *supra* (*see also* R111, 147–48, 1414). With the support of Medicare funding, these plans pay healthcare providers the entire amount owed to them, subject to deductibles and copays. These privately administered plans are typically more efficient and often receive larger federal subsidies than the payments made under traditional Medicare, allowing them to offer greater benefits at reduced cost (NYSCEF No. 118 at 15).[1] *See*

[1] Unless otherwise indicated, we use "NYSCEF No." to refer to the New York County Supreme Court docket (Index No. 158815/2021).

Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* 414–20 (2022), https://perma.cc/GV7P-JRKQ.

Medicare Advantage plans have formed part of the City's offerings for nearly as long as Medicare has been around. And over time, these plans have held increasing prominence among the City's offerings (R111, 148). At present, around 50,000 retirees and dependents are enrolled in Medicare Advantage plans (*see* Verified Answer ¶ 423, *Bentkowski v. City of N.Y.*, Index No. 154962/2023 (Sup. Ct. N.Y. Cnty. June 16, 2023), NYSCEF No. 82).

B. The evolution of Administrative Code § 12-126 and the floor it sets for healthcare coverage

1. The failed proposal to compel the City to pay for any basic healthcare plan

Legislators responded to the changing backdrop. Shortly before Administrative Code § 12-126's enactment, the State Legislature authorized the City "to contract" with private companies to provide health insurance to employees and retirees and to pay "all or any part of the sum to be paid under such contract." Gen. City Law § 20(29), (29-a); *see also* Gen. Mun. Law § 92-a(2). The City

Council then embarked on codifying its obligation to cover the contractual healthcare costs for its active and retired workforce in what would become § 12-126.

The Council's first attempt proved too expansive. As proposed, that bill would have required the City to "pay for the entire cost of *any* basic health insurance plan" for essentially all employees, retirees, and their dependents (R1324 (emphasis added)). As a result, then-Mayor John Lindsay vetoed the bill. Among his concerns was the risk that the law "expos[ed] the City to unforeseeable and possibly unwelcome additional demands on its financial resources" (R1326). Specifically, the Mayor objected to requiring the City to pay "the entire cost of any basic health insurance plan" because "the City would be bound to an open-ended obligation to pay for coverages which it cannot now possibly anticipate" (R1326).

2. Local Law 120 of 1967 and the obligation to pay the cost of a single healthcare plan, with a category-based monetary cap

Local Law 120 of 1967, later codified as Administrative Code § 12-126, addressed many of these problems. The law jettisoned the open-ended obligation to pay for "any basic health insurance plan"

in favor of requiring the City to cover "the entire cost of Health Insurance Coverage for City employees, City retirees, and their dependents" (R1320–21, 1331–32). "Health Insurance Coverage" was defined in the singular as: "[a] program of hospital-surgical-medical benefits to be provided by health and hospitalization insurance contracts entered into between the city of New York and companies providing such health and hospitalization insurance" (R1320, 1332 (emphasis added)). Thus, consistent with the City's authority under state law (*see supra* at 8), Administrative Code § 12-126 tied the City's financial obligation to the contractual cost of insurance.

Further limiting the City's financial obligation, the law also capped the amount that the City was required to pay to obtain a full "program of hospital-surgical-medical benefits" (R1320–21, 1333–35). Under the law, the City was obliged to pay no more than "one hundred per cent of the full cost of H.I.P.-Blue Cross (21-day plan) on a category basis" (R1321, 1335). As explained, HIP-Blue Cross had been around since 1965, though by this point the plan was really two different plans: it differed significantly for Medicare-

eligible individuals and everyone else—for the former, Medicare was the foundation of coverage (R1338–39).

The law also recognized that Medicare-eligible individuals were different in other ways. To adapt to Medicare, the law prescribed additional requirements "[w]here such health insurance coverage is predicated on the insured's enrollment in [Medicare]" (R1320–21). The City would also reimburse Medicare enrollees for the Part B premiums paid to the federal government (R1321).[2]

The law also omitted language that would have limited the City's flexibility in selecting a healthcare plan. Unlike the City's then-existing agreements with municipal unions, the law did not require the City to pay for a "choice of health and hospital insurance" (R1350–51, 1342–45). And the City Council considered *and*

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[2] While Medicare Part A provides hospital insurance, Part B provides coverage for medical insurance for doctor services, outpatient care, durable medical equipment, and many preventative services. *See* U.S. Ctrs. for Medicare and Medicaid Servs., *What Part B Covers*, https://perma.cc/F3V2-AQP6 (captured Oct. 6, 2023). Part B premiums are not at issue in this litigation, though they are another significant benefit—totaling hundreds of millions of dollars annually—that the City extends to its retired workforce.

rejected a proposal that would have prohibited the City from reducing benefits in the future (R1320–21, 1331–35).

3. Local Law 28 of 1984 and the updated category-based monetary cap

By 1984, the HIP-Blue Cross product that § 12-126 referenced for its category-based monetary cap had been discontinued and replaced by a new HMO plan: HIP-HMO (R1141–43, 1408–11, 1414).[3] But like its predecessor, HIP-HMO was really two different plans. For those ineligible for Medicare, the plan provided "primary health insurance coverage" (R1414–17). But for those eligible for Medicare, the plan took the form of what would become known as a Medicare Advantage plan: a private plan leveraging Medicare funding, but with coverage provided through HIP's HMO (R1414).

Local Law 28 of 1984 addressed this changed landscape, amending § 12-126 to update the category-based monetary cap accordingly. Under the revised law, the City would "pay the entire

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[3] An HMO, or health maintenance organization, is a managed care insurance plan through which a primary care physician manages a member's healthcare needs and typically requires the use of network doctors and facilities (R111). By contrast, a PPO, or participating provider organization, typically offers the freedom to use either a network or out-of-network provider (R111).

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"—that is, based on the category of coverage provided, such as whether the coverage provided primary insurance or depended upon Medicare (R1134).

Corresponding HIP-HMO plans are still available today through HIP's successor, EmblemHealth, though the labels have changed. Like their predecessors, contemporary HIP offerings continue to recognize the fundamental difference between people who are eligible for Medicare and those who are not. The HIP-HMO for those ineligible for Medicare is HIP HMO Preferred, and reflecting its role as the "primary insurer," the monthly premiums in fiscal year 2021 were around $776 (R106, 133, 1282–83, 1293).

Meanwhile, the HIP-HMO for those eligible for Medicare is HIP VIP Medicare, also known as VIP Premier (HMO) Medicare ("HIP VIP HMO") (R148, 157, 1282–83). As a Medicare Advantage plan, the plan is funded through direct federal subsidies as well as the City's premium payments (R111, 148, 157). Reflecting the plan's secondary role, the monthly premiums for HIP VIP HMO in

fiscal year 2021 were around $182—less than a quarter of the premiums for HIP HMO Preferred (R1282–83, 1293–94).

In 2022, when the City intended to roll out its new Medicare Advantage plan, the monthly premiums for HIP VIP HMO were even lower, $7.50—the same as the premiums for the new Medicare Advantage plan (R698, 1642, 1970–71). Though this litigation prevented the City from implementing that plan, HIP VIP HMO's monthly premiums remained at $7.50 through 2022 and 2023.[4]

C. The City's agreements with municipal unions to provide coverage above and beyond what is required by Administrative Code § 12-126

Collective bargaining remains the core process by which the health benefits offered by the City are determined. Administrative Code § 12-126 thus codifies a minimum obligation that the City must meet, subject to a category-based monetary cap (R1134). But

[4] Despite financial projections from the Office of Actuary that inaccurately assumed that HIP would increase the rates for HIP VIP HMO coverage in the absence of a new Medicare Advantage plan, the City has, in fact, paid $7.50 per month per enrollee for HIP VIP HMO coverage in 2022 and 2023. *See, e.g.*, N.Y.C. Office of the Actuary, *Fiscal Year 2023 GASB 74/75 Report* 22 (June 30, 2023), https://perma.cc/2UMM-CDWW. In any event, as explained below (at 45-52), the actual year-to-year rates of HIP VIP HMO are irrelevant to the statutory interpretation questions now before this Court.

the City has often agreed to exceed its minimum obligation under the Administrative Code through collective bargaining.

For example, in 2021, the City agreed with the Municipal Labor Committee (MLC)—an association of more than 100 municipal labor unions—to make Senior Care a premium-free option for Medicare-eligible retirees, as the City and MLC had agreed in past years (R1282–83, 1294; NYSCEF No. 61 at 3–5). Senior Care, jointly administered by GHI and Empire BlueCross BlueShield, is a Medigap plan. For that reason, Senior Care's monthly premiums are far lower than the premiums for plans available to those ineligible for Medicare: about $192 in fiscal year 2021 (R1282–83, 1293–94). By contrast, monthly premiums for the counterpart GHI/Empire product for those ineligible for Medicare were about $776—roughly four times higher—because, as with HIP HMO Preferred, the plan operates as the primary insurer (R106, 113, 126, 1293).

Senior Care has been the most popular plan for Medicare-eligible retirees, with roughly 200,000 enrollees (R892). Nevertheless, out-of-pocket expenses have risen over the years: in 2021, Senior Care started charging participants a $50 medical benefit deductible

and a $300 hospital inpatient deductible (NYSCEF No. 61 at 5). Participants are also responsible for certain copays and other Medicare deductibles (R102, 151, 885–86).

By operation of the City's agreement with municipal unions, retirees who did not select Senior Care or a HIP-HMO were required to pay only premiums that exceed the cost of Senior Care (R1282–83, 1293–94; NYSCEF No. 61 at 3–5). For fiscal year 2021, the total monthly premium for these more expensive plans ranged from roughly $263 to $789 for individual plans (R1293). *See, e.g.*, N.Y.C. Office of Labor Relations, *Retiree Health Plan Rates as of Jan. 1, 2022* (2021), https://perma.cc/HFM8-8463.

D. The City's considerable efforts to confront rapidly rising healthcare costs

The City faces profound financial headwinds today, with Mayor Adams recently directing agencies to reduce their budgets by as much as 15%—the fourth such reduction in less than two years. *See* Hurubie Meko, *Citing Costs of Migrant Care, Adams Calls for More Budget Cuts*, N.Y. Times, Sept. 9, 2023, at A13. Anticipating a budget deficit approaching nearly $20 billion in a few

years, the City has grown its reserves to record levels. *See* Office of the N.Y.S. Comptroller, *Review of the Financial Plan of the City of New York* (2023), https://perma.cc/WE68-S9RU. Key watchdogs have called for even more funds to be set aside. *See, e.g.*, Office of N.Y.C. Comptroller, *Preparing for the Next Fiscal Storm* 3–4 (May 2022), https://perma.cc/8PF9-CD83; The Citizens Budget Commission, *CBC Releases Letter to Mayor and Speaker on FY2024 Budget Adoption* (June 26, 2023), https://perma.cc/EZ6K-TRNR.

But even before the current fiscal crisis, rising healthcare costs pushed the City and MLC to examine "savings and efficiencies in the method of health care delivery," including leveraging substantial Medicare subsidies, to preserve the "longer term sustainability of health care for workers and their families" (NYSCEF No. 61 at 6–8). Skyrocketing healthcare costs are a nationwide phenomenon; even before the pandemic, national healthcare spending was expected to easily outpace gross domestic product and reach $7 trillion by 2031. *See* Sean P. Keehan, *National Health Expenditure Projects*, 2022–31, 42 Health Affairs 886, 887 (2023).

Retiree healthcare liabilities are the main driver of acute fiscal problems faced by many state and local governments for "post-employment benefits other than pensions." *See* Marc Joffe, *Survey of State and Local Government Other Postemployment Benefits Liabilities* 29 (Feb. 2021), https://perma.cc/8LAD-22KY. According to one survey of 30,000 jurisdictions, the City has the largest net liability for such benefits in the country, surpassing $100 billion. *Id.* at 4.

Medicare Part B premiums have also more than tripled in the past 20 years, with a nearly 15% increase in 2022 alone. *See* Tricia Neuman et al., *Monthly Part B Premiums and Annual Percentage Increases*, Kaiser Family Foundation (Jan. 12, 2022), https://perma.cc/3QYA-NG3J. Overall, the City's Part B reimbursement costs for retirees have risen sevenfold over a similar 20-year period—from $54 million in 2000 to $382 million in 2020 (*see* NYSCEF No. 118 at 16; *see* R1259, 1281–83, 1294–95, 1302). The trend continues: in 2023, the price tag rose to roughly $519 million.

Nonetheless, the City and MLC agreed that any adjustments to the City's healthcare offerings should "maintain and improve

upon existing retiree benefits while at the same time reducing cost" (NYSCEF No. 61 at 8; *see* R884, 908–09; NYSCEF No. 118 at 16). At first, the City and MLC focused on reducing expenses for active employees (R909; NYSCEF No. 61 at 7–8). Two agreements between the City and MLC made significant changes to active employee plans, including increased copays in multiple areas (R909; NYSCEF No. 61 at 7–8). The result has been $4.5 billion in savings over eight years, with efforts ongoing to save over $1 billion more.

For many years, no changes were made to retiree plans, although costs were rapidly increasing there (R909). By 2020, however, the City and MLC concluded that crafting a new Medicare Advantage plan for Medicare-eligible retirees would provide "equivalent or better benefits" as compared to Senior Care (NYSCEF No. 118 at 17; *see* R884–90, 908–09), while still realizing $600 million in annual savings simply by taking full advantage of untapped Medicare subsidies (NYSCEF No. 61 at 8; *see* R909).

Using their joint bargaining power, the City and MLC ensured that the new plan would provide benefits equal to or better than Senior Care (R883–909; NYSCEF No. 61 at 11; NYSCEF No.

118 at 17), and the MLC's member unions "voted overwhelmingly in favor" of the new plan (NYSCEF No. 61 at 8–9; *see* R907–09). Other plans, though no longer free to retirees, would remain available to those who wished to pay the monthly premiums for their chosen insurance (NYSCEF No. 61 at 3–11). Senior Care, in particular, would remain an option, with the monthly premiums at about $192 (R885, 1300; NYSCEF No. 118 at 19).

The new plan offered equivalent or enhanced benefits while achieving hundreds of millions of dollars in annual savings by taking full advantage of untapped funding through the Medicare Advantage program (R907–09; NYSCEF No. 118 at 15–16). *See* U.S. Ctrs. for Medicaid and Medicare Servs., *Understanding Medicare Advantage Plans*, https://perma.cc/73AX-C9ZB (captured Oct. 6, 2023). Every dime saved would go to the Health Insurance Stabilization Fund, which the City and MLC jointly administer to help fund health insurance offerings, including benefits for chemotherapy, specialty drugs, preventative care, welfare benefit funds for employees and retirees, as well as a fund for widows and orphans (R1281–85, 1298; NYSCEF No. 118 at 15–16).

E. Petitioners' challenge to the City's plan to roll out a new healthcare offering for Medicare-eligible retirees

Petitioners—a handful of City retirees and a corporation purporting to represent a small fraction of that population (R26–28, 32–34, 61)—sued to block the new plan. At first, petitioners argued that § 12-126 requires the City to pay up to $600 per month per person for the healthcare plan of each retiree's choosing, though they identified no source for that figure (R28, 34, 69).

The case proceeded on a rather irregular procedural path. The City moved to dismiss the petition and, over several months, the parties and amici made a number of submissions regarding the plan's implementation. Before the City's motion was decided and any answer had been filed, however, petitioners moved for summary judgment, prompting an opposition from the City, amicus briefs supporting the City from the MLC and others, petitioners' reply to both the City's and amici's arguments, and post-hearing submissions (NYSCEF Nos. 201, 205–06, 208, 212–13).

The City argued that § 12-126 requires it to pay for only one plan and caps its financial obligation at "the full cost of H.I.P.-

H.M.O. on a category basis" (NYSCEF No. 79 at 6). That obligation would be satisfied through a new Medicare Advantage plan because the City would cover all the costs under the underlying insurance contracts, making the plan premium-free for retirees. Nothing in § 12-126, the City argued, requires it to subsidize other plans as well. The MLC, for its part, agreed (NYSCEF No. 205).

The City also argued in a post-argument submission that even if § 12-126 required payment for other plans, the cap "on a category basis" would not equal the premiums for the HIP-HMO available to individuals who are ineligible for Medicare, but rather the substantially lower premiums for the HIP-HMO actually offered to Medicare-eligible retirees—namely, HIP VIP HMO (R1970–71; *see also* NYSCEF No. 205 at 15). Petitioners responded, contending that the argument came too late and disputing it on the merits (R1972–74).

F. The rulings below

Supreme Court, New York County (Frank, J.), denied the City's motion to dismiss and granted the petition in part (R7–10). Although the court held that the City could offer a Medicare Advantage plan, the court permanently enjoined the City "from

passing along any costs of the New York City retirees' current plan to the retiree or to any of their dependents, except where such plan rises above the H.I.P.-H.M.O. threshold, as provided by New York City Administrative Code Section 12-126" (R10).

According to the court, § 12-126 means that "so long as the [City] is giving retirees the option of staying in their current program, they may not do so by charging them the $191 the [City] intends to charge" (R8). As the court made clear, its ruling did not require "giv[ing] retirees an option of plans," but if the City did choose to do so, it was required to pay up to the statutory cap. In determining the level of the statutory cap, the court bypassed petitioners' preservation objections and reached the question's merits, ruling that the court's "understanding" was that "the cost of the retirees' current health insurance plan," Senior Care, did not surpass § 12-126's monetary cap (R9). The court cited the fact that the City had in the past paid the full Senior Care premium, without acknowledging that the practice arose from collective bargaining (R9).

The City perfected an appeal at the earliest opportunity (R3). But after petitioners successfully delayed the appeal for months,

the providers of the new Medicare Advantage plan backed out (1st Dep't Case No. 2022-01006, NYSCEF No. 33). Through procedural delay, petitioners achieved one of their goals. But the appeal proceeded because the permanent injunction remained in place, preventing the City from implementing a Medicare Advantage plan with another provider while offering retirees a choice of plans (*id.*).

The Appellate Division, First Department, upheld the permanent injunction. Describing the question of whether § 12-126 requires the City to pay for more than one plan as an issue of "pure statutory interpretation," the Appellate Division adopted Supreme Court's conclusion that "§ 12-126(b)(1) requires respondents to pay the entire cost, up to the statutory cap, of any health insurance plan a retiree selects" (R1998). But the Appellate Division likewise limited this obligation to plans actually "offered to retirees" (*id.*), similarly leaving the door open for the City to implement a new Medicare Advantage plan if it discontinued other optional retiree plans.

On the question of whether the requirement to pay for Medicare-eligible enrollees was tied to the enormously higher rate applicable to individuals ineligible for Medicare, the court demurred

(*id.*). According to the Appellate Division, the nature of § 12-126's statutory cap was "raised for the first time on appeal" and "further evidence" was needed to determine what the statute means (*id.*).

G. The aftermath of the rulings below

The consequences were swift. Within weeks of the Appellate Division's ruling, an arbitrator overseeing healthcare negotiations between the City and MLC ruled that the parties should implement the alternative that Supreme Court and the Appellate Division had laid out. The City then reached agreement with Aetna on a new Medicare Advantage plan, informed retirees that the new Aetna plan or HIP VIP HMO would be their only options, and determined to cancel all other retiree plans, including Senior Care.

An experienced provider that already insures roughly 1.3 million people through its preexisting group Medicare Advantage plans—including thousands of City retirees—Aetna worked with the City and MLC to customize a plan that improved upon those options as well as Senior Care. For example, a side-by-side comparison shows that the new Aetna plan, as compared to Senior Care, offers an out-of-pocket maximum, a lower deductible, lower copays

for inpatient hospital admissions, hearing and vision coverage, and other wellness benefits absent from Senior Care. *See* Major Benefit Comparison, *Bentkowski v. City of N.Y.*, Index No. 154962/2023 (Sup. Ct. N.Y. Cnty. June 13, 2023), NYSCEF No. 63. And in exchange for the City paying $15 per month per enrollee, the Aetna plan also dramatically limits the services requiring prior authorization compared with Aetna's prior offerings (as well as the abandoned Medicare Advantage plan). *See* Affidavit of M. Catherine Moffitt, M.D. ¶¶ 34-40, *Bentkowski v. City of N.Y.*, Index No. 154962/2023 (Sup. Ct. N.Y. Cnty. June 13, 2023), NYSCEF No. 72.

But in a separate litigation, Supreme Court enjoined the Aetna plan as well. *See* Decision & Order, *Bentkowski v. City of N.Y.*, Index No. 154962/2023 (Sup. Ct. N.Y. Cnty. Sept. 19, 2023), NYSCEF No. 105. The court reasoned that the City's publication of documents summarizing available insurance plans was tantamount to a perpetual promise to keep certain plans in existence. The court also held that Administrative Code § 12-126 bars the City from offering plans where the federal government provides direct subsidies to insurers, though the City has offered such plans for

almost 60 years. The City's appeal from these rulings is pending in the Appellate Division (1st Dep't Case No. 2023-04716).

JURISDICTIONAL STATEMENT

This Court has jurisdiction to hear this appeal because the Appellate Division's order finally determined an action originating in Supreme Court (R1997–98). *See* CPLR 5602(a)(1)(i). This Court granted leave to appeal on June 13, 2023 (R1995).

ARGUMENT

Administrative Code § 12-126 provides the City's public servants and their partners something that few workers in America enjoy: premium-free healthcare not just through the employees' working life, but through retirement as well. But the law is not boundless, and the Appellate Division's understanding makes little sense.

The Appellate Division accepted that nothing in § 12-126 requires the City to provide more than one insurance plan. That conclusion follows the law's plain language, which omits any reference to a "choice of plans"—let alone any description of what the choice must include—departing sharply from previous resolutions framed precisely that way. Given that § 12-126 was otherwise patterned on those same resolutions, the Council's rejection of provisions about "choice" speaks volumes. Both lower courts understood that.

But the Appellate Division failed to follow that insight to its logical conclusion. It is hard to see why the City Council would create a regime that does not require *any* alternative healthcare plans to be made available, but then compels the City to subsidize alternative plans if they are made available. There is no good reason to

prevent the City from offering optional plans under an arrangement where retirees who elect them would pay for them. Nor does any text in § 12-126 purport to enact that regime.

The Appellate Division's deeply flawed and incomplete interpretation of § 12-126 hamstrings the City's ability to respond to mounting fiscal challenges and undermines retiree choice by incentivizing the cancellation of optional plans. Indeed, in accordance with an arbitrator's order following the ruling below, the City and MLC decided to adopt a new Medicare Advantage plan and cancel all other plans except one referenced in § 12-126, which is also a Medicare Advantage plan. Absent reversal, the City may never again be in a position to offer a suite of health insurance options to retirees. Nothing in § 12-126 requires that nonsensical result.

POINT I

THE APPELLATE DIVISION ERRED IN REQUIRING THE CITY TO PAY FOR MORE THAN ONE INSURANCE PLAN

As this Court has repeatedly said, in matters of statutory construction, "[t]he primary consideration … is to ascertain and give effect to the intention of the Legislature." *People v. Santi*, 3 N.Y.3d

234, 243 (2004). The inquiry begins with the statutory text—"the clearest indicator of legislative intent"—and also considers the law's "spirit and purpose," as illuminated by its context and legislative history. *Matter of Albany Law School v. N.Y.S. Office of Mental Retardation & Dev. Disabilities*, 19 N.Y.3d 106, 120 (2012).

The City's plan to pay for a new Medicare Advantage plan for Medicare-eligible retirees fully satisfies its obligation under § 12-126. The law requires only that the City pay the cost of a single insurance plan. Indeed, as the lower courts acknowledged, § 12-126 does not require the City to offer Medicare-eligible retirees *any* additional plans. But the courts nonetheless held that *if* the City does make additional plans available, § 12-126 limits the City's ability to require those who decline the new plan to pay for their choice of a different plan. Neither the law's text nor sound policy supports encumbering the City's and retirees' options in that way.

A. Section 12-126's text requires the City to pay for only one insurance plan.

The law's text states in relevant part that "[t]he city will pay the entire cost of health insurance coverage for city employees, city

retirees, and their dependents." And the City would plainly pay the entire cost of coverage for Medicare-eligible retirees through a new premium-free Medicare Advantage plan. That conclusion is unchanged even if the City gives retirees the ability to decline that plan and opt-in to others, for which they must then pay.

Other factors confirm this reading. The law defines "health insurance coverage" in singular terms, as "[a] program of hospital-surgical-medical benefits." Substituting that definitional language into the operative sentence, it becomes "[t]he city will pay the entire cost of [a program of hospital-surgical-medical benefits] for city employees, city retirees, and their dependents." A premium-free Medicare Advantage plan meets that requirement, full stop.

Petitioners contend that the law's reference to a "program" of necessarily means "all of the health insurance plans offered by the City (1st Dep't Case No. 2022-01006 NYSCEF No. 36 at 39). But while § 12-126 makes clear that the "program" referred to in § 12-126 must cover "hospital-surgical-medical benefits," the law does not say that it must include all plans that the City makes available. Petitioners' reading imposes an obligation that the text does not.

Nor does petitioners' reading make sense in the context of the law as a whole. The City's obligation to pay for "health insurance coverage" is not an obligation to pay for "all of the health insurance plans offered," but rather an obligation to pay for a single plan in which an individual can enroll. And the framing of the statutory cap, defined in terms of the cost of a specific plan—the HIP-HMO plan appropriate for the enrollee—likewise reflects the City's obligation to pay for a plan. These elements confirm that "health insurance coverage" refers to a single plan.

Neighboring textual elements drive the point home. For example, § 12-126 provides that if certain deceased uniformed officers were enrolled in a "health insurance plan," their surviving spouses are entitled to "such health insurance coverage" (as well as "health insurance coverage" predicated on Medicare) if they pay 102% of the group rate for "such coverage." Admin. Code § 12-126(b)(2)(ii)–(iv). A surviving spouse electing "such coverage" is clearly paying for only one plan, not more than one, and the City's obligation to pay for "health insurance coverage" is similarly satisfied by paying for only one plan.

As another example, the law refers in multiple places to "health insurance coverage" predicated on Medicare enrollment, Admin. Code § 12-126(b)(1), (b)(2)(i)–(iv). But that phrase would make no sense if "health insurance coverage" meant all the plans offered by the City—most of which are not predicated on Medicare given that they are available to active employees ineligible for Medicare. Interpreting "health insurance coverage" to refer to a single plan is the only reading that renders the statute intelligible "as a whole." *Avella v. City of N.Y.*, 29 N.Y.3d 425, 434 (2017).

The Appellate Division dismissed all this without explanation. Supreme Court, for its part, reasoned that because the law's text provided that the City "will pay"—rather than offer to pay—the City was required to pay for multiple plans (R9). But the phrase "will pay" does not denote a categorical and unconditional obligation that operates irrespective of individuals' choices. For example, City employees may decline city healthcare coverage altogether, often because they elect to be covered under a partner's insurance. But § 12-126 does not require the City to pay for health coverage for those employees nonetheless. In a similar vein, the law's "will

pay" language does not preclude the City from giving retirees (or employees) the choice of declining premium-free coverage in favor of an optional plan that they must pay for. Perhaps for this reason, petitioners' Appellate Division briefing did not embrace Supreme Court's reasoning.

Petitioners instead hung their hat largely on the definition of "health care coverage" as a program of insurance benefits to be provided by "contracts" with "companies"—plural terms that they say require the City to pay for multiple plans (*see, e.g.*, NYSCEF No. 189 at 9–10). But words in "the plural number include the singular," Gen. Constr. Law § 35, absent indications that the legislature intended a different application, *People v. Mitchell*, 38 N.Y.3d 408, 414 (2022). And unlike the City Council's decision to define "health insurance coverage" in singular terms, where all signs are that the term was indeed meant in the singular (*see supra* at 31-32), petitioners point to nothing indicating that the Council's use of the plural in this context meant to compel payment for multiple plans—much less for all offered plans. Indeed, it would be odd for the

Council to introduce such an obligation obliquely, through nuances gleaned from ancillary definitional terms.

In any case, the nuances petitioners perceive are illusory, as it is common for a single insurance plan to comprise multiple "contracts" and "companies." Petitioners' preferred plan, Senior Care, does just that, as coverage offered through contracts with EmblemHealth and Empire. And § 12-126's original reference for its category-based cap, HIP-Blue Cross, also did precisely that (R151, 1321). In fact, *all* of the City's offerings as of the law's enactment involved multiple contracts with multiple companies (*see* R1350-51) (identifying HIP-Blue Cross, GHI-Blue Cross, and Blue Cross-Blue Shield-Major Medical (Metropolitan Life Insurance Company)).

A final point on this front: even if § 12-126 could be construed as requiring the City to pay for more than one plan, which it cannot, petitioners' reading still could not justify Supreme Court's broad injunction requiring the City to pay for petitioners' preferred plan, Senior Care, as opposed to any two plans of the City's choosing (R10). Indeed, the City's most recent efforts to roll out a new Medicare Advantage plan included the option for Medicare-eligible

retirees to enroll in either an Aetna Medicare Advantage plan or HIP VIP HMO—neither of which would charge enrollees premiums. *See* Aetna, *Here For You* 2 (2023), https://perma.cc/EJP7-E348.

B. Legislative history further confirms the City's construction.

The law's definition of "health insurance coverage" gains added significance when one considers the law's enactment history. The City Council rejected a prior version of the law that would have required the City to pay for "any basic health insurance plan," after the Mayor vetoed that bill. The Council thus knew how to draft language that would require the City to pay for any available plan that met certain criteria, yet specifically declined to adopt such language in § 12-126. The Appellate Division thus "read into [the] statute a provision which the Legislature did not see fit to enact." *Chem. Specialties Mfrs. Ass'n v. Jorling*, 85 N.Y.2d 382, 394 (1995).

The City Council declined other opportunities to incorporate language requiring the City to pay for retirees' choice among multiple plans. Two years before § 12-126's adoption, the City agreed

with municipal unions to cover "total payment *for choice* of health and hospital insurance" among multiple plans (R1342 (emphasis added)). The resolution adopting this agreement also included a separate provision guaranteeing that a choice would be provided and identifying the specific plans retirees could choose (R1342, 1344). But § 12-126 pointedly did *not* include such language—"persuasive evidence" that the Council omitted it deliberately. *Hazan v. WTC Volunteer Fund*, 120 A.D.3d 82, 86 (3d Dep't 2014).

Ignoring this history, petitioners have tried to elevate a report from the City Council's Committee on Health and Education—not the Council as a whole—as if it were a definitive statement on the enacted law (R1327; 1st Dep't Case No. 2022-01006 NYSCEF No. 36 at 36). That report stated that the City would "pay for the entire cost of any health insurance plan" (R1327). But as noted above, practically identical language was explicitly rebuffed in the final bill, and the report merely repeated verbatim its description of the more expansive version from its prior report without accounting for *any* of the substantial changes to the bill following the Mayor's veto, calling the reliability of the report into serious question (*compare*

R1320 *with* R1327).[5] Committee-level reports can have scarce value in general, *see Fletcher v. Kidder, Peabody & Co.*, 81 N.Y.2d 623, 634 (1993), and a committee report that ignores the law's actual text and enactment history has none.

C. The law's policy objectives cannot justify the Appellate Division's reading.

The Appellate Division's understanding of the law also makes little practical sense. *See Lubonty v. U.S. Bank Nat'l Ass'n*, 34 N.Y.3d 250, 255 (2019) (noting statutes must be interpreted "to avoid unreasonable or absurd application[s]"). As both of the lower courts acknowledged, nothing in § 12-126 requires the City to provide more than one insurance plan. It 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

[5] The report carried over other inaccurate language as well, including on points that are not subject to reasonable dispute. For example, the report continued to state that the law would provide coverage only to employees "who are members of the New York City Retirement System" (R1327). But the Mayor vetoed the bill in part because of that limited scope, citing potential legal difficulties (R1326). And the revised bill (as well as the enacted law) contained no such limitation; it covered qualifying employees regardless of their membership in a retirement system (R1320). Plainly, the "zombie" committee report sheds no light on the meaning of the law's revised language.

makes available, subject only to the law's monetary cap. There is no good reason to eliminate the option of providing below-cap alternatives but requiring those who elect them to pay for them. To the contrary, mandating a subsidy for any below-cap plan incentivizes eliminating such options for retirees. And in fact, because of this litigation, the City has taken steps to limit retirees' choices, although that is not and has never been the City's preferred course.

What's more, the core objective that drives petitioners' argument is one that the City Council rejected for enshrinement in § 12-126. At bottom, petitioners claim that they are entitled to keep the particular plan of their choice on a premium-free basis because it was free to them in the past. But the enactment history does not support that claim. An early version of the bill that became § 12-126 included language that would have barred the City from reducing the healthcare benefits it was then offering—at that time, a subsidized choice of plans (R1320, 1332, 1335). That text was stricken from the final bill. A fortiori the City Council did not intend to freeze particular plan arrangements in place.

It bears repeating: § 12-126 provides municipal retirees and their spouses a benefit that few workers in America enjoy—premium-free healthcare through retirement. By comparison, the State requires recent retirees to contribute 12 to 16% of the costs of individual coverage and 27 to 31% of the costs of family coverage. *See* 4 NYCRR § 73.3(b)(i)-(iii). To put that in more concrete terms, in 2023, recent retirees enrolled in the State's Empire Plan must make monthly contributions between $118 and $157 for an individual plan and between $510 and $608 for a family plan. *See* N.Y.S. Dep't of Civ. Serv., *NYSHIP July 1, 2023 Rate Changes* 5 (May 2023), https://perma.cc/FT8J-B4TP.

The fact is that § 12-126 reflects a rare promise. It makes sense that the City Council would have preserved the City's flexibility to deliver on that promise as policy and budgetary needs dictate over time *and* would have preserved choice for individuals who opt to pay for their own coverage at the City's group rate, so long as the City covers the cost of at least one plan. For this reason too, the City's construction of § 12-126 is by far the better one.

Indeed, the City is duty-bound to "assure the prudent and economical use of public moneys" and to negotiate contracts "of maximum quality at the lowest possible cost." Gen. Mun. Law § 100-a. Yet creating a statutory obligation that would force the City to pay for all healthcare plans up to the price of the applicable HIP-HMO plan would undermine that policy by hamstringing the insurance market: a competitor who might otherwise offer premiums lower than HIP would have little incentive to do so knowing that the City would always have to pay up to HIP's rates. This makes no sense, and nothing in § 12-126 requires that outcome.

POINT II

THE APPELLATE DIVISION ALSO ERRED BY FAILING TO CORRECT A SEPARATE MISREADING OF THE LAW'S MONETARY CAP

Even if § 12-126 were not wholly satisfied by paying the costs for a single plan, which it is, the Appellate Division separately erred in affirming Supreme Court's order requiring the City to subsidize petitioners' preferred plan and other more expensive options. Section 12-126 specifies that the City's payment obligation is "not to exceed the full cost of H.I.P.-H.M.O. on a category basis." For the

Medicare-eligible individuals, the relevant metric is obviously the HIP-HMO plan available to Medicare-eligible individuals (HIP VIP HMO), not plan available to people ineligible for Medicare (HIP HMO Preferred), which is dramatically more expensive because the federal government does not subsidize it. And, contrary to the Appellate Division's ruling, this issue was preserved—it was raised below, petitioners responded to it, and Supreme Court ruled on it—and in any event the point did not require preservation as a pure issue of statutory interpretation.

A. Nothing bars this Court from correcting Supreme Court's misinterpretation of § 12-126's monetary cap.

The Appellate Division erred by reaching the first half of the sentence describing the City's obligation under § 12-126(b)(1) but not addressing the second half of that sentence. According to the court, although the baseline obligation to pay "the entire cost of health insurance" was discernible through traditional interpretive methods, the law's obligation to pay up to "the full cost of H.I.P.-H.M.O. on a category basis" was raised too late and required "further evidence" to resolve (R1998). But not only was this issue

preserved, it is also a pure question of law that the court should have decided regardless. By not doing so, the Appellate Division injected significant uncertainty into its own mandate.

To be clear, the Appellate Division was simply wrong that this issue was not raised in Supreme Court. The City and an amicus both argued below that the statutory cap for Medicare-eligible retirees was the HIP-HMO plan available to them, petitioners responded, and Supreme Court weighed in on the question (R7–9, 1970–71; NYSCEF No. 205 at 15–16; NYSCEF Nos. 208, 213). In particular, petitioners argued to Supreme Court that the issue should be deemed unpreserved, and perhaps the court could have so concluded, but it instead opted to resolve the point solely on its merits. The parties' arguments "alert[ed] Supreme Court to the relevant question," and "the issue was placed squarely before the court," *Geraci v. Probst*, 15 N.Y.3d 336, 342 (2010). The Appellate Division was thus flatly mistaken in holding that the argument was raised "for the first time on appeal" (R1998); *see also U.S. Bank N.A. v. DLJ Mortg. Capital, Inc.*, 33 N.Y.3d 84, 89 (2019) (argument preserved if party asked lower court to resolve it).

Even setting these points aside, this Court has long held that "question[s] of statutory interpretation" may be raised for the first time on appeal, even in this Court. *Richardson v. Fiedler Roofing, Inc.*, 67 N.Y.2d 246, 250 (1986). It is evident from the statute's text, requiring no further evidence, that the cap for Medicare-eligible retirees, "on a category basis," refers to the HIP-HMO plan that is available to Medicare-eligible retirees and not to a HIP-HMO plan that is unavailable to such retirees, that bears no actuarial relationship to the costs of covering those retirees, and that is several times more expensive than any comparable plan would be.

While the Appellate Division also questioned the basis for the City's expectation for what HIP VIP HMO would cost in 2022 (R1998), that factual question bears no relevance to the meaning of the local law's text. Whether § 12-126's statutory language establishing the cap as "the full cost of H.I.P.-H.M.O. on a category basis" refers to the HIP-HMO plan that is available to Medicare-eligible individuals or a HIP-HMO plan that is not turns on the "threshold question[]" of "legislative intent," not the price of HIP VIP HMO in a given year. *Am. Sugar Refining Co. v. Waterfront Comm'n*, 55

N.Y.2d 11, 25 (1982). If petitioners wish to challenge the publicly announced and State-approved price for HIP VIP HMO,[6] whatever that price may be in the future, that is an entirely separate dispute. By refusing to address the proper interpretation of the statutory cap, the Appellate Division ignored this critical distinction.

B. Section 12-126 requires the City to pay only up to the cost of providing a HIP-HMO plan to Medicare-eligible individuals.

And the answer to the statutory question that the Appellate Division avoided is clear. Although Supreme Court did not specifically identify the threshold it was applying, at a minimum the court ordered the City to pay premiums for Senior Care, which in fiscal year 2021 amounted to roughly $192 per month. Petitioners, for their part, argued that § 12-126 requires the City to pay up to $776 per month, corresponding with the premiums for HIP HMO Preferred—a plan available only to people ineligible for Medicare.

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[6] Health insurers in New York must apply to the State when they seek to alter premiums. *See* N.Y.S. Dep't of Fin. Servs., *Health Insurance Premiums and Rate Increases*, https://perma.cc/8SG2-258F (captured Oct. 4, 2023).

Neither is the right lodestar. Section 12-126 directs the City to "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 only HIP-HMO plan that is available to Medicare-eligible retirees "on a category basis" is HIP VIP HMO, and § 12-126 requires payment only up to that plan's threshold.

The statute's plain text dictates this understanding. The law explicitly caps the City's obligation at "one hundred percent of the full cost of H.I.P.-H.M.O *on a category basis*." Admin. Code § 12-126 (emphasis added). This means that the cap varies by the category of insurance provided, thus ensuring that the comparison is an apples-to-apples one. For example, the cap applicable for an employee or retiree who has an individual health insurance plan should not be based on the rate for a family HIP-HMO plan—individual and family plans are different categories. Similarly, the cap applicable to a plan for Medicare-eligible individuals should not be based on the rate for a HIP-HMO plan for people ineligible for Medicare—those, too, are different categories.

This understanding is embodied in § 12-126's express references to Medicare enrollees. The law specifically requires the City to pay Medicare Part B premiums when an individual's coverage is "predicated" on Medicare. Admin. Code § 12-126(b)(1). Thus, the City Council was well aware that some coverage would depend upon enrollment in Medicare, and specified that such coverage should receive different treatment from coverage available to individuals who are not eligible for Medicare. By its terms, then, § 12-126 recognizes that coverage for Medicare-eligible individuals falls into its own category.[7]

The same distinction between categories is reflected in the City's longstanding practices. For example, HIP distinguishes between the HMO plan for non-Medicare-eligible individuals (HIP HMO Preferred), and the HMO plan for Medicare-eligible retirees (HIP VIP HMO). Understandably, the costs of those plans are dramatically different: HIP HMO Preferred is the sole source of

[7] The local law contains an analogous textual echo for family plans—which petitioners acknowledge are a different category from individual plans—in its express reference to coverage of "dependents."

coverage, while HIP VIP HMO is a Medicare Advantage plan substantially subsidized by the federal government and, as a consequence, it is far less expensive. *See also* N.Y.C. Office of the Actuary, *Fiscal Year 2019 GASB 74/75 Report* 126 (June 30, 2019) (identifying gap in premiums between "HIP HMO" plan for Medicare-eligible retirees and "HIP HMO" plan for others), https://perma.cc/Q9R3-GEMQ. Other insurers—like GHI, Aetna, CIGNA, and Empire—follow the same approach (R148).[8] Plans offering primary insurance are often four or more times costlier than Medicare-based ones.

This same distinction is seen throughout the broader health insurance industry, where providers routinely speak of "Medigap plans" or "Medicare wrap-around coverage" and consistently offer such coverage at a fraction of the amount charged for primary coverage. It would not be an apples-to-apples comparison to base the

[8] The original statute's use of HIP-Blue Cross as the baseline plan further demonstrates § 12-126's intent to apply different rates for those eligible and those ineligible for Medicare. When the 1967 statute was enacted, the HIP-Blue Cross for Medicare-eligible individuals was fundamentally distinct, with the plan "remov[ing] … benefits duplicated by Medicare" (R1339).

law's monetary cap for Medicare-eligible individuals on the cost of HIP-HMO coverage for non-Medicare-eligible individuals. To the contrary, that approach would violate the law's express requirement that the cap must be assessed "on a category basis."[9]

Indeed, even without the language varying the cap "on a category basis," the only reasonable understanding of the reference to "H.I.P.-H.M.O.," as applied to Medicare-eligible individuals, is that it speaks to the HIP-HMO plan that is relevant for Medicare-eligible persons, rather than the one that is not. After all, statutory interpretation is about giving "effect to the intention of the Legislature," *Santi*, 3 N.Y.3d at 243, and the Council could not have intended to impose an obligation that has no logical relationship to the actual costs of insuring Medicare-eligible individuals, and would in fact be several magnitudes higher.

Consider the HIP-HMO figures for fiscal year 2021, when covering a Medicare-eligible individual cost less than $182 per month,

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[9] Nor can the applicable cap be based on the cost of Senior Care, which is not an HMO at all (R148, 151). While the City in the past agreed as a matter of collective bargaining to pay the cost of Senior Care (and to pay for other plans up to that cost), the cost of Senior Care is not relevant to § 12-126.

while the monthly premiums for a Medicare-ineligible individual was $776 and the monthly premiums for the corresponding family plan were over $1,900 (R1293). Other HMOs showed an even starker divide: non-Medicare family plans from other providers cost over $2,701 per month, compared with just $576 for Medicare-eligible family plans (R1293). Ignoring these foundational differences would only frustrate the Council's intent. *See Lubonty*, 34 N.Y.3d at 255 (noting that statutes must be interpreted "to avoid unreasonable or absurd application[s]").

The difference in cost also reveals the error in petitioners' position that § 12-126 requires the City to pay up to $776 per month, corresponding to a plan that is offered to persons ineligible for Medicare. If petitioners were correct in identifying the threshold at that plan, the City would be required to pay the entire cost of some "luxury" Medicare-eligible premium plans that cost far more than Senior Care ever has (*see supra* 16). But the City has never paid for those more expensive plans, nor have petitioners argued that it should.

Failing to account for the role of Medicare in assessing the statutory cap makes little sense for other reasons too. After all, the City's residents pay taxes to the federal government—and thus fund Medicare—as well as paying taxes to state and city governments. In fact, New York taxpayers are typically net donors who pay more in federal taxes than they receive in return in federal benefits. *See* Office of the N.Y.S. Comptroller, *New York's Balance of Payments in the Federal Budget: Federal Fiscal Year 2019*, at 5 (2020), https://perma.cc/445R-ZKFV (in total dollars, New York's gap between federal taxes paid and spending received was largest among all 50 states). Again, when it enacted § 12-126, the City Council recognized that healthcare coverage for Medicare-eligible individuals could be predicated on Medicare enrollment and included a special provision requiring the City to reimburse Medicare Part B premiums for such individuals—a substantial outlay. It stands to reason that the Council never intended to impose a one-size-fits-all approach, and instead would have expected that the City's payment obligations would be appropriately adjusted to

account for the federal Medicare subsidies that City taxpayers likewise pay to fund.

The City continues to offer HIP-HMO plans,[10] and it is these plans that form the baseline for the current statutory threshold. As they have since the 1960s, the plan for retirees (HIP VIP HMO) still relies primarily on Medicare funding to provide coverage, resulting in dramatically lower premiums than the plan for active employees (HIP HMO Preferred). To use any other threshold would contradict the law's text, structure, and legislative history, and force the City's residents to pay twice for Medicare-funded benefits.

* * *

For all these reasons, the City wholly satisfies § 12-126's mandate by paying the costs of a single plan, including a Medicare Advantage plan, for Medicare-eligible retirees up to the cost of HIP VIP HMO. Although the City is free to provide more than the law

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[10] Contrary to petitioners' claim below, HIP VIP HMO is still offered to Medicare-eligible retirees and will continue to be if the City is permitted to implement a new Medicare Advantage plan. N.Y.C. Office of Labor Relations, *Retiree Health Plan Rates as of April 1, 2022* (2022), https://perma.cc/A6WE-UBPD; *see also, e.g.*, Aetna, *supra* at 35-36 (describing City's current efforts to implement an Aetna Medicare Advantage plan while retaining HIP VIP HMO).

requires—as it often has through collective bargaining—§ 12-126 does not limit the City's flexibility to respond to changing economic circumstances while still offering retirees robust premium-free healthcare. And, even if the Court were to conclude that § 12-126 requires the City to pay for any below-cap plans that are made available—rather than to pay for just one plan—the law's monetary cap equals the cost of HIP VIP HMO, which the cost of Senior Care and more expensive plans exceed.

CONCLUSION

The Court should reverse and deny the petition in its entirety.

Dated: New York, NY
October 23, 2023

Respectfully submitted,

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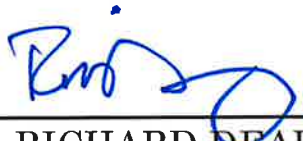
CERTIFICATE OF COMPLIANCE

I hereby certify that this brief was prepared using Microsoft Word, and according to that software, it contains 9,845 words, not including the table of contents, the table of cases and authorities, the statement of questions presented, this certificate, and the cover.



RICHARD DEARING

APL-2023-00086

Court of Appeals
State of New York

NYC ORGANIZATION OF PUBLIC SERVICE RETIREES, *et al.*,

Plaintiffs-Respondents,

against

RENEE CAMPION, *et al.*,

Defendants-Appellants.

AFFIRMATION OF SERVICE BY UPS

CHLOÉ K. MOON, an attorney admitted to practice in the courts of this state, affirms under the penalties of perjury that: on October 23, 2023, I served three copies of the accompanying Brief for Appellants and Record on Appeal by transmitting the document to UPS for overnight delivery to the following at the addresses indicated below:

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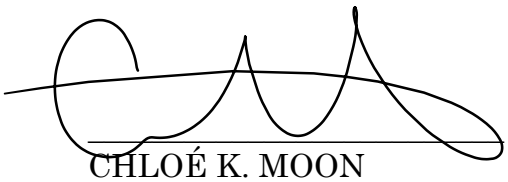

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