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Case No. N22C-09-526 CLS

IN THE SUPERIOR COURT FOR THE STATE OF DELAWARE

RISEDELAWARE INC., *et al.*, Plaintiffs, v. SECRETARY CLAIRE DEMATTEIS in her official capacity as Secretary of the Delaware Department of Human Resources and Co-Chair of the State Employee Benefits Committee, *et al.*, Defendants.	:	C.A. No. N22C-09-526-CLS

OPENING BRIEF IN SUPPORT OF
PLAINTIFFS' PETITION FOR ATTORNEYS' FEES

Dated: November 14, 2022

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INTRODUCTION

This exceptional case warrants an award of attorneys' fees as an exception to the American Rule that parties to litigation pay their own attorneys' fees. Plaintiffs (also hereinafter "RISE") have achieved through this litigation an important benefit for 30,000 State retirees in protecting their traditional Medicare benefit for another year. Their rights to be informed and to be heard in the future about changes contemplated by Defendants have been upheld, given that Defendants must now comply with open government laws. The public record also now includes important information about the State's unlawful approach to changing the infrastructure of healthcare benefits for State retirees (current and future alike) without public notice and participation, which otherwise would never have been known.

RISE accomplished these achievements despite the State's disproportionate power to push Medicare Advantage on State retirees. Their vexatious conduct created an almost insurmountable obstacle to any legal challenge by retirees.

After Medicare Advantage was improperly adopted out of public eyesight, the individual defendants, Secretary Claire DeMatteis and Director Cerron Cade, intentionally delayed notification to State retirees for over three of the seven months before enrollment. Then, when finally giving notification of the already-adopted HMAP, they advanced misinformation to retirees and legislators alike – including

that any change was too late because Highmark had contract rights (when it did not). In doing so, they created a seemingly impossible hurdle to corrective action. Only because of Herculean efforts by RISE and its counsel was the improper change to Medicare Advantage stopped.

An appropriate award of attorneys' fees, we submit, will provide a needed encouragement for the undertaking of meritorious lawsuits that benefit thousands of people and that should deter improper State conduct.

STATEMENT OF FACTS

The Court's ruling of October 19, 2022 ("Decision") made important findings of facts about the SEBC's adoption and Defendants' communications of Medicare Advantage for State retirees (pp. 2-7, 9-12) that are adopted by stipulation for the Final Order. Those facts, as supplemented based on evidence submitted establish that an award of attorneys' fees is warranted.

A. SEBC Adoption of Medicare Advantage Regulation

This Court's Decision noted the evident lack of disclosure by responsible leadership to both the public and SEBC members in adoption of the Medicare Advantage regulation on February 28, 2022. *Decision* at 3.

The Agenda for the February 28, 2022 meeting did not give notice of the significant policy change being voted on, as required by open meetings law. *Decision* at 3, 11 n.10. The agenda referred instead to "2021 Health Third Party

Administrative Services RFP Award Recommendations."[1] This was a violation of FOIA as the Court found. *Id.*

The meeting minutes reflect that Co-Chairs, Secretary DeMatteis and Director Cade, did not raise or explain to SEBC members that they were being asked to restructure retiree healthcare. *Id.* Or that the restructuring involved significant negative impacts for retirees, including prior authorizations and provider network restrictions. *Deci*sion at 5-6.[2] Rather, the focus of presentations and discussion was on economics for the State, without regard to health impacts on retirees. Clarkin Aff(2d) ¶10.

B. DHR and OMB Silence

After adoption of Medicare Advantage, DHR and OMB remained uncommunicative. They intentionally kept retirees in the dark for three months until early June. *See* Plaintiffs' Motion for SJ; Rentz Aff. ¶¶ 26-28. They did not even take advantage of the already scheduled newsletter to announce the change. *Id.* The alleged (paternalistic) reason was to protect retirees from "confusion" while other enrollments proceeded in May. But this silence meant retirees were effectively foreclosed from any real attempt at legislative change before the June 30 close of the

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[1] This item referenced a wrong year, as noted in the *Decision* at 3.

[2] The Clarkin Aff(2d) ¶¶7-10 confirms the record on the SEBC meeting minutes and agendas pursuant to Rule of Evidence 1006.

legislative session.

DHR has claimed that legislators were presented with the change to Medicare Advantage in the budget process with the Joint Finance Committee. Rentz Aff. ¶31. But the State has never provided evidence of such a presentation. Our own research found none.[3] LePage Aff. ¶9. For example, the presentation by Secretary Rick Geisenberger to the JFC does not say State retiree healthcare has been restructured or raise Medicare Advantage. *Id.*

C. June's "EXCITED" Announcement

Even though no contract was in place, the first announcement to State retirees about Medicare Advantage came in a letter mailed June 1 from the heads of the State Benefits Office (part of DHR) and the Pensions Office (part of OMB). Representing they have "your best interest in mind," they expressed how "EXCITED" they were "to share positive changes for Medicare-eligible retirees." SJ Appendix at A0003-04. Notably, the SEBC had not even discussed what might be in the "best interest" of retirees.

The letter represented that the new plan provided "the same level of medical plan benefits" as the current Medicare supplement (Medicfill). A0003.[4] Highmark's

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[3] DHR apparently finally made some kind presentation to some legislators in mid-August. The State refused a FOIA request for that presentation. LePage Aff. ¶6.

[4] This letter was apparently emailed to the two legislature Communications Directors Rentz Aff. ¶32.

two general mailings in the summer of glossy marketing materials continued to convey that benefits were the same, while ignoring and then later downplaying Prior Authorization and network restrictions. SJ Appendix A005-19, 25-40.

These representations were not correct. As the Court has found, the plans were "substantially different" because of Medicare Advantage's network restrictions (access to providers is not "the same") and its requirements for prior authorizations[5] (benefit coverage is not "the same"). *Decision* at 6.

D. DHR and OMB's Push As State Retirees Expressed Concern

On August 12, Rep John Kowalko published an Opinion piece in the News Journal warning State retirees about the State's move to Medicare Advantage. Exhibit A. The op-ed brought to readers' attention that "Medicare Advantage plans move you out of the traditional Medicare program and allow a private company to oversee your medical care." And that such plans have requirements for pre-authorization.

Secretary DeMatteis and Director Cade on September 1 published an Opinion piece in response: "The coverage for Medicare services and prescription drugs remains the same as the past Medicare Supplement plan. State pensioners and their dependents have the same access to doctors and hospitals who accept Medicare."

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[5] As Highmark's representative succinctly put the contrast: "Original Medicare has virtually no prior authorization." LePage Aff Exhibit 4

Exhibit B. These representations, again, were not correct.

They further represented that: "The SEBC went through an extensive public process over the past year on the transition to a Medicare Advantage plan." *Id.* This was not correct as the SEBC actually went through *no* real public process prior to voting on plan adoption. Clarkin Aff(2d) ¶¶7-9. And even after that, whatever actions relating to Medicare Advantage were taken remained under the radar with meeting agendas hardly like to spark notice. *Id.*

On September 12, in response to growing retiree concerns, certain legislators held a town hall at Goldey Beacom with Secretary DeMatteis, Director Cade, and Highmark representatives. On short notice by word-of-mouth, RISE assembled a large turnout of hundreds of State retirees. Diller Aff. ¶16. Retirees were astute and agitated.[6]

E. The State's Misrepresentations When No Contract Was Signed

Rather than change course, the State doubled down with a full court press to stop public opposition. On September 13, Secretary DeMatteis and Director Cade wrote the Senate Democratic Caucus to tamp down legislator concern.[7] "We are writing to confirm and explain the legal, statutory, financial and practical reasons

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[6] *See* Video clip Exhibit 3 (Highmark will lose money). LePage Aff ¶10b.

[7] *See* Exhibit C. Of course, at that point, the only possibility for legislation in 2022 would have been by special session, well known as always remote.

why the transition cannot be postponed." They claimed the State was legally stuck: "Highmark has a legal right to rely on [the February 28 SEBC] contract award…." Exh D p.1.

This representation was not true. There was no executed contract. And the Request for Proposals (RFP) provides in Section "4.0 Award of Contract" (p.21)[8]: "Notice in writing to a vendor(s) of the acceptance of its proposal by the SEBC *and* the subsequent full execution of a written contract will constitute a contract and *no vendor will acquire any legal or equitable rights or privileges until the occurrence of both such events*." (emphasis added).[9]

Meanwhile, as confirmed at Goldey Beacom, Rep. John Kowalko had been asking for the contract without success. *See* Diller Aff. ¶17. And the contract status had become less clear when Director Cade said at Goldey Beacom: "Just to clarify timing, this Plan was not adopted back in February. It was actually voted on in early June by the SEBC." LePage Aff ¶10a Video Clip Exhibit 2.

State officials, Secretary DeMatteis or Director Cade, then claimed to RISE in a meeting on September 14 that Highmark had contractual rights that could not be broken. Peterson Aff(2d) ¶9-10. They refused to delay implementation of the

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[8] https://bidcondocs.delaware.gov/DHR/DHR_2201MedicalTPA_rfp.pdf

[9] The letter also claimed epilogue language in the June 28 appropriations bill "codifies the change to Medicare Advantage." Such a claim has not been supported. *See* Peterson Aff(3d) at ¶3.

Medicare Advantage plan. Diller 10/13/22Aff. ¶22. This appeared to leave RISE out of non-litigation options, even as the October 3 start of enrollment loomed.

F. The RISE Lawsuit

The hurdles for a viable lawsuit were enormous. The basic facts were far from clear and hard to determine. Statements by Secretary DeMatteis and Director Cade had created significant obstacles: (1) HMAP had resulted from an extensive public process (when it had not); (2) the change had been adopted in June not February (when it had not); and (3) HMAP was a done deal and Highmark could sue the State (when it was not and could not).

After an intense effort with counsel, RISE filed its expedited suit on September 25. *See* Diller 10/14/22Aff. ¶22.

Although the Complaint asked for a stay of execution, the State proceeded on September 28 to execute an HMAP contract with Highmark – eschewing the judicial process and without notice to Plaintiffs.

Meanwhile, misinformation given out by Secretary DeMatteis and Director Cade to legislators was having the effect that could be expected. *See* Peterson Aff(3d) ¶2-7. Some legislators expressed to constituents that: the lawsuit had no merit; "Highmark would probably sue us to the tune of hundreds of millions of dollars"; and the lawsuit was "dangerous for the pensioners" because success would result in "no coverage from the state[e] at at all starting 1/1/23." Peterson Aff(3d)

¶4, 6-7. RISE was left to try to correct this egregious misinformation where it learned of it. *E.g.* Peterson Aff(3d) ¶4.

Plaintiffs moved to stay implementation of the Medicare Advantage plan on October 4, 2022 pursuant to 29 *Del. C.* §10144. After briefing and a hearing, the Court issued its October 19 Decision granting the Stay: "Defendants' implementation of a Medicare Advantage Plan for State retirees is stayed until further Order by this Court"; and "Defendants shall take all necessary and proper steps to ensure that the healthcare insurance and benefits available to State retirees prior to October 3, 2022 or in which they were enrolled prior to that time, remain in full force and effect." *Decision* at 13.

After the Order, DHR's website has contained a Notice (emphasis added):

> On October 19, 2022, the Superior Court of the State of Delaware granted an interim Motion to Stay on the State's Medicare Open Enrollment and transition to a Medicare Advantage plan beginning January 1, 2023…. *The SEBC remains committed to providing benefit eligible State pensioners with high quality, accessible and affordable healthcare benefits, which the transition to a custom designed Medicare Advantage plan provides.*

LePage Aff ¶11. This Notice presumably reflects the "commit[ment]" of the Secretary of DHR. It presents a not-so-subtle tealeaf as to future action by the individual Defendants to impose Medicare Advantage on State retirees. As Yogi Berra put it, "It ain't over till it's over."

On October 24, given the Decision, the SEBC did what purportedly was impossible – MedicFill is now extended through 2023. *See* LePage ¶12. And the existing healthcare insurance and benefits of State retirees remain in place. The benefits achieved by the litigation are manifest. For next year, retirees will not have their medical care decided by an insurance company's employees or have to look for "in-network" providers; treatments will not be delayed and denied by an insurer; and they will not face HMAP's "cost-sharing," "co-insurance," and other costs not present under their Medicfill benefit.

ARGUMENT

"Under Delaware law, litigants are ordinarily responsible to pay the costs of their own representation in litigation. Express statutory authorization and certain equitable doctrines provide limited exceptions to that rule." *Korn v. New Castle County*, 922 A.2d 409, 412 (Del 2007), citing *Dover Historical Society, Inc. v. City of Dover Planning Commission*, 902 A.2d 1084, 1090 (Del. 2006) (citations omitted). The grant of fees is a matter for the Court's discretion. *See Dover Historical*, 922 A.2d at 1089.

First, a statutory exception applies here because of the fee shifting statute in Title 29, Chapter 100, for violation of open meetings laws. Second, equitable principles can be applied (whether in support of a statutory award or independently) because the Court granted relief equitable in nature. "The Superior Court does hear

cases in which it is occasionally required to apply equitable principles. In such cases the Superior Court has jurisdiction to award attorneys' fees even if no contract or statute requires it." *Dover Historical*, 922 A.2d at 1090.

The exercise of discretion to award attorneys' fees is warranted in this exceptional case where Plaintiffs achieved a highly significant benefit of maintaining traditional Medicare (with Medicfill) for 30,000 people. Plaintiffs achieved this benefit despite deeply troubling conduct by individual Defendants that used the State's disproportionate power to overwhelm efforts by retirees to stop implementation of HMAP.

I. THE APA ALLOWS FEES FOR PLAINTIFFS' SUCCESS IN ACHIEVING THE STAY ORDER

The Decision properly determined that Defendants violated FOIA's open meetings laws in adopting HMAP, which gives the Court the power to void that action. *See Decision* at 11 & n.10; *Chemical Indus. Council v State Coastal Zone Indus. Control Board*, 1994 WL 274295, at *7-10, 15 (Del. Ch. 1994) (Coastal Zone Act regulations voided where adopted at meetings held in violation of FOIA). As unlawfully adopted, the HMAP regulation is also subject to final declaratory relief that it is void under Section 10141(a) of Chapter 101.

The statute allows attorneys' fees for violations of open meetings laws: "The court may award attorney fees and costs to a successful plaintiff of any action brought under this section." 29 *Del. C.* §10005(d). Indisputably, Plaintiffs were

successful. The issue, therefore, is whether the Court should exercise its discretion to award fees.

This Court, as affirmed by the Supreme Court, has awarded (partial) attorneys' fees applying Section 10005(d) in a case involving police identification information. *Gannett v. Board of Managers of DELJIS*, 840 A.2d 1232, 1240 (Del. 2003). It was within the Court's discretion "to consider the incentive structure facing the parties to a particular suit in deciding the extent of fees to award." *Id.*

Considering incentives, the Chancery Court declined to award fees under Section 10005(d) where it voided a regulation adopted in violation of FOIA but the successful plaintiffs were large industrial entities. *Chemical Indus. Council*, 1994 WL 274295, at *15. In doing so, the Court saliently noted, "because the plaintiffs have a significant private economic interest in invalidating the Regulations, no fee shifting was (or would be) needed to afford them an incentive to bring suit." *Id.* By contrast, an incentive in the form of fee shifting is a vital incentive to bring - and maintain - lawsuits like the one here. *See* Peterson Aff(3d) ¶9-12.

The statute does not limit an award to fees "incurred." Accordingly, this Court is not limited to fees incurred. *See Scion Breckenridge v. ASB Allegiance*, 68 A.3d 665, 683-685 (Del. 2013) (where contract limited to fees "incurred," no fees could be awarded contractually for *pro bono* counsel). It is free to consider equitable factors. *Scion*, 68 A.3d 665 at 687-688 (case remanded for "exercise of the Vice

Chancellors' inherent equitable powers" to consider defendant's bad conduct for an award of fees).

II. RISE ACHIEVED MONUMENTAL BENEFITS

The importance of the achievement of a common benefit is well-recognized:

> Under the "common benefit" exception, a litigant may, nonetheless, receive an award of attorneys' fees if: (a) the action was meritorious at the time it was filed, (b) an ascertainable group received a substantial benefit, and (c) a causal connection existed between the litigation and the benefit.

See Dover Historical, 922 A.2d at 1090.[10] The purpose by its recognition is to balance the equities to prevent "persons who obtain the benefit of a lawsuit without contributing to its cost [from being] unjustly enriched at the successful litigant's expense." *Id.*

The conditions for finding a common benefit are plainly met here:

(1) The action was meritorious when filed, as established by the Decision, which the parties have stipulated will be incorporated into the Final Judgement.

(2) The ascertainable group of State retirees (including spouses and dependents) received a very substantial benefit from the State's extension of the

[10] For example, in corporate disclosure cases where defendants owe a fiduciary duty to shareholders, "This court has traditionally placed greatest weight upon the benefits achieved by the litigation." *In re Anderson Clayton S'holders Litig.*, 1988 WL 97480, at *3 (Del. Ch. Sept. 19, 1998) (Allen, C.).

Medicfill plan and dropping of Medicare Advantage.[11] They further received the equally significant benefit that the SEBC must follow good government laws in any future effort to restructure retirees' healthcare. Finally, the public record now includes important information about the State's approach to changes to healthcare benefits that would otherwise never have been known.

(3) The litigation indisputably caused the State to take its corrective actions with the resulting benefits to State retirees.

Such a common benefit warrants fees. *See e.g. Korn*, 922 A.2d at 413.

III. DEFENDANTS' VEXATIOUS CONDUCT WARRANTS FEES.

DHR and OMB did not watch out for the best interest of the vulnerable State retirees they are tasked with serving and to whom they owed a fiduciary duty (whether by statute or by their own representations as explained in Plaintiffs' Motion for SJ). Their conduct was egregious in: delaying disclosure of the restructuring of retirees' healthcare; misrepresenting HMAP when they did undertake communications; acting in ways that predictably would interfere (directly and indirectly, e.g. through legislators) with retirees' efforts to reverse the adoption of Medicare Advantage; and by proceeding without notice to Plaintiffs or to the Court

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[11] This benefit could even, if necessary, be quantified from the savings to retirees in not having to replace their Medicare supplement on the open market.

to execute the contract. Their conduct created a political narrative that HMAP could not be undone. *See* Peterson Aff(3d) ¶3-7.

Such vexatious conduct by Defendants warrants fees:

> "One of the well-recognized common law exceptions to the American Rule is the power of a court or an administrative tribunal, otherwise vested with equitable authority, to award attorney's fees when the 'losing party has 'acted in bad faith, vexatiously, wantonly, or for oppressive reasons.'" *Alyeska Pipeline Serv. Co. v. Wilderness Soc'y*, 421 U.S. 240, 258–59 (1975) (citation omitted).

Brice v State of Delaware, 704 A.2d 1176, 1179 (Del. 1998). The purpose of this bad conduct exception is to "deter abusive litigation in the future, thereby avoiding harassment and protecting the integrity of the judicial process." *Id.* (citing *Schlank v Williams*). In *Schlank v Williams*, the D.C. Court of Appeals stated:

> On the other hand, in *Andrews v. District of Columbia* [443 A.2d 566, 569 (D.C.), cert. denied], we cited several cases for the principle that "an award of attorneys' fees is warranted *`[w]here an individual is forced to seek judicial assistance to secure a clearly defined and established right, which should have been freely enjoyed without such intervention....*'" [citation omitted]

572 A.2d 101, 112 (D.C. 1990); *Cf. Chem Indus*. 1994 WL 274295 at *15.

This Court is not limited to consideration of conduct in the litigation itself and can consider the individual Defendants' impeding of the exercise of Plaintiffs' rights. *See Scion*, 68 A.3d 665, 687. It can also consider their action in executing the Contract that the Complaint had asked to stop. *See Dover Historical*, 922 A.2d at 1093 (defendant's destruction of historic homes during the litigation meant to protect the homes warranted fee-shifting award).

IV. WEIGHING THE FACTORS

Other factors point to a substantial award of fees. The *Sugarland*[12] factors are:

> (i) the time and effort by counsel for plaintiffs; (ii) the relative complexities of the litigation; (iii) the standing and ability of petitioning counsel; (iv) the contingent nature of the litigation; (v) the stage at which litigation ended; (vi) whether the plaintiff can rightly receive all the credit for the benefit conferred or only a portion thereof; and (vii) the size of the benefit conferred.

A Herculean effort was required (exacerbated by individual Defendants' obstacles). Counsel were highly competent. The case was very complex in requiring: understanding of Medicare plans and administrative law; location and review of a voluminous record, including online materials; and work with many retirees for perspective and input on an exceedingly short timeline.

While not a contingency case *per se*, counsel undertook a risk that has borne out that RISE might not be able to raise sufficient fees. Peterson Aff. ¶9-11. *See, Berger v. Pubco,* C.A. No. 3414-CC (Ch. 9/8/2008) slip op. at 4 (V.C. Chandler) Exhibit 5. Counsel also gave reduced rates.

As to stage of resolution, seeing a claim through to judgment lends weight to a higher award, both because of greater legal work and greater risk; the instant case required a ruling as the State would not back down.

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[12] *See In re Sauer-Danfoss Shareholders Litig*., 65 A. 3d 1116, 1135-36 (Del. Ch. 2011) (citing *Sugarland Indus., Inc. v. Thomas*, 420 A.2d 142, 149 (Del.1980)).

There should be a bonus to law firms for taking on litigation with a risk of not being fully paid but which brings important benefits to 30,000 people. Accordingly, it is only fair that law firms be paid in a way that recognizes the risk in taking on a lawsuit that benefits 30,000 people but that does not have a substantial damages award.

The Court may award fees for work of *pro bono* attorneys. Neither the Statute nor equitable principles limits fees to those "incurred." *See ASB.* Here, the Legal Liaison for RISE, a licensed Delaware attorney with 35-years of experience in complex litigation in the Delaware courts, has worked around the clock to support the lawsuit at all stages, from preparation of the Complaint to the various motion papers, including for fees. *See* Peterson Aff. ¶11.

The Court's ultimate determination should consider prevention of such conduct in the future, the importance of an incentive for similar meritorious suits and recognition that a small subset of people should not have to shoulder the burden for protecting the rights of 30,000 people. At the same time, there should not a "socially unwholesome windfall," *Korn 10/3/2007 at 7; Berger 9/8/2008* at 2, 4. This makes sense here with taxpayers already shouldering a burden for the State's improper actions. We think it is fair to consider that the State has a $1B surplus.

The Court should take into account all of the above factors when calculating an appropriate fee award. We submit that it is hard to imagine a more meritorious case for fees.

CONCLUSION

Plaintiffs respectfully request an award of attorney fees.

Dated: November 14, 2022

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CERTIFICATE OF SERVICE

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CERTIFICATE OF COMPLIANCE WITH TYPEFACE REQUIREMENT AND TYPE-VOLUME LIMITATION

1 Plaintiffs' Opening Brief in Support of their Motion to Stay (the "Brief") complies with the typeface requirement of Superior Court Rule 107(b) because it has been prepared in Times New Roman 14-point typeface using Microsoft Word 365.

2 The Brief complies with the type-volume limitation of 4,000 words in the Order for Resolving the Remaining Claim and Issues and, because it contains 3,933 words, which were counted by Microsoft Word 365.

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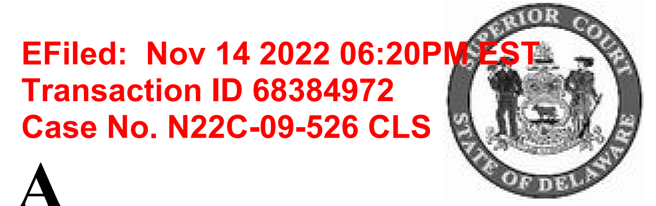

EXHIBIT A

delaware online

OPINION *This piece expresses the views of its author(s), separate from those of this publication.*

Delaware's public retirees must reject Medicare Advantage plan | Opinion

John Kowalko Special to the USA TODAY Network

Published 3:22 a.m. ET Aug. 12, 2022 | **Updated 2:41 p.m. ET Aug. 16, 2022**

State of Delaware retirees, retired Delaware teachers, as well as college and university faculty covered through the state of Delaware's health benefits must act immediately and let their state elected officials know that the proposed move of all these retirees to a Medicare Advantage plan is unacceptable.

What are Medicare Advantage plans? In short, they represent the privatization of one of the most successful federal programs in history and it is an embarrassment that the state of Delaware wants to participate in undermining the traditional Medicare program. Unfortunately, unless you are close to retirement, you are probably unaware as to how this change might affect you. Medicare Advantage plans move you out of the traditional Medicare program and allow a private company to oversee your medical care. It is not simply an insurance change. It is a program change into privatized medical care. Although Medicare Advantage plans tout many "extras," compared to traditional Medicare, you are giving up the rights encoded in the federal program for a contract negotiated every couple of years. What you have now may not be in the next contract. The lack of transparency in the transition process to these plans is not uncommon. New York City retirees filed a class action law suit to prevent the change and received a stay of implementation until the issue could be fully vetted.

A recent article published by the American Association of Retired Persons (AARP) shows that Medicare Advantage plans, because they have requirements for pre-authorization of services, have a 13% higher rate of denial of services than regular Medicare.

This is because the company receiving the premiums paid is both the provider of the services as well as arbiter of whether those services are to be provided. This is like a fox guarding a hen house. This fact is one of many that has triggered an U.S. Inspector General audit of some of these programs. However, as these Medicare Advantage programs continue to expand, Medicare may lack the ability to monitor these programs.

What you should know: What's the difference between Original Medicare and Medicare Advantage?

The reality is that this proposed change in benefits has not been brought before the State Legislature. These proposals have not been vetted nor discussed by the General Assembly and most of my fellow legislators are completely unaware of this plan and its possible detrimental effect on retirees.

Here are some concrete steps that you can take now to draw attention to this issue:

- Write the governor, lieutenant governor, as well as all state representatives and state senators and protest this change. Ask them to stop the implementation of this contract for a Medicare Advantage plan for at least a year. Ask them to return all retirees to the traditional Medifill program for at least another year.
- Inform your other state retiree friends and colleagues about this issue and ask them to contact legislators as well.
- Ask to meet with your state representative and state senator about this issue.
- Set up a community meeting for state representatives and senators to meet with groups of retirees who are concerned about this issue.
- Ask your union and association representatives what they are doing to stop this from happening.
- Attend information meetings sponsored by the State Pension office and ask questions about this plan.
- Educate yourself about this issue. Read everything sent to you by the State Pension Office. Read the AARP article listed above and go to Medicare.gov and read the material posted. Search for other articles.
- Connect with the grassroots group, RiseDelaware at risedelaware@gmail.com to receive information and updates about this issue.

I call upon my colleagues in the state Legislature to act to ensure that this contract is shelved, and state of Delaware retirees be returned to the current Medifill plan until we have a chance to examine how this decision was made. Medicare Advantage plans are great for healthy retirees. They will fail older retirees who will need to fight battles for medical care while they are ill. We can do better for the people who served this state.

Rep. John Kowalko represents the 25th District and is based in Newark.

EFiled: Nov 14 2022 06:20PM EST
Transaction ID 68384972
Case No. N22C-09-526 CLS

EXHIBIT B

delaware online

OPINION *This piece expresses the views of its author(s), separate from those of this publication.*

Delaware state pensioners will get the same Medicare and premium health coverage | Opinion

Claire DeMatteis and Cerron Cade Special to the USA TODAY Network

Published 11:56 a.m. ET Sept. 1, 2022 | **Updated 1:15 p.m. ET Sept. 1, 2022**

We want to share more on the latest developments on Medicare coverage for state pensioners to ensure our state retirees understand they will continue to have the best, most comprehensive Medicare coverage.

We know the healthcare system can be complex, and it can be made even more daunting when you or a family member are dealing with health issues or an emergency. That is why we continue to partner with one of our state's leading nonprofit healthcare companies to protect state pensioners' Medicare coverage for years to come.

For several years, Delaware's State Employee Benefits Committee and the Retirement Benefit Study Committee have worked to identify options that assure that retired State employees retain access to high quality and affordable health care while also making progress toward reducing the State's $10 billion unfunded liability for retiree healthcare that threatens the long-term sustainability of these very important benefits.

What you should know: Delaware is changing its Medicare plan for state workers, here's what it means for retirees

To protect our state pensioners, in June, the Delaware General Assembly approved language in the State's Fiscal Year 2023 budget placing 1% of the prior year's budget into a Trust Fund for retiree healthcare. In February, the SEBC approved a plan that was included in the Fiscal Year 2023 budget assuring that retirees and their dependents continue to receive premium health care services through a customized Medicare Advantage plan specifically designed by Highmark Blue Cross Blue Shield Delaware.

The coverage for Medicare services and prescription drugs remains the same as the past Medicare Supplement plan. State pensioners and their dependents have the same access to doctors and hospitals who accept Medicare.

Highmark Blue Cross Blue Shield Delaware will continue to administer the State Medicare health plan, just as it has for many years with:

- $0 co-pay for visits with your doctor.
- $0 deductible for medical services.
- $0 cost for skilled nursing facility services.
- $0 cost for nationwide in and out-of-network coverage with out-of-network providers receiving the 100% Medicare allowable reimbursement for services provided.
- $0 cost for lab and imaging.
- $0 cost for emergency room and urgent care services.
- Full and immediate coverage for pensioners with pre-existing conditions.

In addition, the new plan adds:

- The Silver Sneakers® fitness program membership
- Help managing your health and wellness; and,
- Home meal service after a hospital discharge.

The SEBC went through an extensive public process over the past year on the transition to a Medicare Advantage plan. Coverage will remain employer-sponsored and state-funded; it is not privatizing state retirees' health care. The new plan takes effect on January 1, 2023, with open enrollment Oct. 3 through Oct. 24.

We understand any change can be met with concern. If you are a state pensioner with questions about the plan, please contact Highmark Concierge Service: available 7 days a week from 8 a.m. to 8 p.m. at 1-888-328-2960 (TTY call 711).

When compared with retiree health plans in other states, Delaware's Medicare Advantage plan remains among the most elite, with the best and most comprehensive Medicare coverage. And like the health coverage available to State employees and pensioners not yet eligible for Medicare, the Medicare Advantage plan will require prior approval for some non-emergency services.

Say you were sent to a specialist because you had intense back pain and needed an MRI. Your doctor would contact Highmark to request an authorization for this test. The request will then be reviewed by the Highmark clinical team of nurses and physicians to make sure that it was the most appropriate test for your symptoms. By doing this, Highmark can ensure you get the best access to care and both you and your doctor are not burdened by extra paperwork on the backend. Highmark BCBS Delaware approves about 93% of all prior authorizations, with 92%

approved on the initial submission. Expedited, non-emergency prior authorizations are approved within an average of a day and a half, with standard, non-emergency pre-authorizations approved within about 4 days. Emergency and urgent care services do not require prior authorization.

There are other benefits too. The fact is that State pensioners who retired prior to July 1, 2012, and earned 100% of state share coverage, continue to pay no monthly premium, and for those retired after this date with 20 years of service, their premium is reduced to $10.80 per month.

For State pensioners who retired after June 30, 2012 with less than 20 years of service and are responsible for some or all of the cost of their Medicare coverage, the monthly fee is reduced by more than half to $216.18 per month. This significant reduction makes the plan affordable and gives retirees access to exceptional medical and prescription coverage that simply is not available in the individual healthcare market.

While it is true that the State's ability to absorb growing healthcare costs has limits, by partnering with Highmark BCBS Delaware, our State pensioners will have access to medical professionals and a concierge service team dedicated to ensuring they receive medically necessary health services and exceptional support in navigating their health and wellness needs.

Over the past month, we have held several education sessions to inform and engage our State Medicare pensioners. We will hold additional sessions in September and October. We also encourage Medicare pensioners and their dependents to visit our website to stay informed: **Highmark Delaware Medicare Advantage webpage**(https://dhr.delaware.gov/benefits/medicare/medicare-advantage.shtml).

Claire DeMatteis is secretary of the Delaware Department of Human Resources. Cerron Cade is director of the state Office of Management & Budget. DeMatteis and Cade co-chair the State Employee Benefits Committee.

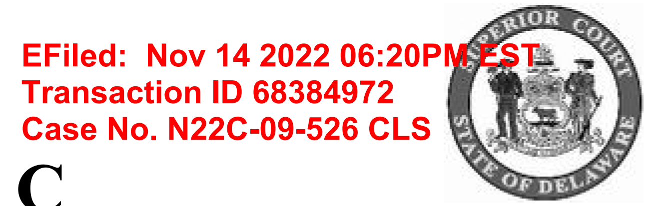

EXHIBIT C

DELAWARE GENERAL ASSEMBLY
STATE OF DELAWARE
411 LEGISLATIVE AVENUE
DOVER, DELAWARE 19901

September 9, 2022

The Honorable John C. Carney Jr.
Tatnall Building
Dover, DE 19901

Dear Governor Carney,

As the State prepares for a January 1, 2023 transition from its Medicfill Plan to a new Medicare Advantage Plan for its Medicare retirees, retired state employees understandably have important questions about how this transition will impact their care.

Their questions are fair and thoughtful. They simply want the peace of mind that their new plan will serve them well and keep them healthy.

Through no fault of your administration, and despite significant analyses and efforts by labor leaders over many months to ensure a transition maintains a robust retiree Medicare plan that also is fiscally sustainable, there has been significant confusion about what Delaware's Medicare Advantage Plan does and does not do, how it compares to Medicare Advantage plans in other states, and whether it will materially change the quality of coverage for our retirees.

That is why we write you today. Our retirees continue to ask questions and make suggestions for how we can optimize the care we are offering them. Amidst the confusion, and in search of time to clarify their understanding and educate themselves as to the new plan, many have asked us whether it is possible to postpone the transition. After multiple rounds of probing that possibility with your cabinet and staff, it now is our understanding that the transition cannot be postponed. We respectfully ask for final confirmation and explanation as to why a delay is not possible; we believe public awareness of that point would help our retirees to understand the full context of the transition.

If in fact it is not possible to delay the transition, we ask that your administration continue to seek modification of the proposed terms of the new plan. We applaud your team's efforts to build on the protections labor leaders secured in the baseline proposal. Recently, for example, the Department of Human Resources updated the General Assembly on several improvements

that had been negotiated with Highmark in response to input in recent weeks. Included in those changes were:

- a four-month delay in the commencement of preauthorization requirements for non-emergency outpatient services
- quarterly reporting on denial/approval rates, turn-around-times, and other aspects of the pre-authorization process
- expansion of out-of-network access
- additional customer service personnel and resources at Highmark to help retirees navigate the transition

We do request you seek additional protections and supports for retirees, including:

- contractual language for performance guarantees beyond data reporting requirements. For example, although data transparency is critical, we want to ensure retirees are entitled to relief if the rates of pre-authorization denials or delays raise concerns as to the quality of care they receive, or if individual denials or delays are unjustifiable and result in any harm.
- the hiring of qualified, dedicated staff at the Department of Human Resources to help answer questions and work with retirees navigating a new relationship with Highmark in the pre-authorization process or experiencing other access concerns. Retirees already are accustomed to working directly with DHR staff to address health plan questions, and we believe it is important to maintain that support even as Highmark develops its own internal processes.
- other measures based on additional input we receive as we and your team engage our constituents in the coming days and weeks.

We recognize the genesis of the transition to Medicare Advantage was based on the imperative to keep our retiree health care plan solvent for years to come. We also acknowledge that more than a dozen public meetings were held before the State Employee Benefits Committee adopted this proposal, and that it had support from cabinet officials, labor leaders, and legislators alike. Ultimately, the General Assembly accepted this plan as part of the public budget process based on the SEBC's research and recommendation and because we know that doing nothing is not an option. But our work does not stop with our votes. It is critical that we use our voices to amplify the questions of our constituents.

All who played a role in this outcome take seriously our responsibility to be good stewards of taxpayer money, while ensuring we keep our promises to our hard-working retirees. That work continues, and we are committed to coordinating with your administration to ensure the needs of our retirees are met during this transition. We thank you for your past and ongoing efforts, and hope you take every possible step to ensure the actual performance of the Medicare Advantage Plan matches the information and assurances our retirees are receiving in the lead-up to the transition.

Sincerely,

Senator David P. Sokola
President Pro Tempore
District 8

Senator Bryan Townsend
Majority Leader
District 11

Senator S. Elizabeth Lockman
Majority Whip
District 3

Senator Darius J. Brown
District 2

Senator Bruce C. Ennis
District 14

Senator Kyle Evans Gay
District 5

Senator Stephanie Hansen
District 10

Senator Spiros Mantzavinos
District 7

Senator Sarah McBride
District 1

Sen. W. Charles Paradee, III
District 17

Senator Marie Pinkney
District 13

Senator Nicole Poore
District 12

Senator Laura V. Sturgeon
District 4

Senator Jack Walsh
District 9

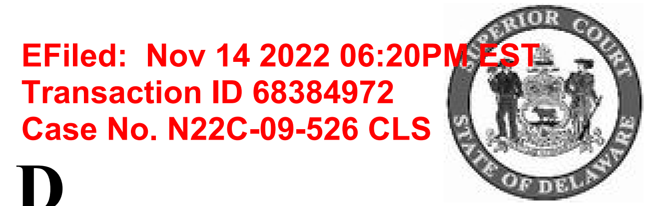

EXHIBIT D

September 13, 2022

VIA EMAIL

Senate Democratic Caucus
Legislative Hall
Dover, DE 19901

Dear Senators,

Thank you for your continued engagement on the transition to the custom-designed Medicare Advantage plan for state pensioners and their dependents effective January 1, 2023, which will be administered by Highmark Blue Cross Blue Shield Delaware. The Governor has asked us to address the issues you articulated in your letter dated September 9, 2022. We are writing to confirm and explain the legal, statutory, financial, and practical reasons why the transition cannot be postponed.

As you are aware and noted in your September 9th letter, in response to concerns raised by you and our state pensioners, Highmark Blue Cross Blue Shield Delaware already has agreed to postpone for four months implementation of prior authorization for outpatient services, which is the issue that seems to most concern retirees. That is a significant concession by Highmark Blue Cross Blue Shield Delaware, which will cost several million dollars; however, it is the right decision to provide pensioners more time to get accustomed to the prior authorization measures that all our active state employees and pre-65 retirees have had as part of their health insurance coverage for decades.

Specifically, the reasons the transition to the State of Delaware pensioner Medicare Advantage plan cannot be delayed include:

- The State Employee Benefits Committee (SEBC), which has statutory authority over control and management of healthcare contracts for state employees and pensioners, issued a contract award letter to Highmark Blue Cross Blue Shield Delaware on March 2, 2022, following the unanimous vote by SEBC members at the public meeting on February 28, 2022, to award the contract to Highmark Blue Cross Blue Shield Delaware. Highmark has a legal right to rely on that contract award as the insurer has been building its Medicare Advantage provider network and addressing concerns related to prior authorization requirements in good faith.

- The contract for the Highmark BCBS Special Medicfill Medicare Supplement plan ends on 12/31/22, and that Medicare Supplement plan no longer exists for State of Delaware pensioners after 12/31/22. The SEBC rebids state healthcare contracts every three years for state pensioners, active employees, and pre-65 retirees.

- The Medicare Advantage plan must be administered on a calendar year basis and cannot be implemented mid-year.

- The annual open enrollment period for the State Medicare population is scheduled for 10/3 – 10/24/22. The Centers for Medicare and Medicaid Services (CMS) has specific requirements that must be met to ensure pensioners are properly and timely notified of enrollment and disenrollment rights and receive required plan information and member identification cards prior

to the plan effective date. The open enrollment dates have been established to ensure the State of Delaware and Highmark Blue Cross Blue Shield Delaware are fully compliant with these federal requirements.

- State employee, pre-65 pensioners and Medicare pensioner health plan premium rates for FY23 have been set and are in effect as of 7/1/22 for the employee and pre-65 pensioner populations. The rates were established, funded, and approved in the FY23 operating budget to generate the necessary revenue to cover the anticipated FY23 expenditures <u>for the entire Group Health Insurance Plan population.</u> Therefore, delaying implementation of the Medicare Advantage plan would force all Medicare pensioner medical plan costs to result in the Group Health Insurance Plan incurring approximately $66 million in unfunded Medicare pensioner medical plan expenditures during calendar year 2023.

- Keep in mind that Highmark Blue Cross Blue Shield is providing health plan administration to approximately 100,000 of the State's 130,000 covered members. This relationship in aggregate has allowed the SEBC to negotiate with Highmark to offer this exclusive Delaware Medicare Advantage plan that combines the benefits of Medicare Part A, Medicare Part B, the current Medicare Part D prescription benefits administered by CVS Caremark/SilverScript and the previous Medicfill plan into one custom plan. The new plan shifts risk to Highmark and requires Highmark and providers including ChristianaCare and BayHealth to take more responsibility for healthier outcomes, provide more efficient care and management of services, and provide strong preventive care and chronic care services. Highmark and these large providers are convinced that they can improve care delivery and the health of our State pensioners that they have publicly stated their willingness to do so, even if they risk losing money directly from this population.

- The FY23 Budget, Section 116, which was introduced on June 7, 2022, approved by the General Assembly, and signed into law on June 28, 2022, codifies the change to Medicare Advantage.

Regarding your request for additional protections and supports for retirees, we continue to work with Highmark Blue Cross Blue Shield Delaware to amend the final contract to include the performance guarantees you recommend. We hope to finalize the contract by the end of this month, as we will make the contract public for full transparency.

In addition, as previously noted, several months ago, the Department of Human Resources (DHR) identified 12 open casual seasonal positions to support critical administrative functions and customer service support related to the Medicare Advantage transition. As we know that our pensioners consider the Office of Pensions as their human resource office during Open Enrollment and throughout the Medicare plan year, these positions will be assigned to that office.

We will continue to work with and engage you, other legislators, Highmark Blue Cross Blue Shield Delaware, and state pensioners on a smooth transition to the specially-designed Medicare Advantage plan for state pensioners, as we continue to work together to ensure the long-term viability and strength of the healthcare benefits we provide our valued state pensioners.

Sincerely,

Claire M. DeMatteis

Claire DeMatteis
Secretary
Delaware Department of Human Resources

Cerron Cade
Director
Office of Management and Budget

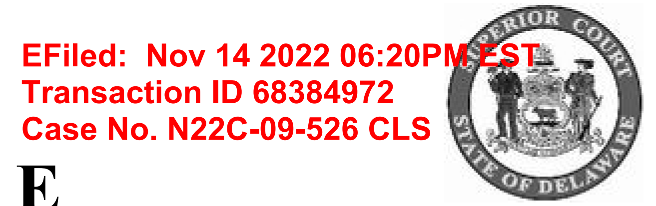

EXHIBIT E

COURT OF CHANCERY
OF THE
STATE OF DELAWARE

WILLIAM B. CHANDLER III
CHANCELLOR

COURT OF CHANCERY COURTHOUSE
34 THE CIRCLE
GEORGETOWN, DELAWARE 19947

Submitted: August 15, 2008
Decided: September 8, 2008

Ronald A. Brown, Jr.
Prickett, Jones & Elliott, P.A.
1310 King Street
Wilmington, Delaware 19801

Allen M. Terrell, Jr.
Richards, Layton & Finger, P.A.
One Rodney Square
P.O. Box 551
Wilmington, DE 19899

Re: *Berger v. Pubco Corp., et al.*
Civil Action No. 3414-CC

Dear Counsel:

This is my decision on defendants' motion to clarify final order and judgment of July 18, 2008 and plaintiff's fee petition of August 13, 2008. For the reasons described briefly below, I conclude that (1) plaintiff's attorney has conferred a significant benefit upon Pubco Corporation ("Pubco") shareholders and is entitled to attorneys' fees and expenses in the amount of $250,000, (2) defendants must provide the reconstructed list of beneficial owners from Cede & Co. to plaintiff, and (3) this Court will not prohibit plaintiff's counsel from communicating with potential class members regarding the information obtained during settlement discussions with defendants.

I. Fee Petition

Plaintiff contends that a $600,000 award for plaintiff's legal fees should be awarded for the successful litigation of this suit. Defendants counter that an award

of only $92,000 is appropriate. Defendants concede that a corporate benefit has been bestowed upon the shareholders and the issue of whether or not there is a corporate benefit is not before this Court. Therefore, the issue is only one of determining the appropriate level of attorneys fees.

Attorneys' fees may be granted when a benefit has been conferred upon a corporation or its stockholders.[1] The corporate benefit doctrine provides that where a common benefit has been conferred upon stockholders, all stockholders should contribute to the costs incurred to confer the benefit.[2] The amount of the attorneys' fee award is within the discretion of the court[3] and should be of an amount sufficient to encourage the undertaking of future meritorious lawsuits while avoiding "socially unwholesome windfalls."[4]

In determining the amount of an award of fees in a given case, this Court typically considers the factors laid out in *Sugarland Industries v. Thomas*.[5] The factors are:

> (i) the amount of time and effort applied to the case by counsel for the plaintiffs; (ii) the relative complexities of the litigation; (iii) the standing and ability of petitioning counsel; (iv) the contingent nature of the litigation; (v) the stage at which the litigation ended; (vi) whether the plaintiff can rightly receive all the credit for the benefit conferred or only a portion thereof; and (vii) the size of the benefit conferred.[6]

The value of the benefit conferred due to the litigation is usually afforded the most weight.[7] "[T]he opportunity to participate in the quasi-appraisal remedy" is

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[1] *Tandycrafts, Inc. v. Initio Partners*, 562 A.2d 1162, 1164 (Del. 1989).
[2] *Weinberger v. UOP, Inc.*, 517 A.2d 653, 656 (Del. Ch. 1986).
[3] *In re Plains Resources*, No. C.A. 071-N, 2005 WL 332811, at *3 (Del. Ch. 2005) (citing *Krinsky v. Helfand*, 156 A.2d 90, 95 (Del. 1959)).
[4] *Korn v. New Castle County*, C.A. No. 767-CC, 2007 WL 2981939, at *2 (Del. Ch. Oct. 3, 2007).
[5] *Plains Resources*, 2005 WL 332811, at *3 (citing *Sugarland Indus. v. Thomas*, 420 A.2d 142, 149-50 (Del. 1980)).
[6] *Plains Resources*, 2005 WL 332811, at *3.
[7] *Helaba Invest Kapitalanlagegesellschaft mbH v. Fialkow*, C.A. No. 2683-VCL, 2008 WL 1128721, at *3 (Del. Ch. April 11, 2008).

"a substantial benefit."[8] In addition, the benefit of "a heightened level of corporate disclosure . . . may justify the award of counsel fees."[9]

In this case, there is no question that plaintiff's litigation conferred the benefit of heightened disclosure and quasi-appraisal. These benefits are substantial, as they afford shareholders additional information from which to determine whether to pursue the quasi-appraisal remedy as well as the opportunity for the remedy itself. In addition to the lawsuit resulting in disclosure of the method of selecting a merger price, the lawsuit created a public record showing that at least two settlements had taken place with complaining shareholders.[10] Both settlements resulted in payments of an additional 50% of the merger price.[11]

Although the benefits were substantial, the litigation was not overly complex or novel. This militates against a larger attorneys' fee award. It was fairly clear that the notice was improper for failure to follow 8 *Del. C.* § 262 in providing a current copy of the statute. The additional argument that the method of arriving at the merger price was *per se* material was only slightly more complex.

Even though the level of complexity was not high, plaintiff's counsel prosecuted this action in a diligent and competent manner. Defendants note that plaintiff's counsel has engaged in similar cases and may have simply copied some of the legal arguments; but this does not necessarily militate against a higher award. Rather, it supports a higher award because "plaintiff's counsel are experienced in practicing before this court" and were, therefore, able to "prosecute[] this action in a diligent and competent manner."[12]

The stage at which the litigation was resolved also calls for a higher award. Rather than being settled, this case resulted in a final ruling on the motion for summary judgment and subsequent order from this Court. Seeing the claim through to judgment lends weight to a higher award, both because of the greater

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[8] *Gilliland v. Motorola, Inc.*, 873 A.2d 305, 314-15 (Del. Ch. 2005).

[9] *Tandycrafts Inc. v. Initio Partners*, 562 A.2d 1162, 1165 (Del. 1989).

[10] Kalette Aff., Aug. 13, 2008, Ex. B at 3; *see also* Kalette Aff., Mar. 20, 2008, Ex. A.; Pl.'s Fee Pet. Ex. A. This Court notes with some cynicism the "coincidence" that one of the two shareholders, Mr. Kalette, who benefited from a settlement amount of an additional 50% of the merger price, was and presumably still is the past and current Vice President, Secretary and General Counsel of Pubco.

[11] *Id.*

[12] *Berger v. Pubco Corp.*, C.A. No., 2008 Del. Ch. 2224107, at *5 (Del. Ch. May 30, 2008); Final Order and Judgment, July 17, 2008.

risk inherent in litigation compared to settlement and because of the greater legal work required to obtain the judgment. In light of the final stage at which the litigation ended, I do not find that the hours worked by plaintiff's counsel were unreasonable (especially in light of the fact that opposing counsel may have logged an even higher amount of hours).

Normally the contingent nature of a case would add greatly to the award because plaintiff's counsel is undertaking a risk in not receiving compensation. "It is consistent with the public policy of Delaware to reward this risk-taking in the interests of shareholders."[13] Nevertheless, the level of risk for bringing the improper disclosure claim was reduced by the fact that an outdated appraisal statute was sent as part of the notice, in direct violation of the statute. Also, the possibility of future contingency fees has not been foreclosed. Only the initial question of improper disclosure has been finally litigated. To reward plaintiff's counsel at this stage in an amount equivalent to possible future contingency fees, as if the class action for quasi-appraisal had been finalized, would be premature. A more accurate assessment of the value of plaintiff attorney's work, evidenced by a common fund, will be evident once the quasi-appraisal process is completed.

Accordingly, I award attorneys' fees and expenses in the amount of $250,000 to plaintiff's counsel. It is useful to note that this award amounts to just over $953 per hour. The fee award is sufficient to encourage future meritorious lawsuits by compensating plaintiff's attorneys for their investment of time, their skillful litigation, and the risks involved in this type of litigation, while avoiding a socially unwholesome windfall.[14]

II. Pubco's Cede & Co. List

Defendants requested a clarification of the order requiring the defendants to "provide plaintiff's counsel with a list of names, addresses and number of shares owned by all Pubco stockholders of record on the date of the Merger as well as all *available* similar information for beneficial stockholders of the Company."[15]

[13] *In re Plains Resources Inc.*, 2005 WL 332811, at *6.
[14] *Korn*, 2007 WL 2981939, at *2.
[15] Order ¶ 3, July 17, 2008 (emphasis added).

Under Delaware law, the right of inspection of a shareholder extends only to material that fairly can be said to be in the corporation's possession.[16] A Cede list can be produced almost instantaneously and is, therefore, in the possession of the Company at all times even if it has not yet been produced.[17] In addition, the list of Pubco beneficial owners has already been reconstructed once by Broadridge Financial Services, Inc., a mailing and servicing agent for Cede, for the purpose of sending out the revised notice.[18] Finally, Pubco "was charged an extra fee for this reconstruction process" and should be deemed to own the information.[19]

Therefore, the Cede list is "available"[20] pursuant to the order and must be exactly reconstructed as necessary and provided to plaintiff's counsel within five days of the issuance of the order accompanying this decision.

III. Use of Information Obtained in Settlement Discussions

Defendants also requested a clarification of the order to determine whether plaintiff's counsel may communicate to beneficial owners the information obtained during settlement discussions with Pubco. Defendants cite as support for prohibiting attorney/beneficial-owner communication various court orders limiting settlement discovery as well as D.R.E Rule 408, which states that settlement discussion content is inadmissible as evidence.

Nevertheless, defendants' appeal to these limitations is unavailing. The limitations on settlement negotiation discovery and use as evidence are to ensure the Court's opinion remains unbiased by settlement discussions and offers. Any proposed settlement may have been motivated for reasons other than weakness of

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[16] *RB Assocs. of N.J., L.P. v. Gillette Co.*, C.A. No. 9711, 1988 WL 27731, at *5-7 (Del. Ch. Mar. 22, 1988).
[17] *Id.* at *6; *Hatleigh Corp. v. Lane Bryant, Inc.*, 428 A.2d 350, 354 (Del. Ch. 1981).
[18] Kalette Aff. ¶ 11, Aug. 13, 2008.
[19] *See id.*
[20] An unaquired Cede list is to be distinguished from an unacquired NOBO list. This Court found in *RB Associates* that an unacquired NOBO list is not within the corporation's possession because it takes much longer to produce and is not necessary for a corporation to effect a proxy solicitation as the Cede list is. *RB Assocs.*, 1988 WL 27731, at *6. A Cede list normally contains a breakdown of the brokers acting as stockholders of record rather than a list of the beneficial owners contained in a NOBO list. In this instance, it is immaterial that Pubco's Cede list, created by the mailing and servicing agent for Cede, may contain a list of the beneficial owners similar to the information within a NOBO list rather than simply a breakdown of brokers.

position, such as a desire to compromise or to end litigation.[21]

In this case, allowing communications with beneficial owners regarding settlement discussions will not bias the future quasi-appraisal proceedings. It simply allows the attorney to communicate an indicium of the case's strength or weakness to potential class members. In the normal course of events, an attorney would be free to communicate a potential settlement offer to his clients to determine whether or not to accept the offer. Allowing pre-litigation communication between an attorney and potential class members is not appreciably different.

In addition, defendants have already opened the door to plaintiff's counsel communicating the $10 settlement offer by placing on the public record a similar settlement between Pubco and a beneficial owner for $10 above the $20 merger price.[22] Therefore, I decline to restrain the communications between plaintiff's counsel and beneficial owners.

Very truly yours,

William B. Chandler III

William B. Chandler III

WBCIII:gwq

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[21] *See Sammons v. Doctors for Emergency Servs., P.A.*, 913 A.2d 519, 533-534 (Del. 2006) (stating the two principles underlying the inadmissibility of evidence are: "1) the evidence of compromise is irrelevant since the offer may be motivated by a desire to terminate the litigation rather than from any concession of weakness of position; and 2) public policy favors compromise in settlement of disputes.").

[22] Kalette Aff., Mar. 20, 2008, Ex. A.

EFiled: Nov 14 2022 06:20PM EST
Transaction ID 68384972
Case No. N22C-09-526 CLS

IN THE SUPERIOR COURT FOR THE STATE OF DELAWARE

RISEDELAWARE INC., *et al.*,	:	
	:	
Plaintiffs,	:	
	:	
v.	:	C.A. No. N22C-09-526-CLS
	:	
SECRETARY CLAIRE DEMATTEIS in her official capacity as Secretary of the Delaware Department of Human Resources and Co-Chair of the State Employee Benefits Committee, *et al.*,	:	
	:	
Defendants.	:	

AFFIDAVIT (SECOND) OF ROBERT CLARKIN

STATE OF DELAWARE)
)
COUNTY OF NEWCASTLE)

I, Robert Clarkin, hereby depose and state as follows:

1. As noted in my earlier Affidavit, I worked for State government in the Department of Labor for decades and in that capacity regularly reviewed and summarized official federal and state documents.

LACK OF TRANSPARENCY

2. I have been asked to provide certain information in this Second Affidavit about the contents of SEBC and RBSC documents (meeting agendas and minutes) that I have been told is under Rule of Evidence 1006 relating to summaries of voluminous records.

3. I raised in a letter on August 18, 2022 to Secretary DeMatteis concerns I had about moving to a Medicare Advantage plan and about the apparent lack of transparency about it (attached as Exhibit 1). At least as my letter said, I could "find no mention of the very significant change in retiree benefits in the Governor's Budget Address on January 27, 2002, in the minutes of Joint Finance Committee meetings, or in the minutes of State Pension Office presentations to the General Assembly."

4. Secretary DeMatteis emailed me back on August 22, 2022 (attached as Exhibit 2). She represented at the outset that, "you will receive the SAME coverage and the same premium healthcare for Medicare services."

5. As to transparency, she did not tell me I was wrong about the lack of disclosures in the Governor's Budget Address, minutes of the JFC, and minutes of State Pension Office presentations to the General Assembly. And she did not point to any disclosure to the General Assembly. Instead, she said that, "The SEBC went through an extensive public process over the past year on the transition to a Medicare Advantage plan." But she did not point to anything specific. She also said the same thing in an Op Ed on delawareonline dated September 1, 2022 which I read at that time.

6. I also reviewed the answers by the State to questions in connection with the RFP and found that the number of "double state share" plan participants is 266 (attached as Exhibit 3).

SEBC AND RBSC MEETING AGENDAS AND MINUTES

7. Secretary DeMatteis stated in her response to me that the "SEBC went through an extensive public process over the past year on the transition to a Medicare Advantage plan." (Exhibit 2). Starting in August 2022, I conducted an extensive review of the SEBC minutes for that past year. I have gone back through and reviewed the meeting agendas and minutes for the SEBC, which are available online, from January 2020 through August 2022. Prior to the SEBC meeting of February 28, 2022, when the SEBC adopted Medicare Advantage, and since January 13, 2020, the SEBC has met 20 times on the following dates not identified as cancelled: 1/3/2020, 2/17/2020, 3/9/2020, 4/13/2020 (cancelled), 5/15/2020 (cancelled), 6/8/2020, 7/27/2020, 8/17/2020, 9/14/2020, 10/12/2020, 11/16/2020, 12/14/2020, 1/25/2021 (cancelled), 2/22/2021, 3/8/2021, 4/19/2021, 5/10/2021, 6/29/2021, 7/19/2021 (cancelled), 8/16/2021, 9/13/2021 (cancelled), 10/11/2021, 11/8/2021, 12/13/2021, and 1/24/2021.

8. While there were many SEBC meetings prior to February 28, 2022, from my review of the Meeting Minutes, there was no discussion during any of the meetings from January 2020 through February 28, 2022 of Prior Authorization,

Network Restrictions, or Medically Necessary (a euphemism for Prior Authorization). The SEBC meeting of August 22, 2022 is the first meeting I found during which Prior Authorization was mentioned. And the minutes for that meeting reflect that SBO Director Faith Rentz stated: "The new plan will require prior authorization for some services." I found no identification or discussion of specific procedures or drugs requiring Prior Authorization.

9. Moreover, none of the agendas for those meetings mention Medicare Advantage or a possible redesign of retiree healthcare coverage. The agenda for the April 25, 2022 SEBC meeting is the first agenda I found that even mentions Medicare Advantage. But that agenda as to healthcare for retirees said only "Medicare Advantage with or without Prescription Coverage Plan Options." In addition, none of those agendas mentions Prior Authorizations.

10. From all the SEBC meeting minutes I reviewed, the overriding concern in SEBC meetings was cost savings to the State. I did not find discussion of how a Medicare Advantage plan would affect the quality and timeliness of delivering healthcare services to retirees.

NEED FOR RETIREE INPUT

11. I have also gone back through the meeting agendas and minutes for the RBSC, which are also available online. Following the Committees reestablishment by Executive Order #34 on July 21, 2021 (with the Director of OMB as Vice-Chair

of the RBSC.), the RBSC has met 7 times to date (on the following dates): 7/26/21, 8/30/21, 9/27/21, 10/25/21, 11/29/21, 2/28/22, and 3/24/22. There has been no meeting after March 24. From a review of the meeting minutes, there is no discussion of Prior Authorization, Network Restrictions, or Medical Necessity. Similar to the agendas for SEBC meeting, none of the agendas for those meetings mention Medicare Advantage and I found no discussion in meeting minutes of how a Medicare Advantage plan would affect the quality and timeliness of delivering healthcare services to retirees.

12. On November 1, 2021, the RBSC issued their Initial Report on Other Post-Employment Benefits (OPEB), Section II, a and b of the report state:

"Continue reviewing the following benefit options for potential implementation effective January 1, 2024 or thereafter:

a. Transitioning coverage of Medicare-eligible retirees from the Medicare Supplement to an employer-sponsored Medicare Advantage plan or to an indexed employer subsidy, funded through a Health Reimbursement Account (HRA), for purchasing Medicare coverage on the individual marketplace. The State Employee Benefits Committee is currently reviewing Medicare Advantage proposals, but review of the HRA/ marketplace option would require an additional RFP to evaluate the cost structure and implementation steps.

b. Develop and implement a plan to educate active and retired members on the issues, challenges and opportunities highlighted in the Findings and Principles for Reform sections of this report and gain feedback on options under consideration through meetings and a survey."

13. I have checked DHR's website as to active healthcare plans. The website offers four plans for active employees, all of which appear to have some degree of prior authorization for certain medical services. To compare, I have also reviewed the contract that Delaware entered into with Highmark for Medicare Advantage and counted approximately 1,623 Procedures, 154 DME's (Durable Medical Equipment), and 342 Part B Drugs requiring prior authorization, for a total of 2,119. The required prior authorizations identified on the DHR website for the active employee plans do not appear to be anywhere near comparable to the 48 pages of prior authorizations in the Medicare Advantage contract. As a matter of practice, the State does not make contracts public, limiting my ability to compare the plans. (Breaking with usual State practice, the Highmark Medicare Advantage contract was made public sometime after it was fully executed on September 28, 2022.)

LITIGATION SUPPORT WORK

14. I met the Legal Liaison for RISE at a RISE meeting on September 15 shortly after the Goldey Beacom meeting. After that, I have been using my expertise

and experience with State government and its document practices to provide factual research effort for use in the litigation. That work has been at the direction of the Legal Liaison. I estimate that I have spent between 125 and 175 hours since then doing that work to support the litigation.

Executed this 14th Day of November 2022

Robert Clarkin

SWORN TO AND ASCRIBED before me this 14th Day of November 2022

JASON KITTINGER
MY COMMISSION EXPIRES May 17, 2023
NOTARY PUBLIC
STATE OF DELAWARE

Notary Public

EXHIBIT 1

Secretary Claire DeMatteis
Department of Human Resources
122 Martin Luther King Jr. Blvd South
Dover, Delaware 19901

August 18, 2022

Dear Secretary DeMatteis,

I am writing to you to express my very deep concern and disappointment with the State's proposed move of retirees from the current traditional Medifill health insurance plan to a Medicare Advantage plan. It is unbelievable that this move from a traditional, federally administered Medicare program to a private for profit Medicare Advantage plan has been made without transparency, without prior warning to retirees, and without offering retirees a reasonable alternative. The mailings to date from the Pension Office offer only one choice - take it or leave it - and they "sell" the benefits of the Advantage plan similar to the never ending, too good to be true, Medicare Advantage plan advertisements shown on TV.

As for transparency, I can find no mention of this very significant change in retiree benefits in the Governor's Budget Address, in the minutes of Joint Finance Committee meetings, or in the minutes of State Pension Office presentations to the General Assembly. Further, I have been advised that a significant number of State Legislators are completely unaware of this planned move.

After working for the Delaware Department of Labor for thirty-six years, I have been retired for thirteen years and have nothing but praise for the current Medifill program. With traditional Medicare as the primary provider of coverage, and Medifill as the secondary provider, the rules and coverage are set and managed by the Federal government and not by a for profit insurance company that will attempt to increase costs, increase hurdles to obtaining medical services, and decrease benefits every year that the contract is renewed with the State. I don't believe this is a move that truly benefits retirees or servers as a roadmap for attracting and retaining the competent, career minded state employees that the citizens of Delaware deserve.

In closing, I would like to suggest that the State stop the implementation of the contract for a Medicare Advantage plan for at least a year, while returning retirees to the traditional Medifill program until such time that the move/contract can be vetted and discussed by the General Assembly,

Thank you,

Robert J. Clarkin
122 Dunbarton Drive
Wilmington, Delaware 19808
302-598-0288
bobclarkin@comcast.net

EXHIBIT 2

From: "DeMatteis, Claire (DHR)"
<Claire.DeMatteis@delaware.gov>
Date: August 22, 2022 at 2:10:30 PM EDT
To: bobclarkin@comcast.net
Cc: "Davis, Anna (DHR)" <Anna.Davis@delaware.gov>
Subject: Your correspondence

Dear Mr. Clarkin,

Thank you for reaching out regarding the transition to Medicare Advantage. I want to stress that despite some misinformation being circulated, you will receive the SAME coverage and the same premium healthcare for Medicare services.

For several years, Delaware's State Employee Benefits Committee (SEBC) and the Retirement Benefit Study Committee have worked to identify options that assure that retired State employees retain access to high quality and affordable health care while also making progress toward reducing the State's $10 billion unfunded liability for retiree healthcare that threatens the long-term sustainability of these very important benefits.

To protect our state pensioners, in June, the Delaware General Assembly approved language in the State's Fiscal Year 2023 budget placing 1% of the prior year's budget into a Trust Fund for retiree healthcare. In

February, the SEBC approved a plan that was included in the Fiscal Year 2023 budget assuring that retirees and their dependents continue to receive premium health care services through a customized Medicare Advantage plan specifically designed by Highmark Blue Cross Blue Shield Delaware.

The coverage for Medicare services and prescription drugs remains the same as the past Medicare Supplement plan. State pensioners and their dependents have the same access to doctors and hospitals who accept Medicare.

Highmark Blue Cross Blue Shield Delaware will continue to administer the State Medicare health plan, just as it has for many years with:

- $0 co-pay for visits with your doctor.
- $0 deductible for medical services.
- $0 cost for skilled nursing facility services.
- $0 cost for nationwide in and out-of-network coverage with out-of-network providers receiving the 100% Medicare allowable reimbursement for services provided.
- $0 cost for lab and imaging.
- $0 cost for emergency room and urgent care services.
- Full and immediate coverage for pensioners with pre-existing conditions.

In addition, the new plan adds:

- The Silver Sneakers® fitness program membership
- Help managing your health and wellness; and,
- Home meal service after a hospital discharge.

The SEBC went through an extensive public process over the past year on the transition to a Medicare Advantage plan. Coverage will remain employer-sponsored and state-funded; it is not privatizing state retirees' health care. The new plan takes effect on January 1, 2023, with open enrollment October 3-24, 2022.
We understand any change can be met with concern. If you are a state pensioner with questions about the plan, please contact Highmark Concierge Service:

available 7 days a week from 8 a.m. – 8 p.m. at 1-888-328-2960 (TTY call 711).

When compared with retiree health plans in other states, Delaware's Medicare Advantage plan remains among the most elite, with the best and most comprehensive Medicare coverage. And like the health coverage available to State employees and pensioners not yet eligible for Medicare, the Medicare Advantage plan will require prior approval for some non-emergency services.

Say you were sent to a specialist because you had intense back pain and needed an MRI. Your doctor would contact Highmark to request an authorization for this test. The request will then be reviewed by the Highmark clinical team of nurses and physicians to make sure that it was the most appropriate test for your symptoms. By doing this, Highmark can ensure you get the best access to care and both you and your doctor are not burdened by extra paperwork on the backend. Highmark BCBS Delaware approves about 93% of all prior authorizations, with 92% approved on the initial submission. Expedited, non-emergency prior authorizations are approved within an average of a day and a half, with standard, non-emergency pre-authorizations approved within about 4 days. Emergency and urgent care services do not require prior authorization.

There are other benefits too. The fact is that State pensioners who retired prior to July 1, 2012, and earned 100% of state share coverage, continue to pay no monthly premium, and for those retired after this date with 20 years of service, their premium is reduced to $10.80 per month.

For State pensioners who retired after June 30, 2012 with less than 20 years of service and are responsible for some or all of the cost of their Medicare coverage, the monthly fee is reduced by more than half to $216.18 per month. This significant reduction makes the plan affordable and gives retirees access to exceptional medical and prescription coverage that simply is not available in the individual healthcare market.

While it is true that the State's ability to absorb growing healthcare costs has limits, by partnering with Highmark BCBS Delaware, our State pensioners will

have access to medical professionals and a concierge service team dedicated to ensuring they receive medically necessary health services and exceptional support in navigating their health and wellness needs.

Over the past month, we have held several education sessions to inform and engage our State Medicare pensioners. We will hold additional sessions in September and October. We also encourage Medicare pensioners and their dependents to visit our website to stay informed - **Highmark Delaware Medicare Advantage webpage** (https://dhr.delaware.gov/benefits/medicare/medicare-advantage.shtml).

Thank you for your service to our state. I hope this information assures you that you will continue to receive exceptional healthcare services.

Best regards,
Claire

EXHIBIT 3

8	Please provide date of retirement for each retired employee listed in the census. If retirement date is not available, please indicate the number of retirees receiving full employer contribution (100% subsidy) versus those that have to contribute.	The following table outlines the level of subsidization that Medicare retirees receive from the State as of May 2021. This data reflects retired State employees and does not include retirees of the University of Delaware and other non-State Participating Groups that participate in the GHIP per Delaware Code (approximately 3,500 plan participants); information on the number of those plan participants that are receiving subsidized premiums by their former employer is not available. The State offers enrollment in the Special Medicfill Plan with OR without the qualified Part D prescription drug coverage; Medicare retirees must opt out of Part D coverage under the State's plan if they are enrolled in another qualified Part D plan.

Subsidy Level (% = State Share):	# Plan Participants	% Total
With Part D prescription drug coverage		
0%	102	0.4%
50%	668	2.8%
75%	1,125	4.7%
100%	21,829	91.0%
Double State Share (DSS)*	263	1.1%
Total	**23,987**	**100.0%**
Without Part D prescription drug coverage		
0%	31	4.5%
50%	61	8.9%
75%	40	5.9%
100%	548	80.2%
Double State Share (DSS)*	3	0.4%
Total	**683**	**100.0%**
Grand Total	**24,670**	

* Details on Double State Share, including the State's contribution to Medicfill premiums for the retirees who are eligible for Double State Share, can be found here: https://dhr.delaware.gov/benefits/dss/index.shtml

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Transaction ID 68384972
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IN THE SUPERIOR COURT FOR THE STATE OF DELAWARE

RISEDELAWARE INC., *et al.*,	:	
	:	
Plaintiffs,	:	
	:	
v.	:	C.A. No. N22C-09-526-CLS
	:	
SECRETARY CLAIRE DEMATTEIS in her official capacity as Secretary of the Delaware Department of Human Resources and Co-Chair of the State Employee Benefits Committee, *et al.*,	:	
	:	
Defendants.	:	

AFFIDAVIT (THIRD) OF KAREN PETERSON

STATE OF DELAWARE)

COUNTY OF NEW CASTLE)

I, Karen Peterson, hereby depose and state as follows:

1. This is further to my earlier Affidavits in this case.

LEGISLATOR COMMUNICATIONS

2. Beginning in August 2022, I sent several e-mails to legislators explaining why I thought the switch to a Highmark Medicare Advantage Plan ("HMAP") was detrimental to retirees and asking them to intervene in the matter.

3. I received a reply from Rep. Debra Heffernan on August 18, 2022 that said, "You are right that we had no idea that when the GA voted for the budget this two word change with serious repercussions was included." Exhibit 1. I believe she was referring to the two-word change tucked into budget epilogue in the June

appropriations bill changing "Medicare Supplement" to "Medicare Advantage" in Title 29, Section 5202(d), which relates only to the so-called "double state share." I did not see how a minor change to Section 5202(d), which apparently was never discussed by the legislature and affects only a small fraction of people (where a retiree and spouse both have worked for the State), could reflect legislative approval or codification of the major change in retiree healthcare from Medicare Supplement to Medicare Advantage. (I understand from information located by Robert Clarkin set forth in his Affidavit that, based on the State's response to a question during the RFP process, the number of double state share plan participants is 266.) But apparently at least some legislators had been told they had somehow approved the change to HMAP through epilogue language that in fact was minor and was not discussed.

4. I received from Rep. Paul Baumbach an email on October 10, 2022 to one I had sent on October 8, 2022. Exhibit 2. Baumbach shared his "deep disappointment" that his fellow legislators who served on the governor's Retirement Benefits Study Committee failed to "raise the alarm" about the switch to HMAP. He went on to say that the contract with Highmark is in effect for three years and that, "Highmark suing the state, especially successfully, would most likely simply add to the $10 billion fiscal hole." He added that he had spoken to a constituent and "provided them with information that they lacked." As a result of

that conversation, the constituent cancelled her $500.00 contribution to RISE Delaware. I then emailed the constituent and, after I gave her accurate information, she re-contributed.

5. I received from Rep. Madinah Wilson-Anton on October 19, 2022 an e-mail in response to a copy of my e-mail to Speaker of the House, Peter Schwartzkopf. Exhibit 3. She said that the House Democrats would be holding a caucus meeting to discuss legislation that would add oversight to the HMAP. She said, "I don't know how it will go, but I'm disappointed that House and senate leadership seem to have cooked up this [oversight] bill with the administration, without consulting the rest of the caucus, and without critically analyzing the information provided by the administration."

6. I received a copy of an e-mail that had been sent by Speaker of the House, Peter Schwartzkopf, to a constituent. The e-mail stated, "I know that pensioners want the legislature to step in and extend Medicfill contract until 2024 but our attorneys are telling us that we can't do that." He went on to say that, "If we tried to do that, Highmark would probably sue us to the tune of hundreds of millions of dollars." He added: "The lawsuit filed by RISE is dangerous for the pensioners. If they are successful in getting the injunction, they seek to stop Highmark from starting their contract, the pensioners would have no coverage from the stat[e] at all starting 1/1/23. The people filing the lawsuit are well aware

that you would not have any coverage and they filed the suit anyway." I wrote to Speaker Schwartzkopf on October 19, 2022 to correct the misinformation contained in his e-mail. Exhibit 4. He did not reply.

7. On October 14, 2022, I met with the Senate Majority Leader, Bryan Townsend, to discuss the HMAP and the State's misrepresentations to retirees. Sen. Townsend stated that he believed that the benefits were the same under both the Medicfill plan and the HMAP. I explained some of the differences and he asked if I would put ten examples in writing and send them to him. Following our meeting, I prepared a four-page comparison of the two plans with fifteen examples of how the plans are different with regard to cost and sent them to him on October 15, 2022. Sen. Townsend also told me during our meeting that there was "no way" that we could win our lawsuit challenging the HMAP.

8. I had mentioned in our meeting, that HMAP had some 2030 Prior Authorization requirements while those are "rare" for Medicare Parts A and B, as noted on the Medicare website. By that time, I knew that was true because I had researched some important procedures that require pre-authorization under HMAP which do not require preauthorization under Medicare, as well as the employees' current Highmark Comprehensive PPO plan: Outpatient diagnostic tests (x-ray, bloodwork); Chiropractic services; Durable medical equipment and related supplies; Ambulance services; Diabetes self-management training, diabetic

services and supplies; Bathroom safety devices; Outpatient mental health care; Outpatient rehabilitation services; Outpatient substance abuse services; Prosthetic devices and related supplies; Outpatient hospital services; Outpatient opioid treatment services; Certain prescription drugs; and Foreign travel coverage.

RAISING FUNDS FOR ATTORNEY FEES

9. The raising of money to pay for attorney fees and costs for this lawsuit has been a very challenging and stressful endeavor. Through the dint of hard work and long hours, especially by AnRea MacDonald, we have raised a tremendous amount of money from perhaps 1000 individuals (through GOFUNDME and personal checks) and from a few organizations. While the money is substantial, it is not close to paying the lawyers. Worrying about raising money has been very stressful for all of us involved with RISE.

10. Because we do not have access to the mailing list of the 30,000 State retirees, our pool of potential donors is pretty much limited to those we can reach by word of mouth or social media. When we embarked on this litigation effort, although we believed we were taking steps to be cost effective, we did not appreciate the amount of money it would end up taking to pay the lawyers and we did not appreciate the limitations in outreach in relying on word of mouth. And of course with our State retiree pool, there are many people in nursing homes or who are seriously ill who are not in a position to deal with such requests.

11. At this point, we have not even raised enough money to pay for the lawyer fees to date. RISE is attempting to further minimize its increasing unfunded liability for attorney fees for the New York and Delaware law firms. Our Legal Liaison, who had already been helping on a *pro bono* basis, has stepped in (still on a *pro bono* basis) to handle litigation tasks as much as possible in November in the current state of the litigation.

12. I feel safe in saying that, without an award of fees, similar litigation would not be possible in the future. There is no legal organization that I know of that would work for free on this kind of litigation or one that would pay for it. We are a small, rag-tag group of retirees trying to save our health insurance benefits for ourselves and 30,000 of our colleagues, who cannot be expected as individuals to cover the very substantial cost of the litigation.

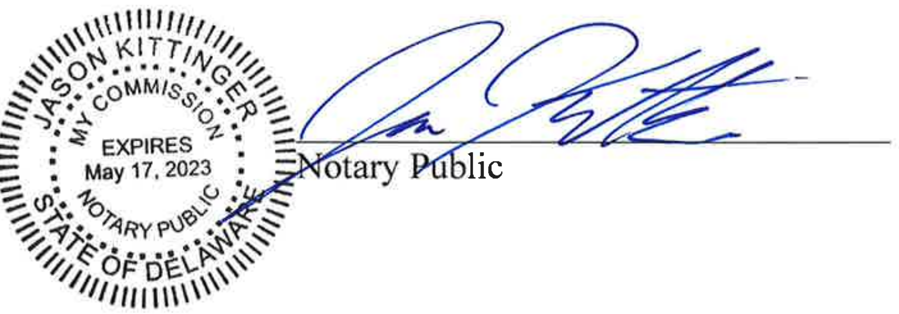
13. I am over the age of eighteen (18) years and am competent to testify.

I declare under penalty of perjury that the foregoing statements are true and correct.

Executed this 14th day of November, 2022.

Karen Peterson

SWORN TO AND ASCRIBED before me this 14th day of November, 2022.



Notary Public

v. 11/14/22 1217

EXHIBIT 1

From: Heffernan, Debra (LegHall) <Debra.Heffernan@delaware.gov>
Sent: Thursday, August 18, 2022 8:25 AM
To: Karen Peterson <karenpeterson183@msn.com>
Subject: Re: Pensioners' Health Insurance Coverage

Karen,

During the call I requested that a cash option be added to give retirees the ability to use the same amount of money to choose their own plan. There are other states and private companies that include this option.

I also requested a list of all services requiring prior authorization and that all routine services such as labs, X-rays, colonoscopy be removed from list.

You are right that we had no idea that when the GA voted for the budget this two word change with serious repercussions was included.

Deb

> On Aug 18, 2022, at 4:45 AM, Karen Peterson <karenpeterson183@msn.com> wrote:
>
> I understand that a telephone conference was held this past Tuesday with legislators and Medicare Advantage representatives to discuss the change in medical coverage for pensioners. Many of you (like me) were long-time state employees before we were elected to the legislature – and will be affected by this change. Others will be affected when they reach age 65.
>
> My understanding of the outcome of the telephone conference is that there is consensus among legislators that coverage will remain the same and that pensioners simply don't understand that fact. I can assure you that I, as one pensioner, do understand the difference between our current Medicfill coverage vs. the new Medicare Advantage coverage (effective Jan.1).
>
> On paper, the coverage of the two programs looks the same. That's true. But have you wondered how Medicare Advantage can provide the "same" services for half the price? The answer can be found in a recently-released report from the federal government.
>
> The Inspector General's office of the U.S. Department of Health and Human Services found that there is "troubling evidence" that Medicare Advantage plans are delaying or even preventing Medicare beneficiaries from getting medically necessary care. They found that

about 13 percent of the denials for pre-authorization for medical services should have been covered under Medicare but were improperly denied. They also found that Medicare Advantage plans refused to pay legitimate claims – about 18 percent of denials for payment were for claims meeting Medicare coverage rules. This will result in pensioners having to pay out of pocket for medical services that are covered by Medicare – or going without those services.

I don't believe that any member of the legislature intended to put pensioners' health coverage at risk. The SEBC's recommendation to switch to Medicare Advantage was made prior to the release of the Inspector General's report. For that reason, the State should reconsider its decision to take away the excellent coverage that we have under the current Medicfill program – and substituting coverage that makes a profit from denying basic Medicare benefits.

Karen Peterson

Sent from Mail for Windows

EXHIBIT 2

From: Baumbach, Paul (LegHall) <Paul.Baumbach@delaware.gov>
Sent: Monday, October 10, 2022 3:06 PM
To: Karen Peterson <karenpeterson183@msn.com>
Subject: Re: Your e-mail

Sen Peterson,

This is the first individual email to me that I have received from you. On 8/18 and on 9/21 you sent one to all 62 legislators. As I am certain that you understand, in the past two weeks I have focused on fielding questions and concerns from residents of my House district, and not ones that are sent to a large class of recipients.

I remotely watched the first town hall at Widener, and heard the presentations and questions/comments, including yours. I of course have heard a wide range of concerns from constituents regarding the retiree health care changes.

I have shared with constituents my deep disappointment in several factors in this change, including the failure of the four legislators on the RBSC to share their work and their recommendations with their fellow caucus members (I can't assess the level of responsibility of JFC members for also failing to 'raise the alarm,' as I do not know the level of disclosure provided to the JFC when the Medicare Advantage paragraph was presented by the Administration for inclusion in this year's budget.) However, I drive by looking out the windshield, not the rear view mirror. In the weeks after the first retiree presentations in July, the state made multiple improvements to the contract, and this week the legislature is preparing draft legislation to enact substantial additional oversight and transparency over the execution of this three-year contract. I am certain that the SEBC will drastically reform the manner in which it next 'competitively bids the administration of the State Group Health Insurance Plans offered to State pensioners.'

Now to address your points:

The clause from Article IX that you cite refers solely to the Implementation Offset. There is no representation that the cited clause presents the complete obligations the Group (state) is subject to in the case of a contract cancellation this year by the state. As I am certain that you know, Article II notes that the Agreement continues for a minimum of three years.

You are disregarding what happens if the state cancels the contract, via Article IX or otherwise. The medigap coverage ends on 12/21/22. What are you suggesting be done on 1/1/23 if the state cancels the contract? This seems like a pretty important question to me.

Highmark suing the state, especially successfully, would most likely simply add to the $10 billion fiscal hole. Where in your three emails do you acknowledge this dire situation, and where in your three emails do you suggest how Delaware should start to address it in a meaningful manner? This, too, seems like a pretty important question to me.

Retirees don't 'have to put up $150,000.00 in legal fees'; they have a choice to do so or not. I do care a lot about retirees 'coughing up $150,000' in what I expect is a waste of time and hard-earned money. I am disappointed that retirees are being presented that $150,000 must be raised, and that the lawsuit will be successful, when there is no such certainty. I spoke with a constituent on Saturday, and provided them with information that they lacked. At the end of the call, they noted that they were disappointed that they had not called me prior to writing a check toward the lawsuit funding.

Thank you for sharing your deep frustration over the health plan change and over reactions from legislators including myself.

Paul Baumbach
Delaware State Representative, 23rd RD
302-562-4546 (cell)
Pronouns: he/him/his

From: Karen Peterson <karenpeterson183@msn.com>
Sent: Saturday, October 8, 2022 7:27 AM
To: Baumbach, Paul (LegHall) <Paul.Baumbach@delaware.gov>
Subject: Your e-mail

Paul,
I received a copy of an e-mail that you recently sent to a constituent(?) regarding the Medicare Advantage plan, I can't tell you how disappointed I was to read your comments.

Your concern about the State being sued by Highmark was particularly galling for two reasons: (1) the contract between the State and Highmark has a cancellation clause in it. Article IX says that if the State cancels the contract, they simply have to re-pay Highmark for the mailings that have already been sent (up to $600,000).* The second reason your comments were galling is because being sued by Highmark would be no skin off your noses. We retirees, on the other hand, have to put up $150,000.00 in legal fees (out of our own pockets) to do the legislators' jobs <u>for</u> them!
You say that you're opposed to the State "wasting money" to fight a possible lawsuit by Highmark but don't seem to give a rat's ass about retirees on fixed incomes coughing up $150,000 to do what the legislature didn't have the moral integrity to do. I accept that the legislature was duped into approving this change -- but when you found out that you had been duped, you did nothing to fix it. If you think that fixing the "process" in three years -- or appointing an ombudsman to placate us -- is sufficient, you're all sadly mistaken.

I hope that when you get old (as I am) and have a debilitating disease (as I do) that nobody pulls the rug out from under you -- as you all have done to us!

Karen

P.S. I sent three e-mails to you prior to the signing of the contract. You did not reply to any of them.

- *ARTICLE IX - IMPLEMENTATION The parties agree to the following related to implementation of MA Plan: • The Health Plan will suspend outpatient prior authorization requirements for Members for a four-month period beginning January 1, 2023 and ending May 1, 2023; • The Health Plan shall provide $600,000 to the Group to offset the costs of the Group's communications to its participants and other costs associated with the Group's transition to the MA Plan ("Implementation Offset"). • The Implementation Offset shall be paid to the Group as an ASO administrative fee invoice credit towards the Group's administrative fees for December 2022.* ***• If Group cancels before the Commencement Date of this Agreement, Group shall refund the Health Plan the Implementation Offset within ten (10) business days following the cancelation.*** [Note: the commencement date of the agreement is January 1, 2023.]

EXHIBIT 3

From: Wilson-Anton, Madinah (LegHall) <Madinah.Wilson-Anton@delaware.gov>
Sent: Wednesday, October 19, 2022 7:32 AM
To: Karen Peterson <karenpeterson183@msn.com>
Subject: Re: Misinformation sent to constituent

Thank you!!! We are caucusing about this before we go in next week (first time since June!!) and I will be bringing your points up and I think other members will as well. I don't know how it will go, but I'm disappointed that House and senate leadership seem to have cooked up this bill with the administration, without consulting the rest of the caucus, and without critically analyzing the information provided by the administration.

Did you send this to all members?

Get Outlook for iOS

From: Karen Peterson <karenpeterson183@msn.com>
Sent: Wednesday, October 19, 2022 5:28:36 AM
To: Schwartzkopf, Peter (LegHall) <Peter.Schwartzkopf@delaware.gov>
Subject: Misinformation sent to constituent

Dear Pete,

I am a plaintiff in the lawsuit against the state and want to correct several statements you made in a recent e-mail to a constituent that was forwarded to me.

First, Article IX of the contract contains a cancellation provision. If the contract is cancelled prior to January 1, 2023, it requires that the state reimburse Highmark for the costs of marketing (with a cap of $600,000). So, your statement that the state could be sued by Highmark "to the tune of hundreds of millions of dollars" is simply not true.

Second, the RFP requirements have already been satisfied by Highmark Medicfill. They submitted a bid during the 2021 bid process, so the State already has that. The State could cancel the Highmark Medicare Advantage contract (per Article IX of the contract) and accept the Medicfill bid that was already submitted.

Third, the current Medicfill contract was a three-year contract that has been extended twice. The state claims that it cannot be extended again but refused to produce a copy of the contract to support its claim. This issue was raised during Monday's oral arguments in Superior Court and the state did not deny that it has failed/refused to produce a copy of that contract. Even if the state were to produce a contract saying that it cannot be extended again, the state has the option of accepting the bid Medicfill submitted during the 2021 RFP process.

Fourth, your statement that the lawsuit we filed is "dangerous" and that pensioners would have "no coverage at all" if we prevail in the lawsuit is shameless fear-mongering. The state is required by law to provide health insurance to retirees and there are ways to do that. And your statement is disrespectful of Judge Scott. He, not you, is given the constitutional powers to decide our lawsuit and a proper outcome.

Fifth, your final statement that, *"the people filing the lawsuit are well aware that you would not have any coverage and they filed the suit anyway"* is downright illogical and disrespectful of us. It is OUR insurance, too! But your statement does point up that you and other legislators have failed to step up to address the problem created by the administration, forcing ordinary citizens to have to file the lawsuit that you now call "dangerous" but that is the only way to stop the dangerous impact that this Medicare Advantage plan will bring.

We would not have had to file a lawsuit if legislators had intervened in this matter when you learned that you, too, had been duped into believing that Medicare Advantage was a good idea, despite all the credible information to the contrary. It's your decision if you choose to do nothing other than add another useless layer of government to the process (ombudsman and subcommittee) but don't try to blame us for the legislature's failings.

Karen

EXHIBIT 4

From: Karen Peterson <karenpeterson183@msn.com>
Sent: Wednesday, October 19, 2022 5:28 AM
To: Schwartzkopf, Peter (LegHall) <Peter.Schwartzkopf@delaware.gov>
Subject: Misinformation sent to constituent

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Karen

EFiled: Nov 14 2022 06:20PM EST
Transaction ID 68384972
Case No. N22C-09-526 CLS

IN THE SUPERIOR COURT FOR THE STATE OF DELAWARE

RISEDELAWARE INC., *et al.*,	:	
	:	
Plaintiffs,	:	
	:	
v.	:	C.A. No. N22C-09-526-CLS
	:	
SECRETARY CLAIRE DEMATTEIS in her official capacity as Secretary of the Delaware Department of Human Resources and Co-Chair of the State Employee Benefits Committee, *et al.*,	:	
	:	
Defendants.	:	

AFFIDAVIT OF STEVEN LEPAGE

STATE OF DELAWARE)
)
COUNTY OF KENT)

I, Steven LePage, hereby depose and state as follows:

BACKGROUND

1. I worked in the computer technology field for the State of Delaware for about 22 years.

2. Prior to my career with the State, I served in the United States Air Force on active duty for 20 years.

3. When I retired from Military Service, I first worked for MBNA Bank. After a year, I left to start working for the State of Delaware. I took a pay cut but I

was attracted to the benefits package, including healthcare while I worked and healthcare coverage for my future in retirement.[1]

MY FOIA REQUESTS

4. I made a number of FOIA requests in 2022 in connection with the State's adoption of a Medicare Advantage plan.

5. On September 17, 2022, I submitted the following request for any information session for the General Assembly about Medicare Advantage as had been recommended by the RBSC on March 24, 2022. I asked, "Did this ever occur and if it did, can you provide the date and time this occurred and provide any material given at the information session?"

6. My request for materials was rejected (because information was in emails to legislators). But the letter response from the Director, Division of Research for the Legislative Council, was informative: "We are aware that the Department of Human Resources held an information session on the Medicare Advantage Plan on August 16, 2022…. Materials were provided to legislators and staff after the session by email." (9/30/22 Letter attached as Exhibit 1). From this letter, it appears there was no information session for legislators prior to that time.

[1] I have objected to being switched to a Medicare Advantage plan. As I see it, the State of Delaware expects to absorb and give away to a private insurance company the federal benefits we have earned throughout our lifetimes, including those of us who put ourselves in harm's way. The State should at least have provided us with options.

7. On October 7, I requested a copy of the Special Medicfill Contract and all the contract extensions for that plan. I received an immediate rejection that day on the grounds that:

> On October 7, 2022, you requested information related to the "Special Medicfill contract." Although you have requested a public record, this falls within one of the enumerated statutory exemptions deemed nonpublic. See 29 Del. C. § 10002(o)(9) which excludes from the definition of public record "[a]ny records pertaining to pending or potential litigation which are not records of any court." This exemption is applicable to your request because the request pertains to pending litigation.

I repeated my request on October 7, pointing out that the Statewide Benefits Office website states that for participants to know their actual benefits and rules under Medicfill, they need to consult the Account Contract on file with the SBO. I also pointed out that, as far as I knew, the Medicfill contract was not under litigation. Finally on November 3, the State gave me a copy.

ASSISTANCE TO RISE WITH TECHNOLOGY

8. I have assisted RISE with certain research for this litigation, particularly where my skills with technology can be helpful. I have done this work as a volunteer and have not charged for it.

9. To assist RISE, I carefully reviewed the videos on the legislative website with the presentations to the Joint Finance Committee in 2022 by Office of Management and Budget (2/1/22), Department of Human Resources (2/2/22) and

Department of Finance (2/2/22). I found no mention in any of their presentations of Medicare Advantage - whether in the power points or orally.

10. To assist RISE, I obtained certain videos of townhall meetings sponsored by certain State legislators relating to the State's efforts to switch retiree healthcare to Medicare Advantage. State officials and Highmark representatives attended those meetings and presented information and responded to questions. Given my technology skills, I have provided to RISE f(or what I understand will be a lodging with the Court) certain clips from the videos of two Town Hall meetings: one at Goldey Beacom on September 12, 2022 and one in Middletown on September 28, 2022. I downloaded the full videos from postings on facebook by a sponsoring legislator (specifically, Rep Ramone for Goldey Beacom and Rep Moore for Middletown) and prepared the following clips:

a. The statement by Director Cerron Cade at the Goldey Beacom Town Hall of September 12, 2022 that "Just to clarify timing, this Plan was not adopted back in February. It was actually voted on in early June by the SEBC." Video Clip Exhibit 2.

b. The statement by Secretary DeMatteis at Goldey Beacom that Highmark will be losing money. Video Clip Exhibit 3.

c. The statement by the Highmark representative at Middletown that "Original Medicare has virtually no prior authorization." Video Clip Exhibit 4.

11. Language on the DHR website includes the following (emphasis added):

> On October 19, 2022, the Superior Court of the State of Delaware granted an interim Motion to Stay on the State's Medicare Open Enrollment and transition to a Medicare Advantage plan beginning January 1, 2023. The State Employee Benefits Committee (SEBC) is reviewing the interim ruling and appeal options. *The SEBC remains committed to providing benefit eligible State pensioners with high quality, accessible and affordable healthcare benefits, which the transition to a custom designed Medicare Advantage plan provides.*

https://dhr.delaware.gov/benefits/oe/medicare.shtml

12. The DHR website also includes updated language (emphasis added):

> The State Employee Benefits Committee (SEBC) held its monthly meeting on October 24, 2022, and to comply with Judge Calvin Scott's interim ruling, the SEBC voted to extend the Medicfill contract for state pensioners for 12 months pursuant to the Emergency Procedures and Critical Need for Professional Services provision of the procurement code, 29 Del. C. § 6907. *Pending the resolution of the litigation, the SEBC will consider its options for Calendar Year 2024, which include renegotiation of the Highmark BCBS Delaware Medicare Advantage PPO plan contract and rebidding of the State Medicare health plan*.

https://dhr.delaware.gov/benefits/medicare/highmark.shtml

13. I have reviewed the document properties online for the two Pension Office newsletters for 2022. The one identified as the March Newsletter was created on March 15 and was modified on March 23, 2022. The one identified as the July Newsletter was created on July 15, 2022 and was not modified.

14. I am over the age of eighteen (18) years and am competent to testify.

I declare under penalty of perjury that the foregoing statements are true and correct.

Executed this 14th day of November, 2022.

Steven LePage

SWORN TO AND ASCRIBED before me this 14th day of November, 2022.

NICHOLAS AARON DRAKES
MY COMMISSION EXPIRES April 21, 2023
NOTARY PUBLIC
STATE OF DELAWARE

Nicholas Drakes
Notary Public

My commission expires: April 21, 2023

v. 11/14/22 936

EXHIBIT 1

STATE OF DELAWARE

LEGISLATIVE COUNCIL
DIVISION OF RESEARCH
Office: 302-744-4114 LEGISLATIVE HALL Fax: 302-739-3895
DOVER, DELAWARE 19901

September 30, 2022

SENT VIA E-MAIL
Steven LePage

Personal Information
Redacted

Dear Requestor,

Thank you for contacting the Delaware General Assembly's Freedom of Information Act (FOIA) request mailbox. I received your request for any materials provided at an information session suggested by Senator Trey Paradee at the Retirement Benefits Study Committee's March 24, 2022, meeting.

The minutes from the Retirement Benefits Study Committee's March 24, 2022, meeting state "Senator Paradee suggested that they work with the communications department for the four caucuses of the General Assembly. He also suggested an information session for the General Assembly, so they know and are aware of the changes."

We are aware that the Department of Human Resources held an information session on the Medicare Advantage Plan on August 16, 2022. Your request for materials provided at this information session is denied. Materials were provided to legislators and staff after the session by email. Under § 10002(o)(16), Title 29 of the Delaware Code, e-mails sent or received by legislators and their staff are not required to be disclosed under FOIA. Additionally, because the Department of Human Resources presented the information session, any materials presented to the legislators and staff at the session were and remain in the custody of the Department of Human Resources.

Again, thank you for your inquiry. If you have any questions about this response, please feel free to contact me at (302) 744-4114 or reply by e-mail to mark.cutrona@delaware.gov.

Sincerely,

Mark J. Cutrona
Director
Division of Research

<u>EXHIBIT 2</u>

VIDEO FILE TO BE PROVIDED

<u>EXHIBIT 3</u>

VIDEO FILE TO BE PROVIDED

EXHIBIT 4

VIDEO FILE TO BE PROVIDED