SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

In the Matter of the Application of

LISA FLANZRAICH, BENAY WAITZMAN, LINDA WOOLVERTON, ED FERINGTON, MERRI TURK LASKY, PHYLLIS LIPMAN, on behalf of themselves and others similarly situated, and the NYC ORGANIZATION OF PUBLIC SERVICE RETIREES, INC., on behalf of former New York City public service employees who are now Medicare-eligible Retirees,

Petitioner,

For Judgment Pursuant to CPLR Article 78

- against -

RENEE CAMPION, as Commissioner of the City of New York Office of Labor Relations, CITY OF NEW YORK OFFICE OF LABOR RELATIONS, the CITY OF NEW YORK,

Respondents.

Index No.: 158815/2021

PETITIONERS' OBJECTION TO RESPONDENTS' PROPOSED IMPLEMENTATION OF THE MEDICARE ADVANTAGE PLAN

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1. Remarkably, but sadly, the City's revised implementation plan for its proposed Medicare Advantage plan ("MAP") is even more arbitrary, more capricious, more confusing, and more of an abuse of its discretion than its original attempt.

2. As detailed below and in the affidavits attached, it does not cure the deficiencies identified by the Court, but instead doubles-down on its rushed implementation and misleading marketing materials, ignoring both the letter and the spirit of the Court's order. As a result, the City's proposed "implementation timeline" and "informational campaign" will only compound the problems identified by the Court in its October 21, 2021, Order. The Court should reject these inadequate proposals and send the City back to the drawing board.

3. Further, Petitioners respectfully request the Court (1) order the City to cease providing information about the MAP until an appropriate implementation plan has been approved by the Court that will ensure accurate information is provided; and (2) specifically direct all of Respondents' representatives to respond to queries by stating that the MAP is currently subject to this Court's review and that further information and updates will be provided if and when the Court approves an implementation plan.

I. The City Has Ignored the Court's October 21, 2021 Order

4. On October 21, 2021, this Court ordered respondents to "maintain the status-quo enrollment … until the respondents cure deficiencies with the implementation of the proposed new Medicare Advantage Plan." (Order at 4). Instead of focusing on curing these deficiencies, the City has continued to inform retirees that they will be automatically switched to the MAP as of January 1, 2022—even though any such switch would be in direct violation of the Court's order.

5. Respondents have also continued to put out various forms of misinformation without first submitting them to the Court or awaiting its approval. And they are still unable to

provide straight answers to even the most basic questions about retiree benefits under the proposed MAP.

6. In its October 21 Order, the Court observed that as of oral argument on October 20, 2021, "medical providers were still being contacted to see if they will agree to this plan." The City's submission confirms that this is still the case, describing intended outreach to providers that has not yet occurred. (DiBenedetto Aff. ¶¶ 9-11). The Court's order clearly intended a process in which providers were contacted *before* any opt-out deadline is imposed, not simultaneously.

7. Retirees should be able to ask their doctors whether they will accept the Medicare Advantage plan and receive accurate answers before making any opt-out decision. They should not be forced to rely on Respondent's unproven assertions that "most doctors" will accept it. Respondents have notably failed to submit any of the contracts that they claim require "most doctors" to accept MAP. And these assurances are particularly cold comfort to the 9% of retirees whose doctors fall into the class of doctors the City openly admits do not accept MAP.

8. Further, as of this week, retirees are still receiving conflicting and inaccurate information about which doctors are participating. One retiree called the 833 number on November 9, 2021 to ask about specific hospitals in her area and doctors that she sees. The representative assured her that these hospitals and doctors were in network, and that they were listed on the official website. The retiree checked following the call and found that *none* were listed on the website. When the retiree searched again yesterday (on November 11) the website had been updated. The hospitals were now on the website but were specifically listed as *out of network* – contrary to the statements by the phone representative two days before. And the

doctors the phone representative claimed were in network and on the website were still not listed as of yesterday. (Michelle Robbins Aff.).

9. Another problem identified in the October 21, 2021 Order was that "much of the program terms are still unsettled and unclear." Order at 3. That remains the case. As but one example, retirees asking for a list of procedures that require prior authorization – which, as detailed below, is a critical data point for retirees deciding whether to opt out of the MAP – were told that no such list exists, apparently because there are "sooo many." (Fran Scharf Aff.).

10. In addition, there are glaring discrepancies between the "Enrollment Guide" of informational materials about MAP sent to retirees in September 2021, and the apparently final "Explanation of Coverage" document that governs MAP benefits. The information originally provided is no longer accurate – if it ever was. At a minimum, Respondents need to send retirees an updated information booklet that correctly describes the key features of the MAP.

11. More fundamentally, some retirees *still* have not received any information packets, however misleading, despite calling and requesting that information be sent to them. (*See* affidavits of Charles Trachta, Cindy Greenberg, David Greenberg, Elizabeth Brizo, Janet Valenti, Michael Cogan, Sarah Shapiro, Marsha Tirah, and Tina Shapiro.)

12. Informed choice is impossible in these circumstances. It is not too much to ask that the City provide elderly and disabled retirees with accurate information so they can make an informed decision concerning their healthcare coverage.

13. Further, while the Respondents' submission touts the many information sessions they are holding or intend to hold, they provide *no* information about *what is being done to ensure that information provided at these sessions is accurate*. The core problem with the previous information sessions was not that there were too few sessions or too few people taking

phone calls (although that was also a problem). The primary problem was that retirees were bombarded with conflicting and inaccurate information. Nothing in the Respondents' submissions explains what is being done to identify the cause of these inaccuracies and correct them. Until that is done, additional information sessions will only lead to additional confusion.

14. Respondents appear to be operating on the premise that their role is to convince the Court that all retirees should want the MAP plan, and therefore the Court should allow the City to force retirees onto it without any meaningful opportunity to make an informed decision to opt out. The Court already rejected this incorrect premise in its October 21, 2021 order.

15. Respondents were directed to cure specific deficiencies in their implementation, not reargue that the MAP plan is the better choice. Respondents have corrected none of the deficiencies that caused the Court to impose an injunction. The proposed new deadlines and informational sessions are irrational and arbitrary, and the Court should reject them.[1]

II. The City's Revised November 30 Deadline is Unconscionable

16. The City's proposed November 30, 2021 deadline for retirees to opt out is just two weeks from the date the City's "new" implementation proposal is to be submitted to this Court for review. If the Court takes more than a day to review the matter, retirees would have less than two weeks before the deadline, not accounting for mail time. And one of those weeks is Thanksgiving.

[1] This submission focuses on the ways in which the City's latest submission fails to comply with the Court's October 21, 2021 Order or cure the deficiencies identified by the Court. Petitioners will also show, at an appropriate time, that forcing retirees to accept the Alliance plan or pay $191.57 a month to maintain their current health benefits is unlawful for the reasons stated in its Verified Amended Petition. Among other things, Petitioners' contracts and the SPD give the right to change plans exclusively to retirees – not to the City, and the City's attempt to strip them of vested benefits conveyed by contract and NYC Administrative Code §12-126 is a violation of both their contractual and statutory rights.

17. That is a ludicrous and unconscionable schedule: retirees may not even receive the materials before the deadline. And the information being provided to retirees by the City continues to be wrong, misleading, incomplete, and often contradictory. Even if it were fully accurate and arrived in less than a week, there is no way that seniors – many of whom do not access information via the internet – could make an informed decision by November 30, including because many people are unavailable over the Thanksgiving holiday and many doctors' offices will be closed. That the City would even *suggest* such a deadline reflects an astonishing disregard for the concerns raised by the Court.

18. Ms. Levitt, in her affidavit also states, confusingly, that it will "be possible [sic] retirees to opt out of, or into, the new plan until December 31, 2021." (Levitt Aff. ¶ 6). Communication of the two deadlines is sure to confound senior citizens. And assuming it is the latter, having six weeks – interrupted by Thanksgiving and Christmas – to research their doctors' participation and decipher what procedures will require prior authorization – is not enough time. Respondents also ignore that switching back and forth between healthcare plans is not a simple and painless process, even assuming the changes are processed correctly.

19. The earlier roll-out debacle lasted ten weeks and there is no reason to believe it will go any smoother the second time around. The City's unreasonable timing proposal will only increase the chaos and confusion. The City apparently doubts the Court's authority to order a reasonable schedule, asserting that: "The initial deadline can only be extended from October 31, 2021 to November 30, 2021 because that is the final date that it will be possible to submit Medicare waivers to Centers for Medicare and Medicaid Services (CMS) for a January 1, 2022 start date and assure that retirees will have welcome kits and ID cards by January 1, 2022." (DiBenedetto Aff. ¶ 5).

20. But CMS can entertain the City's requests for waivers at any time. What the City apparently means is that without the November 30 deadline, the City might not secure the Federal funding it seeks starting January 1, 2022; it might have to wait until April or June or September or even 2023. The City's desire to save money does not cure the deficiencies in its irrational and arbitrary proposals. There is no urgent need for the City to immediately stop paying for the healthcare coverage of people who served it faithfully for years. Nor would such a need allow the City to trample on the retirees' rights by implementing a rushed and illegal transition.

21. Importantly, the City has failed to identify what in its plan requires waivers from CMS. If the City is not in compliance with Federal law or Medicare regulations, it owes its constituents the decency of telling them. The most obvious need for a CMS waiver is the City's intent to force retirees into the MAP and require them to opt out of it should they not want to participate. This contradicts Medicare's long-held policy to assure the individual's "process for exercising choice."[2]

22. In sum, odds are that many retirees cannot even be provided with informational materials by November 30, much less review them and have questions answered. The Court should reject the arbitrary and irrational schedule proposed by the City.

[2] 42 U.S.C. § 1395w-21(c). Although during the Trump administration various employers forced retirees into Medicare Advantage plans – but giving an option to opt out – those unchallenged efforts were contrary to sub-regulatory guidance contained in the Medicare Managed Care Manual. That guidance states that "[t]he enrollment requests reported to the MA organization by the employer/union will reflect the choice of retiree coverage individuals made using their employer's or union's process for selecting a health plan." And given that, here, there is no question that retirees are neither represented by the City or their former unions, this "mass enrollment" approach by the City and the Alliance is improper – and utterly confusing to senior citizens.

III. The City's Proposed Information Campaign Is Inadequate

23. Respondent's proposed "information campaign" would not enable retirees to make an informed decision concerning the MAP, even if it were conducted on a more reasonable schedule. Because the City is hell-bent on forcing retirees into the MAP – and to do so by the end of the year – its proposed education plan is a hodge-podge of inadequate, poorly thought-out half-measures.

A. Retirees Need To Be Provided Accurate Informational Materials

24. As an initial matter, some retirees still have not even been provided with the informational materials ("Enrollment Guide") that was supposedly sent to all retirees in September 2021. To compound this confusion, when retirees have called the Alliance's 833-telephone hotline and requested an Enrollment Guide – and were assured a copy would be sent – it never arrived. (*See* David Greenberg Aff.; Janet Valenti Aff.; Cindy Greenberg Aff.)

25. Respondents' "information campaign" proposal does not explain when these packets will be provided, or what steps are being taken to ensure that all retirees receive the informational materials. And the most serious and basic inadequacy in Respondents' informational campaign is that it fails to acknowledge that the Enrollment Guide describing the MAP must be rewritten and mailed to every retiree. It is critically important that Respondents provide updated, accurate hard copy materials to the retirees. The City fails to recognize that many of the retirees are senior citizens who do not use the internet, or do not use it well. Yet the City does not even mention the need for having to write, edit, proof, print, or mail a new Enrollment Guide.

26. Instead, the City proposes to send only a short "Draft Letter to Retirees." (Levitt Aff., Ex. B.) This letter does not adequately describe the plan or its true coverage, limitations, or requirements. Instead, it appears designed to market (an inaccurately and inadequately

explained) MAP rather than facilitate an informed choice. As detailed below, there are countless omissions, contradictions with other Alliance-provided materials, and misrepresentations in the draft letter.

27. The operative document detailing the MAP's true benefits, limitations, and requirements is the Explanation of Coverage ("EOC"). The Enrollment Guide states: "This guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits and the exclusions are contained in Benefits Chart and Evidence of Coverage (EOC), which are received upon enrollment. In the event of a conflict between the Benefits Chart/EOC and this guide, the terms of the Benefits Chart and EOC will prevail." (EG, p. 38).[3]

28. Significantly, the operative document – the EOC – was not made easily available to retirees and contains material differences from what the City represents to retirees as the MAP's coverage. This is a classic case of bait-and-switch.

29. The EOC – or more precisely, two different versions of the EOC – was only recently made available by OLR on two different OLR websites. The first, in draft form, was posted on an OLR website in the last days of October. And then a different document was posted on November 5. Incredibly, neither document was ever sent to retirees. One was a 312-page document[4] and the other a 212-page document – and posted on a different OLR webpage.[5] How is a retiree supposed to know about these key documents? And how is a senior citizen supposed

[3] https://www1.nyc.gov/assets/olr/downloads/pdf/health/5325101%20511301MUSENMUB_001_CTYONY%20GRS%20PY%202021%20City%20of%20New%20York%20Senior%20Care_Update_508.pdf. (Last accessed on November 11, 2021).

[4] https://www1.nyc.gov/assets/olr/downloads/pdf/health/Alliance-Medicare-Advantage-Agreement-Documents-Draft-102921.pdf (Last accessed on November 9, 2021)

[5] https://www1.nyc.gov/assets/olr/downloads/pdf/health/evidence-of-coverage-nyc-medicare-advantage-plus-plan-102621.pdf (Last accessed on November 12, 2021).

to compare them or know which is operative? It is just another – but very important – example of the City's attempt to obfuscate.

30. Making matters worse, the City posted these EOCs just days before the November 10 contract hearing. This made it impossible for retirees to review them before the hearing and have their questions addressed. In addition, the Court had enjoined the City's implementation of the MAP pending its review of an improved implementation plan, which had not yet been provided. The proposed revised implementation plan was not sent to Petitioners until 6:51PM on Friday evening, November 5. Counsel may be expected to digest and compare these various documents in a week. But it is not fair to expect a senior citizen to analyze these documents, contact their doctors, and decide about their health plan in such a compressed time frame.

31. It therefore made little sense to hold an important information session on November 10. There was no way for retirees to reasonably compare the EOC, the Enrollment Guide, and the proposed plan. The EOC was 312 pages and according to the Enrollment Guide, was the controlling document. And without reviewing the City's proposed revised implementation plan, there was no way to know whether the City planned to change the contract, the EOC, the Enrollment Guide – or anything at all.

32. On November 4, Petitioners therefore asked the City to delay the contract hearing. On November 8, the City refused to do so. (*See* Steve Cohen Aff., Ex. A).

33. Significantly, a careful review of the information contained in the EOC reveals that it is materially inconsistent with the information in the Enrollment Guide, as demonstrated below.

1. Doctor Participation in the MAP is Exaggerated, or Simply Wrong

34. The City continues to try to convince retirees that the vast majority of doctors will participate in the MAP. If that is in fact the case, retirees should be able to confirm this with their own doctors.

35. The City's sleight-of-hand approach to enrolling doctors in the new MAP – or more accurately, representing to retirees that doctors will be participating – is to assert that if doctors are already participating in one of three other health plans offered by the Alliance, they are automatically participating in the MAP. That is a creative approach to pump up participation. But it also runs up against the basics of contract law. So, without actually seeing the contracts that providers have with the insurance companies, neither the Court nor retirees has any way to know if their doctors are contractually bound to participate.

36. What retirees do know is that the City and Alliance are using weasel-words to convey that participation. In an Anthem "provider bulletin" dated September 2021, it says: "Providers participating for Medicare Advantage PPO with a local Blue Plan *are considered participating* in Empire Medicare Advantage PPO Network Sharing." (Emphasis added.).[6] What is missing is any acknowledgement from the providers that this is, in fact, the case.

37. Petitioners do know, however, that the Alliance is continuing to misrepresent actual doctor participation. As detailed in the affidavit from Judith Brilliant, it is clear that the Alliance is still saying that specific doctors are participating in the MAP when they are not. (Judith Brilliant Aff.). And as noted above Michelle Robbins was told on Tuesday, November 9

[6] https://www.anthem.com/da/inline/pdf/abccare-0672-21.pdf. (Last accessed on November 12, 2021).

that her doctors and hospitals are in network, but two days later the website stated that they were out of network. (Michelle Robbins Aff).

38. How can retirees be certain of anything the Alliance says when the most fundamental information – whether a doctor is participating or not – is not accurate? They can't.

39. The EOC promises a "Provider Directory" (p. 57), but none is included or attached.

40. Finally, the Parker affidavit makes clear (¶12) that only 91% of current retiree doctors are currently in-network for the MA Plan (if they even choose to accept this kind of plan going forward, for which there is no guarantee). A further 5% *may* accept the plan based on *past* willingness to take Medicare Advantage, even though they do not currently take it. *What that effectively means is that 9% - or nearly 1 in 10 – of the doctors that the retirees rely on have no guarantees as to whether they will accept the Alliance MA Plan*.

2. The City/Alliance Continues to Mislead Retirees With Respect to Out-of-Network Doctors

41. Repeatedly, the City and the Alliance have promised retirees that they could see any doctor, whether in-network or out-of-network (OON). The Enrollment Guide makes this boast in multiple prominent locations, including in large, highlighted font on page 10: "See any doctor, provider or specialist who participates in Medicare." *See also* EG, p. 10 ("**Convenience** — see any doctor, provider or specialist who participates in Medicare."); *id.*, p. 2 ("[T]his NYC Medicare Advantage Plus Plan . . . allows you to see any doctor or hospital who accepts Medicare."); *id*., p. 13 ("You'll still have the same health plans you know and trust, and the same providers you have always seen."); EG, p. 10 ("Your benefits and coverage won't change, locally or nationwide, in or out of network, giving you added value."); *id*., p. 2 ("You're not tied

to a provider network, and you pay the same copay or coinsurance percentage whether your provider is in- or out-of-network.").

42. Ms. DiBenedetto talks about OON providers in her affidavit: "If a patient visits an out-of-network provider and the provider takes Medicare Advantage, the patient will only need to make the co-pay and the provider may bill the plan directly for the service." (DiBenedetto Aff. ¶ 13 iv).

43. Ms. Levitt discusses OON doctors several times in her Affidavit: "You can see out-of-network providers." (Levitt Aff. Draft Letter to Retirees, p. 15). And on the next page: "**Flexibility**: If you go to an out-of-network provider participating in Medicare, you will only need to pay your deductible or co-pay and the provider can bill the plan directly for services." And again, on page 17: "If you go to an out-of-network provider, that provider will Medicare almost certainly bill the NYC Advantage Plus Plan directly, and you will only be responsible for your deductible or co-pay/coinsurance for covered services." *See also* Levitt Aff., Ex. B at 16 ("Put another way, if you go to any doctor, in or outside the network, who takes Medicare, you will have no expense other than your deductible or co-pay/coinsurance for the covered services.").

44. But the Alliance is telling doctors something very different: "Out-of-network/noncontracted providers are under no obligation to treat NYC Medicare Advantage Plus Plan members, except in emergency situations." (Parker Aff. Exhibit B, p. 17).[7]

[7] This fact is mentioned in the Enrollment Guide, but it is buried in fine print in the back, many pages away from the false and misleading statements about how MAP members can see any doctor they want. Such disclosure is inadequate. *See United Paperworkers Int'l Union v. Int'l Paper Co.*, 985 F.2d 1190, 1199 (2d Cir. 1993) ("buried" disclosures are inadequate); *United States v. Locascio*, 357 F. Supp. 2d 536, 549 (E.D.N.Y. 2004) (noting that, in order to avoid liability for deceptive advertising, disclosures must be "clear and conspicuous," which is measured by their "placement," "prominence," and "proximity" to the misleading statement); *In*

45. And, in fact, it matters a great deal whether a provider is in network or out of network. If a MAP member goes to an in-network doctor, the fee is fully covered by the MAP. By contrast, if a MAP member goes to an out-of-network doctor, the plan pays only the Medicare-allowable amount. If the doctor's fee is higher, that additional amount is the member's responsibility. Furthermore, the member must pay up front and then hope and wait to get the Medicare reimbursement from the MAP. (EG, p. 10). This is a huge concern for retirees with limited funds.

46. And the Levitt affidavit claims that any provider who accepts Medicare will accept Medicare Advantage (¶31). But this is simply not true. Rather, if a MA enrollee goes out of network to a Medicare-participating provider, the plan could choose to make the individual's cost sharing 100%. The provider does not have to accept 100% of the Medicare rate for the service.

3. The List of Healthcare Tests and Procedures Requiring Prior Authorization is Far More Extensive than Listed in the Enrollment Guide

47. The City, in the Enrollment Guide and in the affidavits submitted by Ms. Levitt and Ms. Parker, attempt to downplay the burden on seniors of having to now endure prior authorization in order to get the most basic diagnostic tests and procedures. Ms. Levitt states, "The preauthorization requirements about which some concerns have been voiced are very similar to the requirements under the Empire-Emblem CBP plan for active Employees. Therefore, most New York City retirees have had experience with preauthorization requirements as active employees and as pre-Medicare retirees." (Levitt Aff. ¶35). Ms. Levitt perhaps forgets

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re Flag Telecom Holdings, Ltd. Sec. Litig., 618 F. Supp. 2d 311, 324 (S.D.N.Y. 2009) (holding that disclosures regarding presales were inadequate because they were not "in close proximity" to pages discussing those presales).

that the retirees are all senior citizens and disabled people who have not had to endure any prior authorization delays and bureaucracy since they went on Medicare. None. Many retired years ago before insurance companies began employing prior authorization schemes.

48. The most outrageous thing Ms. Levitt says, however, is that "The prior authorization requirements ensures that a New York City retiree receives proper care, by working with the physicians to determine whether the services are medical necessary." (sic) (Levitt Aff. ¶36). Ms. Levitt should review the findings of the American Medical Association which cite serious medical complications often arising from delays caused by prior authorization procedures.[8]

49. Fully 83% of doctors report that prior authorization requirements harm the continuity of care, 20% of patients always or often abandon the treatment their doctors have recommended while awaiting authorization; and another 55% sometimes do, and 24% of doctors report that delays in prior authorization have led to serious adverse events for patients in their care; and fully 16% report that such delays have led to a patient's hospitalization.

50. Ms. Levitt is at best being disingenuous. The point of imposing a prior authorization requirement is for the insurer to deny and delay – and very often avoid paying for – some significant portion of the treatments ordered by doctors. The American Medical Association findings underscore the dangerous and pernicious impact of prior authorization. Retirees need to know in which circumstances their medical treatment will be dictated by the insurance company – often against their doctors' recommendations. The purpose of prior authorization is not, as Ms. Levitt suggests, to ensure that a "retiree receives proper care, by

[8] See NYSCEF 93 Exhibit 7.

working with the physicians to determine whether the services are medically necessary." (Levitt Aff, ¶36). It is, pure and simple, for insurance companies to reduce costs and increase profits.

51. Meanwhile, the list of medical tests and procedures requiring prior authorization is being hidden – and then being misrepresented by the City. According to the Enrollment Guide provided to retirees in order to convince them to accept the MAP, prior authorization is only required for:

- Inpatient hospital coverage (p. 16)
- Skilled nursing facility (SNF) care (p. 16)
- Rehabilitation, including physical, occupational, and speech therapy (p. 16)
- Complex radiology — MRI, CT, and PET scans (p. 16)
- Prosthetics/orthotics (p. 16)
- Transplants (p. 16)
- Outpatient hospital coverage (p 19)

52. But the EOC contains many more areas of basic medical care that will require prior authorization -- which the Enrollment Guide explicitly excludes from prior authorization:

Medical Test or Procedure	**EOC Requires Prior Authorization**	**Enrollment Guide Excludes from Prior Authorization**
Home health care services including PT	P. 8	P. 23
Inpatient mental health care	P. 5	P. 20
Physician Services, including doctor's office visits	P. 11	P. 19
Urgent Care (Retail health clinics)	P. 11	P. 20
Acupuncture for chronic low back pain	P. 13	P. 21
Outpatient mental health care, including partial hospitalization services	P. 15	Mental health services (out- and inpatient) (P. 20)

Outpatient rehabilitation services	P. 20	PT (part of outpatient rehabilitation services, which includes physical, occupational, and speech language therapy) (P. 21)
Durable medical equipment (DME) and related supplies	P. 22	DMEs under home health agency care, which doesn't require PA, but "durable medical equipment (DME) copay or coinsurance, if any, may apply," (P. 23)
Outpatient diagnostic tests and therapeutic services and supplies	P. 25	Diagnostic services / labs / imaging & eye disease / injury diagnosis/treatment outpatient physician services don't require (p. 20, 23), but outpatient hospital coverage does (p. 19)
Healthy Meals	P. 45	P. 25
Healthy Pantry	P. 46	P. 26

53. These omissions are material and inexcusable. Unless they opt-out, retirees will have to get prior approval before they see a doctor or walk into an urgent care center. While these requirements seem contradictory – how can one get a doctor to seek prior authorization without first seeing that doctor or get prior authorization before going to an urgent care center? – that is precisely what the documents being provided by the City say. And that lack of logic and confusing communications is at the heart of the inadequacy of the City's plan for implementing the MAP. The documents and the plan are rife with misinformation and contradictions – undoubtedly because the City is trying to rush through a half-baked plan without regard to the harm it will cause retirees.

54. The EOC includes other important health services for which prior authorization will be required, which are never mentioned in the Enrollment Guide. These include:

- Podiatry services

- Outpatient substance abuse services
- Pulmonary rehabilitation services
- Supervised exercise therapy (SET)
- Home infusion therapy
- Opioid treatment program services

55. In the Draft Letter to Retirees attached to Ms. Levitt's affidavit, there is a bolded statement that is, at best, misleading: "**Prior Authorization**. Under the plan, the vast majority of covered services are not subject to a 'prior authorization' requirement, but some – like non-emergency hospital admissions – are." (Levitt Aff. P. 15). The Enrollment Guide is a bit more candid, listing three categories of healthcare services – and approximately 14 subcategories – that will require prior authorization.[9]

56. But in the materials being provided to healthcare providers by the Alliance, doctors are being told that the list of procedures subject to prior authorization is substantially more extensive. It is included in Kimberly Parker's affidavit, Exhibit B, and lists seven categories and 87 subcategories where they will have to seek prior authorization. That is a serious misrepresentation.

Enrollment Guide Prior Authorization Requirements	**City of New York GRS Alliance Program Provider Bulletin October 2021 (Kim Parker Affidavit, Ex. B)**
Inpatient hospital coverage for Medicare-covered hospital stays Outpatient hospital coverage Skilled nursing facility (SNF) care • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services	Inpatient admissions • Elective inpatient admissions • Rehabilitation facility admissions • Skilled nursing facility admissions • Long-term acute care (LTAC) care Inpatient services: • Heart transplant • Islet cell transplant • Kidney transplant • Liver transplant

[9] Phone representatives are even more candid, describing the number of procedures that require prior authorization as "sooo many." Fran Scharf Aff.

• Physical therapy, occupational therapy, and speech language therapy • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors) • Blood, including storage and administration • Medical/surgical supplies • Laboratory tests • X-rays and other radiology services • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/practitioner services	• Lung or double lung transplant • Multivisceral transplant • Pancreas transplant • Simultaneous pancreas/kidney transplant • Small bowel transplant • Stem cell/bone marrow transplant (with or without myeloablative therapy)
	Outpatient services: • Donor leukocyte infusion • Stem cell/bone marrow transplant (with or without myeloablative therapy) • Orthotics (performed primarily on ankle, back, foot, and knee) • Elective inpatient surgery • All potentially cosmetic surgeries • Arthroscopies/arthroplasties • Bariatric/gastric obesity surgery • Breast reconstruction • Cervical fusions • Continuous glucose monitoring (CGM) • Coronary artery bypass graft (CABG) • Defibrillator/pacemaker insertion or replacement • Genetic testing • Endoscopies • Epidermal growth factor receptor testing • Home health • Hyperbaric oxygen therapy • Intracardiac electrophysiological studies (EPS) catheter ablation • Knee and hip replacements • Knee orthoses

	• Laminectomies/laminotomies • Laparoscopies • Nerve destructions • Nonemergency ground, air, and water transportation • Occupational therapy • Oncology (Breast), mRNA, gene expression profiling • Pain management • Physical therapy • Sleep studies and sleep-study-related equipment and supplies • Spinal orthoses • Spinal procedures • Tonsillectomy/adenoidectomy • UPPP surgery (Uvulopalatopharyngoplasty - removal of excessive soft tissue in the back of the throat to relieve obstruction) • Vascular angioplasty and stents • Vascular embolization and occlusion services • Vascular ultrasound
	Behavioral health services • Day hospital/partial hospital admissions • Inpatient admissions • Intensive outpatient therapy • Psychological and neuropsychological testing • Rehabilitation facility admissions • Transcranial magnetic stimulation (TMS) for depression
	Transplants: human organ and bone marrow/stem cell transplants • Prior authorization is required for Medicare-covered transplant admissions.
	Radiology services • CT scan (including CT angiography) • Echocardiograms • MRA scan • MRI scan • MRS scan

	• Nuclear cardiac scan • PET scan • Radiation (oncology) • Radiation therapy
	Durable medical equipment (DME) and prosthetics • Automated external defibrillators • Bone stimulators • Cochlear implants • Cough assist (insufflator/exsufflator) • High-frequency chest wall oscillator • Insulin and infusion pumps • Left ventricular assist device • Nonstandard wheelchairs • Nonstandard beds • Oral appliances for obstructive sleep apnea • Patient transfer systems • Pneumatic compression devices • Power wheelchair repairs • Power wheelchairs, accessories, and power-operated vehicles (POVs) • Prosthetics, orthotics • Sleep-study-related equipment and supplies • Speech-generating devices and accessories • Spinal cord stimulators • Tumor treatment field therapy • Ventilators • Wound pump

57. The City's dissemination of false and misleading information regarding MAP's prior authorization requirements makes it impossible for retirees – rightfully fearful of prior authorization – to make an informed decision regarding whether to opt out of the plan. Indeed, because prior authorization poses well-documented risks, particularly for elderly and disabled retirees with serious medical conditions, knowing whether their current and/or anticipated treatments will be subject to prior authorization is a major factor in their healthcare choice. The

inaccurate information the City is feeding retirees prevents them from making a competent choice.

58. The City's false and misleading information regarding prior authorization also has potentially devastating financial implications for retirees, which the City characteristically glosses over. For retirees whose doctors are out-of-network, it is (astoundingly) the retirees' responsibility to ensure that their doctors seek and obtain prior authorization before receiving treatments subject to prior authorization requirements (of course, that critical fact, like so many others, is only cryptically referenced in the Enrollment Guide). (EG, p.16.) If prior authorization is not sought for a given treatment that requires it, and the claim associated with that treatment is later deemed by the Alliance not to be medically necessary, the retiree will have to shoulder the entire cost of the treatment, which could be thousands of dollars. *Id*. Therefore, it is absolutely critical that retirees – particularly those who are or may be treated by out-of-network providers – be told exactly which treatments require prior authorization, since the MAP makes them responsible for ensuring that their doctors seek and obtain such authorization before delivering those treatments. (This is also a reason why retirees desperately need accurate information on whether providers are in network.)

59. Of course, all of this assumes that retirees – the vast majority of whom have never had to deal with prior authorization before – are even aware that, under the MAP, the retirees are responsible for ensuring that their out-of-network doctors seek and obtain prior authorization, and that the doctors' failure to do so may render the retirees liable for the cost of any unauthorized treatments. The City – apparently not wanting to alarm retirees – downplays this crucial fact in the Enrollment Guide, merely "encourag[ing]" MAP members with out-of-network providers to "ask [their] provider to request [prior authorization] for [them] before

[they] get care." *Id*. And the City's draft letter to retirees, attached to Claire Levitt's affidavit, makes no mention whatsoever of this subject.

60. This is not informed choice. The potential expense for retirees is devastating. Respondents need to accurately inform them about it.

4. The City Continues to Mislead Retirees With Respect to the Turn-Around Time and Burden of Prior Authorization Requests

61. The City has repeatedly said that retirees don't have to request prior authorization reviews, and that is the responsibility of doctors. "Whose responsibility is it to receive prior authorization? It is the provider's responsibility to ask for prior authorization from Empire BlueCross BlueShield Retiree Solutions You aren't responsible for asking for it when you see a provider that accepts NYC Medicare Advantage Plus." (EG, p. 16). Except that the EOC devotes six pages to the request and appeals process that retirees have to go through – not doctors. (EOC, p. 129–135.)[10]

62. Similarly, seniors will be completely perplexed about whom and what to believe about the turn-around time of prior authorization decisions. Ms. Levitt states in her latest affidavit, "if the medical situation matter is urgent, the provider and Alliance completes a prior authorization review within approximately twenty-four to forty-eight hours. In most other situations the provider and Alliance undertake a prior authorization review, which is typically completed in 3-5 days." (Levitt Aff. ¶37). Ms. DiBenedetto states, "If the matter is urgent, the provider and Alliance completes a preauthorization review in twenty four to forty eight hours. ix)

[10] In fact, the EOC spells out several scenarios distinguishing what happens when a retiree requests a review as opposed to a doctor requesting it: "If you ask for a fast coverage decision on your own, without your doctor's support, your plan will decide whether your health requires that we give you a fast coverage decision." (EOC, p. 130). Who is supposed to do it – the doctor or the patient? Reading the EOC – the controlling document – retirees would undoubtedly be confused.

In most other scenarios, the provider and Alliance complete a preauthorization review within six days." (DiBenedetto Aff. ¶13 viii, ix).

63. Ms. Levitt and Ms. DiBenedetto are not entirely consistent, but both say under 24-48 hours and under six days. But that is not what the EOC says. It does say, "If your health requires it, ask us to give you a 'fast coverage decision.' A fast coverage decision means we will answer *within 72 hours* if your request is for a medical item or service." (EOC, p. 129).[11] As to the under six days in which a less urgent prior authorization will allegedly be completed, the EOC states several times: "A standard coverage decision means we will give you an answer *within 14 calendar* days after we receive your request for a medical item or service." (EOC, p. 129) (emphasis added). Ms. Levitt and Ms. DiBenedetto's affidavit and affirmation make absolutely no reference to three-to-five days or under six days.

64. Again, the City is wrong in its representations to retirees – about matters that are materially important to senior citizens and disabled first responders.

5. Other Contradictions Between the EOC and the Enrollment Guide

65. There are several other important contradictions between what the Enrollment Guide tells retirees and what is actually provided in the EOC.

66. **There is no guarantee the MAP will remain premium-free**. The City has repeatedly said the MAP is premium-free to retirees. The EOC says, "Effective January 1, 2022, City of New York is automatically enrolling Medicare-eligible retirees, along with their eligible dependents, into a premium-free plan: The NYC Medicare Advantage Plus Plan." (EOC opt-out form, PDF p. 34 of 44). Ms. Levitt repeats it in her affidavit: "In the new proposed program,

[11] The EOC also qualifies when a fast decision will be made: You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function." (EOC, p. 130).

New York City retirees continue to have a program of premium-free health insurance health and their reimbursements of the Medicare part B premiums." (Levitt Aff. ¶ 26).

67. Except that is not what the Alliance is contracting for with the City. The EOC states, "The City of New York will pay all premiums in most cases. **Generally, your plan premium won't change during the benefit year**. You will be notified in advance if there will be any changes for the next benefit year in your plan premium." (EOC, §4.2, p. 54 (emphasis added)). In short, retirees have no guarantee that the MAP will remain premium-free for even a year. And, as the contract between the Alliance and the City reveals, premiums may increase suddenly and without limit, depending on "Alliance's fee policy, which may be revised from time to time." (EOC, Article 6.A, p. 4).

68. In fact, the EOC contract Addendum A – the section concerning the Alliance's "Quote Stipulations" – notes that "Multi-Year pricing may be adjusted if any of the following stipulations are not met: . . . ." One of these stipulations is as follows: "Assumes group/fund membership will not vary more than 10% from the original enrolled membership (enrollment as of January 1, 2022, exclusive of members who successfully opt out prior to December 31, 2021) and county mix does not change by more than 10% from quote assumptions." (EOC, Addendum A).

69. There is a similar stipulation in Addendum B, which deals with "Performance Guarantees", or the guarantees that the Alliance has made to the City about its performance under the agreement through 2028. There is a list of these guarantees on the following pages, which include guarantees related to implementation (conducting meetings, file processing, call lines, issuing IDs and welcome kits, etc.), member services (call lines, annual notices, etc.),

quality (outreach, engagement, case manager assessments, etc.), financial services (coding accuracy), data management, and account management. (EOC, Addendum B).

70. In other words, if the MAP doesn't live up to the City's hyped promises and people choose to opt out in year two, the Alliance can increase the premium or reduce its services to members – in order to compensate for its lost profits. Retirees need to be informed of this perverse incentive structure.

71. The Enrollment Guide and the Draft Letter omit another critical factor for retirees to consider in making a choice: a premium can be imposed on retirees of in year two of the MAP. The Enrollment Guide appears to take a half-step in admitting that possibility: on page 18 where – on the first page of "Summary of Benefits" – it says, "Premium $0." But there is a footnote notation after $0, and the actual footnote is not included anywhere in the document.

72. **"Care" (cost) managers will be imposed on certain patients**. Second, one very important aspect of the MAP that is completely ignored in the Enrollment Guide – but included in the EOC – is the imposition of a "care manager" on seniors who incur more than $75,000 in healthcare expense in a year. (EOC, Addendum B, p. 9). The Alliance's performance bonus is directly related to their ability to control costs, and is of great concern to retirees like Ralph Francisco, a former Paramedic Lieutenant with the New York City Fire Department who sustained injuries in the line of duty. As detailed in his affidavit, the 833-hotline representative gave him completely erroneous information; the online provider directory did not include either his current doctors or hospital; and told him that the nearest facility was over an hour away in another state. (See Francisco Aff).

73. **Out-of-network reimbursements will take twice as long as represented**. Third, an oft-repeated promise of the City and the Alliance is that retirees can see any doctor – even

providers out-of-network. And if the doctor requires a retiree to pay for that service at the time it is provided, the Alliance will reimburse the retiree within 30 days. Ms. Levitt repeated that promise in her most recent affidavit. (Levitt Aff., ¶ 31). Ms. DiBenedetto repeats it her latest affirmation. (DiBenedetto Aff. ¶ 13 v). Unfortunately for retirees, the EOC says something completely different. It states: "We will say yes or no to your request. If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request." (EOC, p. 136). Again, the City and the Alliance lie to retirees about an important issue to senior citizens and disabled individuals living on fixed incomes: 60 days is not 30 days.

74. **The MAP's star-rating is a sham**. Fourth, the Alliance states in the Enrollment Guide that: "For 2021, Empire BlueCross BlueShield Retiree Solutions received the following Overall

75. Star Rating from Medicare: ★★★★ 4 Stars". (EG, p. 44). That is simply not true. The Alliance "borrows" a four-star rating for a still-non-existent MAP from the ratings of other plans administered by Blue Cross Blue Shield.

76. Because the existing plans are independent from the Alliance's new MAP, the Alliance has knowingly misrepresented their ratings as those of this new Plan.

77. In fact, one of the Alliance partners, EmblemHealth, has the worst ranking of any health insurance company in New York State, according to the New York State Department of Financial Services Consumer Guide to Health Insurance.[12]

[12] https://www.dfs.ny.gov/system/files/documents/2021/08/ny_consumer_guide_health_insurers_2021.pdf. (Last accessed November 8, 2021).

78. The only EmblemHealth and Blue Cross Blue Shield plans that apply in New York – EmblemHealth Insurance Company, EmblemHealth Plan, Inc., and Empire HealthChoice Assurance, Inc. – are among the worst-rated since 2015. Out of 14 plans, these three ranked 10th on average in EPO/PPO complaint resolutions and 11th on average in EPO/PPO prompt pay complaint resolutions between 2015 and 2020, as evidenced in the table below.

2015-2020 New York EPO/PPO Health Plan Complaint Resolution Rankings[13]

Complaint Type	Year	EmblemHealth, BCBS Plan	Rank
Complaints	2020	EmblemHealth Insurance Company	12 out of 15
Complaints	2020	EmblemHealth Plan, Inc.	15 out of 15
Prompt Pay	2020	EmblemHealth Insurance Company	12 out of 15
Prompt Pay	2020	EmblemHealth Plan, Inc.	15 out of 15
Complaints	2020	Empire HealthChoice Assurance, Inc.	10 out of 15
Prompt Pay	2020	Empire HealthChoice Assurance, Inc.	11 out of 15
Complaints	2019	Empire HealthChoice Assurance, Inc.	9 out of 14
Prompt Pay	2019	Empire HealthChoice Assurance, Inc.	11 out of 14
Complaints	2018	Empire HealthChoice Assurance, Inc.	10 out of 13
Prompt Pay	2018	Empire HealthChoice Assurance, Inc.	10 out of 13
Complaints	2017	Empire HealthChoice Assurance, Inc.	6 out of 13

[13] https://www.dfs.ny.gov/consumers/health_insurance/health_insurance_complaint_rankings. (Last accessed November 9, 2021). Rank: Each health insurance company's ranking is based on how many complaints were resolved by Department of Financial Services in favor of the member or provider, relative to the company's premiums. A lower number results in a higher ranking. A higher ranking means that the health insurance company had fewer complaints relative to its size.

Prompt Pay	2017	Empire HealthChoice Assurance, Inc.	8 out of 13
Complaints	2016	Empire HealthChoice Assurance, Inc.	8 out of 14
Prompt Pay	2016	Empire HealthChoice Assurance, Inc.	11 out of 14
Complaints	2015	Empire HealthChoice Assurance, Inc.	10 out of 13
Prompt Pay	2015	Empire HealthChoice Assurance, Inc.	12 out of 13
Average			11 out of 14

79. The Alliance's shameless use of "borrowed credibility" to try to convince retirees that the new MAP has any track record at all – much less a four-star rating – is indicative of the misinformation that has plagued this entire process from the start and continues to plague it today. Retirees are being told they will be getting a Lexus; in fact, the underlying vehicle is a Yugo.

80. **The MAP shifts the cost of prior authorization errors onto seniors**. Fifth, the EOC warns that if a MAP member fails to "follow[] all the rules for getting the care," the Alliance "will not pay." EOC at 103. There is no mention of this fact in the Enrollment Guide. This is an extraordinary shifting of responsibility for navigating the bureaucratic morass that is prior authorization. It means that if the doctor is out-of-network, the burden shifts from the doctor to the senior; and if the Alliance determines that the test or procedure is not medically necessary – or if the senior does not follow the cumbersome rules – then the senior must pay. (EOC at 103.) There is no mention of this terrifying prospect in the Enrollment Guide or the proposed Draft Letter to Retirees.

81. **Care and doctors can change annually**. Sixth, the Enrollment Guide states, "Your benefits and coverage won't change locally or nationwide, in or out of network, giving you added value." (EG, p. 10). But the EOC states, "Each calendar year Medicare allows us to

make changes to the plans we offer. This means we can change the costs and benefits of your plan after December 31, 2022, or on your group-sponsored plan's renewal date. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2022." (EOC, p. 55).

6. The EOC says that Retirees have no recourse if the Alliance screws up.

82. The contract between the City and the Alliance includes another extraordinary provision: retirees are not to be considered third-party beneficiaries, and thus would not have any third-party rights. The contract states: "**Section 8.08 No Third Party Rights**" - The provisions of this Agreement shall not be deemed to create any right of action in favor of third parties against the Contractor or the City or their respective officials and employees." (EOC, Section 8.08). This illogical statement runs counter to the recent decisions in *Plavin* – where Alliance partner EmblemHealth is the defendant – where both the Third Circuit and the New York State Court of Appeals both explicitly stated that active employees and retirees were third-party beneficiaries of the contract between the City and EmblemHealth, and got their health benefits from the GHI-CBP.[14] The attempt by the Alliance and/or the City to end-run the courts is a disgrace.

B. <u>Respondents Are Unable to Provide Sufficient or Accurate Information in Hearings, Webinars and Phone Calls</u>

83. Respondents need to prepare an accurate and comprehensive program description that can be approved by the Court and then provided to retirees. They cannot provide inaccurate written materials and expect retirees to disregard those statements in favor of contradictory statements made at hearings and webinars.

[14] *See Plavin v. Group Health Incorporated*, 857 Fed.Appx. 83 (Mem), 83 (3d Cir. 2021) and *Plavin v. Group Health Inc.*, 35 N.Y.3d 1, 8 (2020).

84. In other words, Respondents cannot cure the serious deficiencies in their written information materials by providing correct information at hearings and webinars, even if they could manage to provide accurate information in those fora – a feat they have yet to achieve.

1. November 10 Hearing.

85. The proposed "Communications to Retirees" (Levitt Aff, Exhibit B.) refers to a November 10 public hearing. That hearing was fundamentally flawed. It was an open conference call line where countless unmuted participants attempted in vain to ask urgent healthcare-related questions while City representatives laughed at the futility of the endeavor. One media report described it as "chaotic."[15] Retirees were barely able to voice their questions and concerns, much less have them appropriately addressed.

2. Webinars.

86. The proposed Communications to Retirees also references "74 webinars with approximately 37,000 New York City retirees in attendance." In the City's proposed revised plan, Ms. Levitt notes that the City plans to hold webinars with retirees in order to better educate them about the MAP. Ms. Levitt notes that since August, approximately 74 webinars have been held and some 34,000 retirees attended. (Levitt Aff. Exhibit B). That averages approximately 459 people per webinar – a surprisingly high number. But 34,000 attendees represent less than 14% of all NYC retirees. And her statement that "live retiree education with Q&A sessions will continue through November and December" is without detail or support. There are only 48 days between now and December 31, including the Thanksgiving and Christmas holidays. Does the City plan to hold one a day between now and the end of the year – excluding the two holidays of

[15] https://www.nysfocus.com/2021/11/11/retired-city-workers-oppose-medicare-advantage-health-costs/. (Last accessed on November 11, 2021)

course – and think it will attract the same average number of attendees to each? If so, it might conceivably reach some 21,000 retirees, just 8% of the target audience. The City's outreach plan is, very simply, too little too late.

87. Further, the issue is not only the number of webinars that are held, but whether accurate information is provided to attendees. It appears from their submission that Respondents have done *nothing* to identify the source of previous errors in these types of presentations, or even to admit there were problems. Consequently, it is sad but not surprising that the City has no plan to correct them.

88. Most of those webinars were organized by unions. Unfortunately, the information communicated at many of the webinars was incorrect or misleading. More significantly, the information being conveyed by some unions continues to be wrong or misleading – even after this Court ordered the City to come back with a revised plan that addressed the inadequacies and misinformation.

89. One recent example will suffice: On October 27, 2021 Henry Garrido, Executive Director of DC 37 hosted a teleconference.[16] Among the many misstatements made by Mr. Garrido is one which deserves special attention because of its simplicity. At 9:28 of the YouTube recording, Mr. Garrido was asked "I'm speaking on behalf of Janet, I'm her daughter… she heard that you have UBER rides that will take her to her doctor's appointment?" Mr. Garrido responded: "Under this program, the number of UBER that I mentioned, we were able to negotiate thousands of UBER rides…. But I believe the last as of the last number, the DC 37 MLC group coalition was able to negotiate 12,000 UBER rides as an added benefit to the new program. And so that will be added an added bonus that you don't have now."

[16] https://www.youtube.com/watch?v=eJj_vzOk1Gs. (Last accessed November 10, 2021).

90. Unfortunately, there is no such Uber benefit in the contract, the EOC, or the Enrollment Guide. The EOC does include a provision for transportation services that are much more limited than Mr. Garrido's promise: "You must schedule trips 2 business days in advance…Trips will not be covered for non-health related services such as going to buy groceries, personal errands or other reasons when accessing non-covered services." (EOC, p. 48). Such an exaggeration is not the end of the world. But retirees cannot rely on made-up information promulgated by uninformed union representatives.

3. Telephone Hotline

91. The information being promulgated by the Alliance representatives on the 833-telephone hotline is often equally erroneous. Among the most grievous misstatements being put forth by Alliance representatives involves retirees' "once-in-a-lifetime" option to change health plans – a benefit designed to protect against any dramatic and unanticipated health changes.

92. The City's most recent Health Benefits Program Summary Plan Description reads, "Retirees may transfer or add an Optional Rider during the Transfer Period, which takes place on even numbered years. During this period, all retirees may transfer from their current health plan to any other plan for which they are eligible… *Retirees who have been retired for at least one year can take advantage of a once-in-a-lifetime provision to transfer or add an optional rider at any time*." (emphasis added).[17]

93. The once-in-a-lifetime option is an important failsafe for retirees who may face surprise medical issues. Yet retirees are unable to get a straight answer on how this will work in the context of the City's implementation of the new MAP. In the City's 2022 Sponsored Plans

[17] https://www1.nyc.gov/assets/olr/downloads/pdf/health/health-full-spd.pdf. p. 18. (Last accessed November 12, 2021).

Comparison (a document that describes the various health plan choices offered to retirees) they are told: "The Aetna Medicare PPO ESA plan is a City Sponsored retiree health plan (you can enroll for the remainder of 2021 by using your "Once-in-A-Lifetime" change, you will NOT be able to enroll in 2022)."

94. But when retirees Michelle Robbins and Michelle Stromer asked whether they would have to use the once-in-a-lifetime transfer to switch into Aetna's plan this year, OLR representatives told them that they could switch without using their once-in-a-lifetime transfer (Madeline Salerno Aff., Ex. A). On the other hand, OLR representatives first told Susan Nattis that she would not need to use her once-in-a-lifetime transfer to switch to Aetna, and then that she would need to use it (Susan Nattis Aff., Ex. A). Retirees need a clear answer to this important question so they can make an informed decision.

95. This confusion extends beyond switching to the Aetna plan specifically. The draft Medicare Advantage Group Agreement reads, "Retirees who do not wish to be enrolled in the new Plan, effective January 1, 2022, will have the ability to opt-out and remain in their current retiree health plan only. Retirees will NOT have the option to transfer to another health plan during the annual Fall Retiree Transfer Period, effective for January 1, 2022."[18] This stands in direct contrast with the Fall Transfer Period that retirees have been guaranteed through the Summary Plan Description, cited above.[19]

96. With limited time and information, retirees have yet to receive a straight answer as to whether to use their only once-in-a-lifetime transfer to keep their current plan or switch to a

[18] https://www1.nyc.gov/assets/olr/downloads/pdf/health/Alliance-Medicare-Advantage-Agreement-Documents-Draft-102921.pdf. Addendum A, p. 1. (Last accessed November 12, 2021).

[19] https://www1.nyc.gov/assets/olr/downloads/pdf/health/health-full-spd.pdf. p. 18. (Last accessed November 12, 2021).

new one. Recent retirees, in particular, may not be able to anticipate their yet-undeveloped healthcare needs, and might prefer to save their once-in-a-lifetime transfer for down the line.

97. And, as detailed above, Respondents continue to provide inaccurate information about which providers are in or out of network, and they cannot answer basic questions about which procedures will require prior authorization.

IV. The City's Proposed Revised Plan Fails the Most Basic Test: The Smell Test

98. Retirees are not irrational people. If the City had been honest and candid with them from the outset and said to them, "Look, healthcare is expensive. We'd like to shift this $500 million annual cost from the City's budget to the Federal budget. But we can only do if you move from a Supplemental/Medigap plan like Senior Care to what is known as a Medicare Advantage Plan. And we know you have the sole option to change plans; we can't do that to you. So, we'd like to work with you, listen to your concerns, make adjustments and use our buying power; and together we should be able to come up with a plan that satisfies your needs and still allows us to shift the cost to the Federal government."

99. But the City did not do that. Instead, it developed a plan in secret and tried to force it on retirees. And in the process, they have repeatedly exaggerated the benefits of the MAP, misrepresented its limitations, and tried to make the claim that the MAP is not just "just as good as" the Senior Care plan, but better.

100. If the MAP were just as good as Senior Care, the City would have structured the program to allow retirees to opt into it; not force it upon them and not only make them opt-out, but also force them to (illegally) pay for the privilege.

101. But it is an unsupportable claim. Putting lipstick on a pig doesn't hide the pig. Or the significant weaknesses of the plan, the inadequacy of the City's proposed implementation of it, or the underlying diminution of benefits.

102. Retirees simply cannot make an informed decision about whether to accept the MAP because the City and the Alliance are far from educating or negotiating with doctors about participating in it. Their assurances that all doctors will accept it or are automatically in-network because they accept a different Anthem or Emblem plan is belied by the facts.

103. Retirees cannot make an informed choice because they are continuously being misled by the City and the Alliance about what is covered in the plan and what is not; most importantly about what tests and procedures will be subject to a health-threatening prior authorization procedure.

104. The City continues to abuse its discretion and authority to administer the healthcare program fairly, honestly, and appropriately.

105. The City's proposed revised plan to implement the MAP is arbitrary and capricious.

* * *

106. In sum, Respondents' proposed timetable and informational efforts are completely inadequate and will only lead to further chaos. The Court should reject Respondents' proposal and order them to submit a proposal that will result in less rather than more confusion, as contemplated by the Court's October 21, 2021 Order.

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POLLOCK COHEN LLP

By:/s/ *Steve Cohen*
Steve Cohen
60 Broad St., 24th Floor
New York, NY 10004

(917) 364-4197
SCohen@PollockCohen.com
Attorneys for Plaintiff