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Case No. N22C-09-526 CLS

IN THE SUPERIOR COURT FOR THE STATE OF DELAWARE

RISEDELAWARE INC.; KAREN PETERSON; and THOMAS PENOZA, 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; DIRECTOR CERRON CADE in his official capacity as Director of the Delaware Office of Management and Budget and Co-Chair of the State Employee Benefits Committee; DELAWARE DEPARTMENT OF HUMAN RESOURCES; DELAWARE STATE EMPLOYEE BENEFITS COMMITTEE; and DELAWARE DIVISION OF STATEWIDE BENEFITS, Defendants.	:	C.A. No.

COMPLAINT

Plaintiffs RiseDelaware Inc. ("RiseDelaware"); Karen Peterson; and Thomas Penoza (collectively, "Plaintiffs"), by and through their undersigned counsel, bring this Complaint against defendants 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 (the "DHR Secretary"); Director Cerron Cade, in his official capacity as Director of the Delaware Office of

Management and Budget and Co-Chair of the State Employee Benefits Committee (the "OMB Secretary"); Delaware State Employee Benefits Committee ("SEBC"); Delaware Department of Human Resources ("DHR"); and Delaware Division of Statewide Benefits ("DSB") (collectively, "Defendants") and state as follows:

PRELIMINARY STATEMENT

1. Tens of thousands of retired State employees rely on health care benefits provided by the State of Delaware that supplement their federal original Medicare benefits. That access to appropriate and adequate healthcare for senior citizens is now being materially threatened by the State.

2. Through its State Employee Benefits Committee ("SEBC"), the State has decided – without following the procedures required for an open government, and without input from those most affected – to change fundamentally the health care benefits long-relied upon by Delaware's retirees. In particular, as of January 1, 2023, the State is requiring all retirees to enroll in a Medicare Advantage Plan or lose their State-funded health care.

3. Medicare Advantage plans are *not* the same as Medicare Supplemental plans. Medicare Advantage policies are private-insurance-company-run, for-profit plans that replace original Medicare and do not provide important medical benefits and federal protections for older people. They can cause substantial disruption to physician access, delay for critical medical services, and impose significant costs on

access to care. Supplemental coverage is also paid for largely by the State, while Advantage plans are mostly funded by the federal government.

4. In making this transformational change from Medicare Supplemental coverage to Medicare Advantage, the State paid no heed to the recommendations of a different committee specially constituted by Governor Carney to study options for reducing Delaware's unfunded liability for retiree health care benefits. That committee proposed a different, better option for addressing the issue. And it recommended that no change be implemented until January 2024; a judicious and necessary course of action because adoption of a sustainable health care plan should occur with the participation and input of those affected.

5. Inexplicably, the SEBC clandestinely ignored this well-reasoned proposal and, on February 28, 2022, adopted the regulation shifting all of Delaware's retired State employees onto the Medicare Advantage plan. In its haste to implement this new plan, Defendants have confused and misled retirees, failed to comply with the procedural protections of the Delaware Administrative Procedures Act ("APA"), and violated the Freedom of Information Act ("FOIA").

6. Defendants are like a jet plane racing down the runway with its wings yet to be attached. Confusingly, they say they have not yet executed a contract that will implement the change to Medicare Advantage. Yet "open enrollment" begins on October 3, 2022. (As of the date of this filing, no contract appears on the State

website). This has created massive confusion and anger. Retirees are wholly unable to make an informed decision about whether to enroll in the new Medicare Advantage plan – about which they have received confusing, contradictory and often erroneous information – or stay with traditional Medicare and give up their State-subsidized benefits.

7. Plaintiffs were forced to file this litigation given Defendants' failure to conform their conduct to the most basic principles of procedural fairness. Plaintiffs will demonstrate that Defendants' conduct violated the APA, FOIA, and DHR's statutory obligations. Based on the substantial rights and procedural deficiencies at stake, Plaintiffs are entitled to interim relief to prevent the irreparable harm that would befall retirees by forcing them to choose between a Medicare Advantage plan, that was improperly considered and adopted, or the loss of State-funded health insurance benefits. Without such relief, this plane will crash, grievously harming thousands of retirees who dedicated their careers to the service of this State.

PARTIES

8. RiseDelaware Inc. is a nonprofit corporation organized and existing under the laws of the State of Delaware, with its principal place of business located in New Castle County, Delaware. RiseDelaware was established and is managed by Delaware retirees to act as a sentinel on issues involving State health care benefits provided for Medicare-eligible Delaware retirees (those who are or will be receiving

the State retiree healthcare benefit, including those who have worked for the State of Delaware and others who receive that benefit). Its directors are Elisa Diller and John Kowalko.

9. Karen Peterson is a Delaware retiree. Ms. Peterson was an employee of the Delaware Department of Labor starting in 1974 as an Inspector. She retired from that Department as Director, Division of Industrial Affairs, in 2001. She was a State Senator from 2002 - 2016. From her long public service, she has a State retirement benefit of Medicare Supplemental Insurance provided by Highmark Blue Cross Blue Shield Delaware (through its Medicfill Medicare Supplement Plan). She relies on these benefits and strongly objects to the Medicare Advantage plan. Ms. Peterson has been harmed by the Defendants' conduct, which violates their obligations under the Delaware Administrative Procedures Act ("APA"), 29 *Del. C.* § 10115 – 10118, and the Delaware Freedom of Information Act ("FOIA"), 29 *Del. C.* § 10001 – 10007. Had Defendants complied with these laws, Ms. Peterson would have provided comments, attended relevant meetings, and otherwise participated in the regulatory process so that her voice could have been heard.

10. Thomas Penoza is a Delaware retiree. After retiring from the Newark Police Department as a Captain, Thomas Penoza was an employee of the Delaware Department of Justice ("DOJ") for 20 years, where he worked in Consumer Fraud, Medicaid Fraud, and Special Investigations. He retired in 2014 as the Director of

Special Investigations. One of the main reasons he went to the DOJ was because the State provided a healthcare benefit in retirement, unlike his prior employer. From his long public service, he has a State retirement benefit of Medicare Supplemental Insurance provided by Highmark Blue Cross Blue Shield Delaware (through its Medicfill Medicare Supplement Plan). He relies on these benefits and strongly objects to the Medicare Advantage plan. Mr. Penoza has been harmed by the Defendants' conduct, which violates their obligations under the Delaware APA and FOIA. Had Defendants complied with these laws, Mr. Penoza would have provided comments, attended relevant meetings, and otherwise participated in the regulatory process so that his voice could have been heard.

JURISDICTION

11. Jurisdiction is proper in this Court pursuant to 29 *Del. C.* § 10141(a).

12. Jurisdiction is also proper in this Court pursuant to 29 *Del. C.* § 9012D and 10 *Del. C.* §§ 562, 564.

BACKGROUND

13. In recognition of the vital importance of open government and citizens' participation in democracy, Delaware protects the right of citizens to monitor agency action and provide input during the rulemaking process. These procedural protections are enshrined in, among other places, Chapters 96 and 100 of Title 29 of the Delaware Code, which impose stringent requirements on State agencies when

they engage in official action, including adopting regulations and holding meetings. *See* 29 *Del. C.* §§ 9602(b)(4), 10002(k), 10004, 10102(1).

14. This lawsuit is brought in response to Defendants' spectacular failure to comply with these statutory requirements. Indeed, Defendants have decided to adopt a new regulation that deprives tens of thousands of State retirees over 65 years old of critical healthcare benefits without providing them the required notice, information, or opportunity to be heard.

Medicfill to Medicare Advantage – A Fundamental Change in Health Care Benefits for Delaware's Retirees

15. Delaware law requires the State to provide Medicare-eligible (*i.e.*, elderly and/or disabled) retirees "a plan which is supplemental to Medicare parts A and B, or constructed as a plan under Medicare part C." 29 *Del. C.* § 5203(b). A plan that is supplemental to Medicare parts A and B is known as a "Medicare Supplemental" plan. A plan under Medicare Part C is known as a "Medicare Advantage" plan.

16. The SEBC is a Delaware agency tasked with "adopt[ing] rules and regulations" to fulfill the State's health insurance obligations to Medicare-eligible retirees (among others). 29 *Del. C.* § 9602(b).

17. The rule in place for decades has been that Medicare-eligible State retirees – of whom there are approximately 30,000 – would receive Medicare Supplemental insurance with the option of prescription coverage. For the past

several years, this supplemental insurance has been provided by Highmark Blue Cross Blue Shield Delaware through its Medicfill Medicare Supplement Plan ("Medicfill plan"). With Medicare Supplemental insurance, retirees are not limited to a specific network of doctors, nor are they required to obtain prior authorization from the insurance company before receiving treatments ordered by their doctors.

18. The SEBC abruptly overhauled this rule, now requiring Medicare-eligible State retirees to enroll in a Medicare Advantage plan with prescription coverage or lose their State-funded health insurance. This new plan is called the Freedom Blue PPO Medicare Advantage Plan ("Highmark Advantage Plan"), and it will be administered by Highmark Blue Cross Blue Shield Delaware.

19. The State has rightfully described this as an "important change in State of Delaware Medicare benefits." Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Frequently Asked Questions, State of Delaware, at 2, *available at*: https://dhr.delaware.gov/benefits/medicare/documents/ma-faqs.pdf (last accessed September 23, 2022) ("FAQ") (Exhibit 1).

20. This major healthcare overhaul does not just affect retirees. It also imposes new rules and responsibilities on healthcare providers and the insurance company. Doctors and hospitals must now, for the first time, abstain from administering various tests and treatments for Medicare-eligible State retirees unless and until the insurance company authorizes it. And the insurance company must

now, for the first time with respect to Medicare-eligible State retirees, assume responsibility for providing all benefits covered under Medicare Parts A and B.

21. In short, the SEBC has exercised its regulatory power to drastically alter the healthcare landscape.

22. One of the key features of any Medicare Advantage plan – including the new Highmark Advantage Plan – is "prior authorization." Prior authorization is a process by which the private insurer – which maximizes profits by minimizing payments – will not provide coverage unless and until it (the private insurance company) determines that a procedure ordered by one's doctor is "medically necessary." In short, the private insurance company becomes the final arbiter of what the patient needs – not the doctor. And significantly, prior authorization is not part of traditional Medicare – except for the sole exception of durable medical equipment such as motorized wheelchairs.

23. In a recent survey of doctors conducted by the American Medical Association, 93% of physician-respondents reported that prior authorization requirements caused delays in necessary treatment. And, as a result, 34% reported "serious adverse events" that required medical intervention, 18% reported a life-threatening event, and 8% reported a serious disability or permanent bodily damage. 2021 AMA prior authorization (PA) physician survey, American Medical

Association, *available at*: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf (last visited September 23, 2022).

24. In April 2022, the U.S. Department of Health and Human Services released a report revealing "widespread and persistent problems related to inappropriate denials of services and payment" caused by Medicare Advantage prior authorization requirements. The report noted "millions of denials each year," which are so routine and unwarranted that 75% of denials that are appealed get reversed. The problem has become so extreme that Congress recently proposed bipartisan legislation to address it. Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care, United States Department of Health and Human Services, Office of Inspector General (April 2022) at 2, 5, 13, *available at*: https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf (last visited September 23, 2022); H.R. 3173, Improving Seniors' Timely Access to Care Act, *available at*: https://www.congress.gov/bill/117th-congress/house-bill/3173 (last visited September 23, 2022).

25. Moreover, in a Medicare Advantage plan, if a retiree seeks treatment from a provider who happens to be outside of the plan's network, it is the *retirees'* responsibility to ensure that their doctors seek and obtain prior authorization before receiving treatment. Because, if prior authorization is not sought in advance for a

covered treatment – and the claim associated with that treatment is later deemed not to be medically necessary – the retiree will have to shoulder the entire cost of the treatment, which could be thousands of dollars. *See*, *e.g.*, Highmark Delaware BCBS, Freedom Blue PPO Distinct Evidence of Coverage January 1 – December 31, 2022, *available at*: https://medicare.highmark.com/content/dam/highmark/en/highmarkbcbsde/shopx/plan-documents/2022/freedom-blue-ppo/2022_FB_PPOD_Distinct_H8166-002_EOC.pdf (last visited September 25, 2022); Highmark Delaware BCBS, Freedom Blue PPO Signature Evidence of Coverage January 1 – December 31, 2022, *available at*: https://medicare.highmark.com/content/dam/highmark/en/highmarkbcbsde/shopx/plan-documents/2022/freedom-blue-ppo/2022_FB_PPOD_Signature_H8166-001_EOC.pdf (last visited September 25, 2022).

26. Another common feature of Medicare Advantage is a limited health care provider network. Although virtually all doctors and hospitals accept traditional Medicare – and, by extension, Medicare Supplemental plans such as Medicfill – many doctors and some hospitals refuse to participate in Medicare Advantage plans. That is, in part, because the reimbursement rate is set by the private insurer administering the plan, and that rate is often significantly less than what Medicare pays. Carol J. Wessels & Michelle Putz, *The Future of Assisted Living: A Crisis in*

the Making?, Wis. Law., June 3, 2020*,* at 43 ("Medicare Advantage plans have taken the place of Medicare, often providing one-third less in reimbursement . . . .").

27. A 2017 study by Kaiser Family Foundation made clear that "Medicare Advantage plans restrict the doctors, hospitals, and other providers from whom their enrollees can receive care, while traditional Medicare allows people to see any provider that accepts Medicare (overwhelming majority of providers)." Gretchen Jacobson, Matthew Rae, Tricia Neuman, Kendal Orgera, & Cristina Boccuti, *Report: Medicare Advantage: How Robust Are Plans' Physician Networks?*, The Kaiser Family Foundation (October 2017), at 2. Amongst its key findings, the study found that "Medicare Advantage networks included *less than half* (46%) of all physicians in a county, on average." *Id.* at 1.

Defendants' Confusing and Misleading Communications about the Highmark Advantage Plan

28. Defendants' communications to retirees about the Highmark Advantage plan have been, at best, confusing and misleading. At worst, the realities of Medicare Advantage have been hidden in the representations made to retirees by the Defendants.

29. Defendants have repeatedly claimed that the Highmark Advantage plan is not the "same as the other Medicare Advantage Plans [retirees] receive information about in the mail or see on television," but instead has been "specially designed to provide the same coverage available today with the [Medicfill plan]."

FAQ, Exhibit 1 at 2. This claim is simply not true. One of the key features of the Highmark Advantage plan is prior authorization – a requirement that has profound implications for retirees' access to care.

30. In an effort to obfuscate this fact, the term "prior authorization" is used in response to only *one* of the thirty questions in the Frequently Asked Questions guide provided by Defendants.[1] Instead, and in order to maintain the fiction that the Highmark Medicare Advantage plan is "specially designed," Defendants bury almost all mentions of "prior authorization" beneath seemingly benign references to "medically necessary" services or benefits:

- The custom State of Delaware Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage plan includes the same covered benefits for *medically necessary services* covered in 2022 by Original Medicare plus the additional benefits covered under the Highmark BCBS Delaware Special Medicfill Medicare Supplement Plan. FAQ, Exhibit 1 at 1.

- State of Delaware retirees will receive the same covered services including coverage outside of the U.S. and *medically necessary home health services* under the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan. *Id.* at 6.

- Retirees can choose from a national network of Blue Cross Blue Shield Medicare Advantage PPO providers close to home and anywhere in the U.S. as well as doctors and hospitals outside of the network as long as the providers accept Medicare and accept the Blue Cross Blue Shield Medicare Advantage PPO plan…. Benefits and coverage levels are the same for *medically necessary covered benefits* in and out of the network. *Id.* at 6.

[1] This reference is to the most recently updated Frequently Asked Questions document, but there appear to have been numerous versions of this document.

- When seeking services from out-of-network non contracted providers, the provider can submit a pre-visit coverage decision request directly to Highmark to confirm the service is a covered benefit and *medically necessary*. *Id.* at 6.

31. In the FAQ that describes "prior authorization," Defendants finally outline the extensive list of services – 21 different categories of care[2] – for which retirees must receive prior authorization to receive services covered by the Highmark Advantage plan:

- inpatient hospital care;
- home health care;
- home infusion therapy;
- organ transplants;
- diabetes supplies and services;
- durable medical equipment;
- intensive cardiac rehabilitation;
- non-emergent and air ambulance transportation;
- opioid treatment program/services;
- outpatient substance abuse services;
- Part B drugs;
- Physical/Occupational/Speech Therapy;
- Pulmonary Rehabilitation Services;
- supervised exercise therapy;
- outpatient hospital/ambulatory surgery center care;
- mental health care;
- skilled nursing facility care;
- dental services;
- chiropractic care;
- outpatient diagnostic tests/labs;

[2] Since, as of the date of this Complaint, the contract governing the Highmark Advantage plan has still not been signed, it is unclear whether this is the final list of services subject to prior authorization.

- and some radiology services (for example, CT, MRI, MRA and PET scans). *Id.* at 5.

32. Strikingly, Defendants' communications about the new Medicare Advantage plan also appear to omit any mention of "out-of-pocket costs." Defendants tout the ability of retirees to use out-of-network providers, without discussing potential required payments:

- The Highmark BCBS Delaware Freedom Blue PPO Plan allows retirees and their spouses to use in network (contracted) as well as out of network (non-contracted) doctors and hospitals as long as those providers are eligible to participate in Medicare. FAQ, Exhibit 1 at 5.

- If your doctor does not join the Highmark BCBS Medicare Advantage network, you are eligible to see that doctor as an out-of-network provider, and the doctor will be reimbursed at 100% of the Medicare approved amount (up to the Medicare limiting amount for providers that do not accept Medicare assignment), as long as the doctor is eligible to participate in Medicare and accepts the plan. *Id.* at 5.[3]

- $0 cost for nationwide in and out-of-network coverage with providers receiving the Medicare allowable reimbursement for services provided. Statewide Benefits Office: Benefits Made Easy, Statewide Employee Benefits Committee (September 19, 2022), at 3 ("SBO Presentation") (Exhibit 2).

33. These representations mislead retirees to believe that services provided by out-of-network providers will be fully covered, just as in-network providers are. Yet out-of-network providers will only be reimbursed up to the Medicare approved

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[3] *See also* SBO Presentation, Exhibit 2 at 15: (i) Retirees can still see the provider as an out-of-network provider (ii) The plan will reimburse the provider at 100% of the Medicare approved amount.

amount, leaving retirees responsible for any payment above that threshold. In the current Medicfill plan, a vast majority of providers accept Medicare and so are fully covered by the Medicare approved amount.

34. Moreover, no mention at all is made of the significant out-of-pocket costs likely when services provided by either in-network or out-of-network providers are determined *not* to be "medically necessary."

35. Defendants also repeatedly highlight that "most non-contracted providers agree to accept the Highmark BCBS Freedom Blue Medicare Advantage PPO plan." FAQ, Exhibit 1 at 5.[4] However, as Defendants eventually acknowledge "[providers] have the option to refuse to see patients enrolled in the plan." *Id.* It is currently unclear to retirees which of their providers may now "refuse" to see them, and even more unclear which providers may "refuse" to see them at some point in the future. This uncertainty about the continuity of care, and the possibility that medical treatment may be delayed by a midstream refusal to see an existing patient, leaves retirees with an inability to make an informed choice about whether to enroll in the new plan or to opt out, with the potential to cause irreparable harm.

36. For retirees that now live outside of Delaware, Defendants represent that "[p]ensioners can choose from a national network of Blue Cross Blue Shield

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[4] *See also* SBO Presentation, Exhibit 2 at 15: Most providers accept the plan, and Highmark is outreaching to DE providers to minimize disruption.

Medicare Advantage PPO providers close to home and anywhere in the U.S. as well as doctors and hospitals outside of the network as long as the providers accept Medicare and accept the Blue Cross Blue Shield Medicare Advantage PPO plan." FAQ, Exhibit 1 at 6. However, national surveys have demonstrated the limitations of Medicare Advantage's provider network across the country, likely leaving out-of-state retirees with fewer provider options and potentially causing irreparable harm. *See*, *e.g.*, Jacobson *et al.* at 1, 2.

37. The communications provided by Defendants to Delaware's retirees do not mention these critical features of their new Medicare Advantage plan. Instead, they describe a plan that is the "same" as the old Medicfill plan:

- This plan is only available to SOD Retirees and has been specifically designed to provide the same coverage as the old plan. SBO Presentation, Exhibit 2 at 6.

- The new plan has been specifically designed to cover the same services as the old plan and includes the same SilverScript prescription coverage. *Id*. at 11.

38. This language is carefully constructed so as not to be technically inaccurate – the Highmark Advantage plan will "cover the same services" as the Medicfill plan – a retiree can still, for example, obtain inpatient hospital care. But it artfully does not mention what the cost of that inpatient hospital care will be, what hospital will provide that care, or how long retirees will have to wait to obtain that care.

State Employee Benefits Committee

39. The State Employee Benefits Committee ("SEBC") was established by 29 *Del. C.* § 9602. Its membership consists of eight State government officials and one member of a public employee organization. The eight State officials are:

> the Lieutenant Governor, the Insurance Commissioner, the Chief Justice of the Supreme Court, the State Treasurer, the Director of the Office of Management and Budget, the Controller General, the Secretary of the Department of Human Resources and the Secretary of Health and Social Services, or their designees…The Director of the Office of Management and Budget and the Secretary of Human Resources shall co-chair the Committee. 29 *Del. C.* § 9602(a).

40. The rotating employee organization representative, who serves only a 3-year term, must be selected from the following: (a) the President of the Delaware State Education Association, (b) the Executive Director of the American Federation of State County and Municipal Employees, (c) the President of the Correctional Officers Association of Delaware, or (d) the President of the Delaware State Troopers Association (or a designee of any of the above). 29 *Del. C.* § 9602(a).

41. None of the four employee organizations, which primarily represent dues-paying active employees, are focused on representing the interests of retirees. And there is often a tradeoff between retirement benefits and potential salary increases for active employees. In addition, a primary concern of State officials on

the SEBC is cost-savings, including for unfunded liabilities, as is the case with health care benefits provided by the State.

42. The "powers, duties and functions" of the SEBC include "control and management of all employee benefit coverages including health-care insurance" and "all other currently existing and future employee benefits coverages, including but not limited to all forms of flexible benefits, dental, vision, prescription, long-term care and disability coverages." 29 *Del. C.* § 9602(b)(1). The Committee is also tasked with "selection of the carriers or third-party administrators necessary to provide coverages to State employees." *Id*.

43. The SEBC was also given the express "[a]uthority to adopt rules and regulations for the general administration of the employee benefit coverages." 29 *Del. C.* § 9602(b)(4).

44. Pursuant to that authority, on February 28, 2022, although not designating it as such, the SEBC adopted a regulation for the administration of health care coverage that transformed the benefits landscape for Delaware's retirees. Without notice or the other procedural requirements of the APA, or any participation by the retirees or their representatives, the SEBC issued a directive affecting Delaware's 30,000 retirees, requiring them to either enroll in the Highmark Advantage plan or lose their State-funded health care.

45. Given the lack of notice of the regulation or of the meetings evaluating this dramatic policy decision, it is difficult to piece together the process by which the SEBC made this determination. However, from the minutes of the February 2022 meeting, it appears that a switch to Medicare Advantage had been long been discussed internally and had already reached the time for final decision by the date of that meeting:

> Mr. Giovannello [of Willis Towers Watson, the State's consultant] summarized the key decision points for the SEBC: maintain Medicfill plan or move to Group MA [Medicare Advantage] product, effective 1/1/23 (or later); select Aetna or Highmark Delaware as the plan administrator; and include or exclude Part D drug coverage as part of the Group MA product.

Minutes from the Meeting of the State Employee Benefits Committee (February 28, 2022) at 3, *available at*: https://dhr.delaware.gov/benefits/sebc/documents/2022/0228-minutes.pdf (last visited September 23, 2022) (Exhibit 3).

46. However, Delaware retirees, all of whom would be dramatically affected by this change, could not have known that such a policy decision was even being considered.

47. Nonetheless, at this February meeting, a motion was made and adopted unanimously to move all State retirees to a Medicare Advantage plan administered by Highmark, effective January 1, 2023. *Id.* at 8. *See also* State Medicare Plan

Options Briefing Document, State Employee Benefits Committee (April 25, 2022), *available at*: https://dhr.delaware.gov/benefits/sebc/documents/2022/0425-medicare-plan-options.pdf (last visited September 23, 2022) (Exhibit 4).

48. This policy decision promulgated by the SEBC to move all Medicare-eligible State retirees off Medicare Supplemental health insurance and onto Medicare Advantage set a new standard in the State of Delaware. But strikingly, neither the public agenda for the February 28, 2022 meeting, nor any agendas prior to that date, gave any hint that the SEBC was considering a sweeping requirement that retirees either enroll in Highmark Advantage or lose their State-funded health insurance. Agenda for the Meeting of the State Employee Benefits Committee (February 28, 2022), *available at*: https://dhr.delaware.gov/benefits/sebc/documents/2022/0228-agenda.pdf (last visited September 25) (Exhibit 5).

49. In the February 28, 2022 meeting agenda, item 4 for possible action and approval referred to "Medicare Plan Effective January 1, 2023," making it appear it was simply renewal of the Medicare Supplemental plan that had been in place for years. Item 7 stated: "FY23 Health Plan Premium Recommendations." Neither of these agenda items came close to providing adequate notice to Delaware's retirees that a switch to a new paradigm of Medicare Advantage would be not only discussed but adopted. Agenda, State Employee Benefits Committee Meeting (February 28,

2022), *available at*: https://dhr.delaware.gov/benefits/sebc/documents/2022/0228-agenda.pdf (last visited September 23, 2022).[5]

50. After the contract award had already been granted to Highmark for the Medicare Advantage plan, the agenda for the April 25, 2022 SEBC meeting finally made reference to Medicare Advantage with the item, "Medicare Advantage with and without Prescription Coverage Plan Options." But by then, adoption of this transformational regulation had already occurred. Revised Agenda, Statewide Employee Benefits Committee Meeting (April 25, 2022), *available at*: https://dhr.delaware.gov/benefits/sebc/documents/2022/0425-agenda.pdf?ver=0418 (last visited September 23, 2022).

51. Adding to the opaqueness of the SEBC's regulatory process, just a few days ago, on September 12, 2022, the OMB Director Cade stated that the Medicare Advantage plan "was not adopted in early February but voted on in early June." (video excerpt to be separately provided to the Court). Yet, no meeting appears to

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[5] In its subsequent March and April meetings, the SEBC approved rates for the Medicare retiree plan, and decided to offer a Medicare Advantage plan only with prescription coverage. Minutes from the Meeting of the State Employee Benefits Committee (March 14, 2022), *available at*: https://dhr.delaware.gov/benefits/sebc/documents/2022/0314-minutes.pdf (last visited September 25, 2022); Minutes from the Meeting of the State Employee Benefits Committee (April 25, 2022), *available at*: https://dhr.delaware.gov/benefits/sebc/documents/2022/0425-minutes.pdf (last visited September 25, 2022).

have occurred in early June, and neither the agenda nor the meeting minutes from the June 27, 2022 SEBC meeting include any reference at all to such vote; once again providing no notice whatsoever of the alleged June adoption of this sweeping policy change. Minutes from the Meeting of the State Employee Benefits Committee (June 27, 2021), *available at*: https://dhr.delaware.gov/benefits/sebc/documents/2022/0627-minutes.pdf (last visited September 25, 2022).

Retirement Benefits Study Committee

52. In the same time frame that the SEBC was doing its work, the Retirement Benefits Study Committee ("RBSC") – established by Governor Carney in September 2019 and re-established by him in July 2021[6] – was specifically "charged with studying options for reducing Delaware's unfunded liability for retiree health care benefits," and with "assess[ing] the desirability of the options (or combination of options)[.]" Initial Report on Other Post-Employment Benefits,

[6] The RBSC has thirteen members; six State officials, four appointees of members of the Delaware General Assembly, one appointee of the Secretary of Finance, and two appointees of the Director of OMB. Several of the State officials are also on the SEBC (Director of OMB, Controller General and the State Treasurer, at least). The RBSC includes two State officers who deal directly with State employees and retirees; the Director of the State Office of Pensions and the Director of the Office of Statewide Benefits and Insurance Coverage, who are not on the SEBC. State of Delaware, Executive Order 51 (July 21, 2021), *available at*: https://governor.delaware.gov/wp-content/uploads/sites/24/2021/07/Executive-Order-51.pdf (last visited September 23, 2022).

Retirement Benefits Study Committee (November 1, 2021), *available at*: https://financefiles.delaware.gov/Reports/Committee/RBSC%20Initial%20Report%20-%20November%202021.pdf (last visited September 23, 2022) ("RBSC Report") (Exhibit 6).

53. The RBSC provided a written report of its findings and recommendations on November 1, 2021 to the Governor, the General Assembly, and Delaware Economic and Financial Advisory Council ("DEFAC"). *Id.* at 4. The RBSC Report lays out a clear, alternative option that would achieve the long-term goal of substantially reducing the multi-billion-dollar other post-employment benefits ("OPEB") liability, while also providing a quality health insurance option for Delaware retirees. This option is for a Health Reimbursement Arrangement ("HRA") *with* State contributions. *See* Presentation Packet, Retiree Benefits Study Committee (July 26, 2021), *available at*:https://financefiles.delaware.gov/Reports/Committee/State%20of%20DE%20RBSC%20meeting%207.26.21.pdf (last visited September 23, 2022) ("RBSC Presentation"); Meeting Minutes, Retiree Benefits Study Committee (July 26, 2021), *available at*: https://financefiles.delaware.gov/Reports/Committee/RBSC%20Minutes%20-%20July%202021%20FINAL.pdf (last visited September 23, 2022).

54. In its July 2021 presentation, the RBSC demonstrated that the HRA option with no inflation adjustment would result in an immediate OPEB liability reduction of $3.8B. Even with a 2% inflation adjustment, the OPEB liability would be reduced by $2.6B. On the other hand, although the pending Medicare Advantage plan would save $20M in expected benefits, it would yield less than 1/2 to 1/3 the reduction in unfunded OPEB liability – resulting in only an immediate $1.1B OPEB reduction. RBSC Presentation, Exhibit 6 at 18.

55. Under such an HRA plan, each retiree would also qualify for a State contribution of $5,100, have multiple plan choices, be better off financially than staying in the Medicfill plan (because they would select their own Medicare Supplement/Part D or Medicare Advantage plan), and save $3,300 on average. *Id.* at 28.

56. The RBSC Report concludes that the Committee "reviewed and discussed numerous options, *many of which merit further study but require further analysis, documentation and data from the market* before they are ripe for action by the Governor and General Assembly" *Id.* at 13 (emphasis added). The RBSC recommended continued review of "the following benefit options for potential implementation effective January 1, 2024 or thereafter," including the HRA option. *Id*. at 14.

57. The RBSC also recognized the necessity of feedback from retirees *before* a decision on what option to choose, when it recommended that the Governor and General Assembly: "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." *Id.* at 14 (emphasis added).

58. State officials have publicly stated that Medicare Advantage is needed to address the State's unfunded liability:

> The move to a Medicare Advantage Plan for State retirees will address Delaware's $10 billion in unfunded liability, also known as the Other Post-Employment Benefits Liability. With the General Assembly's agreement to put aside 1% of the prior year's budget toward an Other Post-Employment Benefits Liability trust fund, Ms. DeMatteis hopes the funding will protect the future of the State's retiree health care plan.
>
> Prior to the change in plans, the liability was expected to grow to $31.3 billion by 2050, but with the implementation of Medicare Advantage and yearly allocation to the trust fund, Ms. DeMatteis said the liability could shrink to $3.1 billion by 2050.

Joseph Edelen, *Delaware moving to Medicare Advantage Plan for retirees*, Bay to Bay News, August 28, 2022.

59. According to the work of the RBSC, however – the Committee assigned the specific task of "studying options for reducing Delaware's unfunded liability for retiree health care benefits" – there may indeed be other, better options.

60. The next step in the State's plan appears to turn to the benefits of active State employees, which account for a "material amount" of the OPEB liability:

> The [March 31] report notes that pre-Medicare retiree costs account for a material amount of the OPEB liability. The report recommends developing and implementing plans to survey and conduct focus groups, if feasible, with active employees this year to seek feedback on potential OPEB reform ideas for future pre-Medicare retirees with an eye toward implementation in 2024 or thereafter.

March 2022 Report on Other Post-Employment Benefits, Retirement Benefits Study Committee (March 31, 2022) cover memo, *available at*: https://financefiles.delaware.gov/Reports/Committee/RBSC%20March%202022%20Report.pdf (last visited September 23, 2022).

Open Government – the Public Process for Regulations and Meetings

61. Delaware law recognizes the importance of an open government:

> It is vital in a democratic society that public business be performed in an open and public manner so that our citizens shall have the opportunity to observe the performance of public officials and to monitor the decisions that are made by such officials in formulating and executing public policy.

29 *Del. C.* § 10001.

62. In furtherance of the goals of open government, Chapter 101 of Title 29, Administrative Procedures Act ("APA"), provides procedural requirements for agency action in adopting, amending, or appealing regulations: "All regulations, except those specifically exempted, shall be adopted according to the requirement of this Chapter 101." 29 *Del. C.* § 10113(a). The SEBC is subject to this process. 29 *Del. C.* § 10102(1).

63. Importantly, public notice of the adoption or amendment of a regulation, along with its full text, is required in the Register of Regulations:

> Whenever an agency proposes to formulate, adopt, amend or repeal a regulation, it shall file notice and full text of such proposals, together with copies of the existing regulation being adopted, amended or repealed, with the Registrar for publication, in full or as a summary, in the Register of Regulations pursuant to §1134 of this title.

29 *Del. C.* § 10115(a).

64. The notice must give a synopsis of the subject, substance, issues, and possible terms of the agency action and shall inform citizens as to how they can present their views.

65. The requirement for an open process is not perfunctory. Citizens must have the opportunity to weigh in on government action that affects them: "Before adopting, amending or repealing any regulation, an agency shall give notice as prescribed in 29 *Del. C.* §10115 of this title and shall receive all written suggestions, compilations of data, briefs or other written materials submitted to it by any

person." 29 *Del. C.* § 10116. Such participation gives agencies the opportunity to consider in a meaningful way the comments and concerns of citizens.

66. The statute defines "regulation" broadly. The definition is not restricted to matters that a body, such as the SEBC, itself designates as a regulation, and an agency cannot get around the regulation process by simply not identifying a regulation as a regulation. Rather, it is the *nature and effect of the action* taken by the agency that is determinative. Specifically, 29 *Del. C.* § 10102(7) provides:

> "Regulation" means any Statement of law, procedure, policy, right, requirement or prohibition formulated and promulgated by an agency as a rule or standard, or as a guide for the decision of cases thereafter by it or by any other agency, authority or court. Such Statements do not include locally operative highway signs or markers, or an agency's explanation of or reasons for its decision of a case, advisory ruling or opinion given upon a hypothetical or other Stated fact situation or terms of an injunctive order or license.

67. The State created the Delaware Manual for Drafting Regulations "to assist agencies in meeting their responsibilities and [establish] the guidelines and procedures to be used in complying with regulations and statutory provisions concerning regulatory actions and publication in the Delaware Register of Regulations and the Delaware Administrative Code." Delaware Administrative Code Drafting and Style Manual, September 2014 Edition, Preface, *available at*: https://regulations.delaware.gov/agency/docs/draftingmanual.pdf (last visited September 23, 2022).

68. The Manual emphasizes that a directive's *effect on individuals* renders an action a regulation, not the terms of art used by an agency:

> *All directives affecting individuals, regardless of the terminology the agency uses,* should be adopted as regulations pursuant to the rulemaking process set forth in Title 29, Chapter 101 of the Delaware Code.

Drafting and Style Manual § 2.6 (emphasis added).

69. An agency cannot avoid its responsibilities for open government by deciding not to publish the directives it has formulated and adopted as regulations.

70. Delaware's Freedom of Information Act ("FOIA") provides for open meetings. One requirement is for an agenda that "shall include but is not limited to a general statement of the major issues expected to be discussed at a public meeting." 29 *Del. C*. §§ 10002(a), 10004(e)(2).

71. Plainly, this requirement reflects that citizens should be able to monitor and observe public meetings and participate where permitted. This meaningful engagement can only happen if notice can reasonably be found and is sufficiently informative such that affected citizens can understand when they have interests or rights at stake.

<u>Causes of Action</u>

<u>COUNT ONE</u>

(Violation of the Administrative Procedures Act, 29 *Del. C.* §§ 10115 – 10118)

72. Plaintiffs repeat and reallege the allegations of all paragraphs above as if fully set forth herein.

73. Delaware's APA, 29 *Del. C.* § 10115 – 10118, requires State agencies to adhere strictly to certain procedures when exercising their statutory powers.

74. Most notably for present purposes, the APA states that when agencies adopt regulations, they must comply with the requirements of Title 29, Chapter 101 of the Delaware Code. These requirements include, *inter alia*: (i) filing notice of the regulation with the Register of Regulations pursuant to 29 *Del. C.* § 10115; (ii) receiving written comments from the public pursuant to 29 *Del. C.* § 10116; (iii) holding public hearings pursuant to 29 *Del. C.* § 10117; (iv) allowing for a period of public comment lasting at least 30 days pursuant to 29 *Del. C.* § 10118(a); and (v) making findings and conclusions pursuant to 29 *Del. C.* § 10118(b).

75. With certain exceptions not relevant here, the term "agency" is defined under the APA to include "any authority, department, instrumentality, commission, officer, board or other unit of the State government authorized by law to make regulations, decide cases or issue licenses." 29 *Del. C.* § 10102(1).

76. The SEBC is a State agency imbued with various "powers, duties, and functions," including the "authority to adopt rules and regulations for the general administration of the employee benefit coverages." 29 *Del. C.* § 9602(b).

77. With a few narrow exceptions that do not apply here, the APA broadly defines the term "regulation" to mean "any Statement of law, procedure, policy, right, requirement or prohibition formulated and promulgated by an agency as a rule or standard, or as a guide for the decision of cases thereafter by it or by any other agency, authority or court." 29 *Del. C.* § 10102(7).

78. As explained in the Delaware Manual for Drafting Regulations, "[a]ll directives affecting individuals, regardless of the terminology the agency uses, should be adopted as regulations pursuant to the rulemaking process set forth in Title 29, Chapter 101 of the Delaware Code." Drafting and Style Manual § 2.6.

79. On or about February 28, 2022, the SEBC quietly adopted a regulation that will have a profound impact on healthcare benefits for tens of thousands of individuals. Specifically, the SEBC made a policy decision to move all Medicare-eligible (*i.e.*, elderly and/or disabled) State retirees off Medicare Supplemental health insurance – the exclusive form of health insurance provided to Medicare-eligible State retirees for decades – and onto a new, inferior type of health insurance called Medicare Advantage. This directive, which is memorialized in various statements published online by the SEBC, is scheduled to go into effect on January

1, 2023. *See generally* 2022 Meeting Materials, State Employment Benefits Committee, *available at*: https://dhr.delaware.gov/benefits/sebc/sebc-materials.shtml.

80. Under the SEBC's new regulation, if Medicare-eligible State retirees wish to receive State-funded health insurance coverage in 2023 (as is their right under 29 *Del. C.* § 5202), they must enroll in the Highmark Advantage Plan between October 3 and October 24, 2022. Failure to do so will result in a loss of health insurance to them and (potentially) their dependents. Once Medicare-eligible State retirees enroll in the plan, they will have to navigate an entirely foreign and materially worse healthcare landscape, with different rules and benefits than their previous Medicare Supplemental insurance.

81. The SEBC's overhaul of Medicare-eligible State retirees' healthcare meets the definition of a "regulation" for several reasons: it imposes new "rules," "standards," "procedures," and "requirements" on retirees, healthcare providers, and Highmark Blue Cross Blue Shield Delaware, among others; it alters the "rights" of retirees; and it represents a drastic new healthcare "policy."

82. In addition, the forced switch to a new Medicare Advantage plan also serves as a guide for the decision of cases thereafter by various agencies, including the Office of Pensions, regarding retirees' healthcare enrollment, eligibility, and benefits.

83. The SEBC's new regulation was not adopted in compliance with the APA.

84. The SEBC did not file the required notice with the Register of Regulations.

85. The SEBC did not receive written comments from the public.

86. The SEBC did not hold public hearings.

87. The SEBC did not allow for at least a 30-day public comment period.

88. The SEBC did not issue findings and conclusions based on information submitted by the public.

89. Accordingly, the SEBC's decision to force Medicare-eligible State retirees into the Medicare Advantage plan is unlawful and cannot be implemented.

90. Had the SEBC complied with the APA, Plaintiffs and countless other State retirees would have had an opportunity to object to the reduction of their healthcare benefits and explain why this directive was unwise and dangerous.

91. The SEBC's unlawful overhaul of State retirees' health insurance has harmed Plaintiffs by depriving them of the APA's procedural protections and by materially reducing their healthcare benefits.

COUNT TWO

(Violation of the Administrative Procedures Act, 29 *Del. C.* §§ 10141)

92. Plaintiffs repeat and reallege the allegations of all paragraphs above as if fully set forth herein.

93. Delaware's APA, 29 *Del. C.* § 10141(a) allows "any person aggrieved by and claiming the unlawfulness of any regulation may bring an action in the Court for declaratory relief."

94. Delaware's APA, 29 *Del. C.* § 10141(e) states, in part, that "agency action shall be presumed to be valid and the complaining party shall have the burden of proving… that the regulation, where required, was adopted without a reasonable basis on the record or is otherwise unlawful."

95. Delaware's FOIA, 29 *Del. C.* § 10001 – 10007 was adopted to "further accountability of government to the citizens of this State." It states that "[i]t is vital in a democratic society that public business be performed in an open and public manner so that our citizens shall have the opportunity to observe the performance of public officials and to monitor the decisions that are made by such officials in formulating and executing public policy[.]"

96. In order to ensure public inclusion in the work of government on its behalf, the FOIA includes an "open meetings" requirement, which states, in relevant part: "All public bodies shall give public notice of their regular meetings and of their

intent to hold an executive session closed to the public, at least 7 days in advance of the meeting. The notice must include all of the following: a. The agenda, if the agenda has been determined. b. The date, time, and place of a meeting, including whether the meeting will be conducted under § 10006A of this title." 29 *Del. C.* § 10004.

97. The SEBC is required, by law, to "hold regular meetings at least once every 6 months, which meetings shall be open to the public in accordance with § 10004 of this title." 29 *Del. C.* § 9602(d).

98. The SEBC meetings discussing, and determining, the regulation to provide only Medicare Advantage to Delaware's retirees did not provide any notice, as required by 29 *Del. C.* § 10004.

99. Accordingly, the SEBC's regulation is unlawful and violates the APA. 29 *Del. C.* § 10141(e).

100. This violation has harmed Plaintiffs by depriving them of the APA's and FOIA's procedural protections, and by materially reducing their healthcare benefits.

COUNT THREE

(Declaratory Relief under 10 *Del. C.* § 6501 and 29 *Del. C.* § 10141)

101. Plaintiffs repeat and reallege the allegations of all paragraphs above as if fully set forth herein.

102. The State Employee Benefits Consolidation Act, 29 *Del. C.* § 9604(8), imposes duties upon the Secretary of Human Resources, including: "Communication to State employees of all State employee benefits coverages and any additions or changes of benefits affecting State employees."

103. DeMatteis, the DHR Secretary, failed to provide accurate or complete communications to Plaintiffs regarding the changes in retirees' benefits under the new Highmark Advantage plan.

104. Plaintiffs seek a declaratory judgment that the DHR Secretary failed to execute her duties, in violation of 29 *Del. C.* § 9604(8).

105. In addition, as set forth herein, Plaintiffs seek a declaratory judgment that Defendants violated 29 *Del. C.* § 10115 – 10118 by failing to (i) file notice of the regulation with the Register of Regulations pursuant to 29 *Del. C.* § 10115; (ii) receive written comments from the public pursuant to 29 *Del. C.* § 10116; (iii) hold public hearings pursuant to 29 *Del. C.* § 10117; (iv) allow for a period of public comment lasting at least 30 days pursuant to 29 *Del. C.* § 10118(a); and (v) make findings and conclusions pursuant to 29 *Del. C.* § 10118(b).

WHEREFORE, Plaintiffs respectfully request that judgment be entered in their favor and against Defendants as follows:

(1) for declaratory relief pursuant to 10 *Del. C.* § 6501 and 29 *Del. C.* § 10141 as set forth herein;

(2) for a stay of executing a contract with Highmark, or of any further implementation of a Medicare Advantage Plan pending review pursuant to 29 *Del. C.* § 10144; and

(3) for such other relief as this Court deems just and appropriate.

Dated: September 25, 2022

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EXHIBIT 1

<u>State of Delaware</u>
<u>Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage</u>
<u>Frequently Asked Questions</u>

Beginning **January 1, 2023**, the State of Delaware Group Health Insurance Plan will offer one Medicare plan option - **Highmark Blue Cross Blue Shield (BCBS) Delaware's Freedom Blue PPO Medicare Advantage Plan (with Part D prescription through SilverScript).** The State of Delaware will no longer offer the Highmark BCBS Delaware Special Medicfill Medicare Supplement Plan with or without prescription **after December 31, 2022**.

<u>IMPORTANT TO REMEMBER</u>

- State of Delaware Medicare eligible pensioners and dependents who are enrolled in the Highmark BCBS Delaware Special Medicfill Plan with prescription will **automatically** transition to the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage plan (with prescription through SilverScript) effective **January 1, 2023**.
    - Pensioners should **<u>not</u>** elect to opt out of this plan if you only have medical and prescription plan coverage through the State of Delaware.
- The custom State of Delaware Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage plan includes the same covered benefits for medically necessary services covered in 2022 by Original Medicare plus the additional benefits covered under the Highmark BCBS Delaware Special Medicfill Medicare Supplement Plan.
- Enrollment in the Freedom Blue PPO Medicare Advantage plan will also be paired with enrollment in SilverScript, the State of Delaware Medicare Part D prescription drug coverage administered by CVS Caremark.
- Information on the new plan is available at the Highmark BCBS Medicare Advantage website (https://dhr.delaware.gov/benefits/medicare/medicare-advantage.shtml) and includes these FAQs, mailing/event timelines, general plan information, open enrollment information, premium rates, State Employee Benefits Committee information, Retirement Benefit Study Committee reports/information and much more.
- Access to this information can also be obtained by visiting the Office of Pensions website (https://open.omb.delaware.gov).
    - Pensioners with questions about their enrollment or the State of Delaware Medicare benefits may contact the Office of Pensions at **1-302-739-4208** or **1-800-722-7300**.
    - Pensioners may also contact Highmark BCBS Delaware at **1-888-328-2960 (TTY call 711), seven days a week, 8 a.m. to 8 p.m.** with questions about the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage plan.

1. Why is the State changing medical benefits for Medicare eligible members?

The State Employee Benefits Committee (SEBC) routinely reviews benefit options as required by State procurement requirements and to support the SEBC's mission to provide members high-quality care at an affordable cost. During CY2021, the SEBC competitively bid administration of the State Group Health Insurance Plans offered to State employees and pensioners. In February 2022, the SEBC awarded a 3-year contract to Highmark Delaware for administration of a Medicare Advantage plan to be available to eligible State of Delaware pensioners and dependents beginning January 1, 2023 and to replace the current Highmark BCBS Special Medicfill Medicare Supplement Plan.

The change in the Medicare pensioner health plan offering is part of the broader review that has been underway with the Retirement Benefits Study Committee (RBSC). Both the SEBC and RBSC are public Committees. Agendas, meeting minutes and other materials, including two reports from the RBSC to Governor Carney, the Delaware General Assembly and the Delaware Economic and Financial Advisory Council (DEFAC) released in November 2021 and March 2022, can be accessed through the Highmark BCBS Medicare Advantage website (https://dhr.delaware.gov/benefits/medicare/medicare-advantage.shtml).

The Highmark BCBS Delaware Freedom Blue PPO Plan matches the benefits and out-of-pocket costs for care offered under the Special Medicfill plan today, with added benefits. Medicare Part D prescription drug coverage will continue to be offered through SilverScript (administered by CVS Caremark).

2. **What is a Medicare Advantage plan?**
A Medicare Advantage Plan, also known as Medicare Part C, is an all-in-one alternative to Original Medicare. They include Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage, and many plans also include Medicare drug coverage (Part D). Medicare Advantage Plans are offered by Medicare-approved private health insurance companies that must follow rules set by Medicare. Medicare pays these companies to cover your Medicare benefits. When you join a Medicare Advantage plan, the plan will provide all of your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage.

3. **Is the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan like other Medicare Advantage Plans I receive information about in the mail or see on television?**
No. The State of Delaware Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan is only available to State of Delaware Medicare eligible pensioners and has been specially designed to provide the same coverage available today with the Highmark BCBS Delaware Special Medicfill Medicare Supplement Plan with Prescription.

4. **Are the requirements for Medicare Parts A and B changing?**
No. Enrollment in a Medicare Advantage plan does not impact eligibility and enrollment requirements for Medicare Parts A and B.

5. **Does enrollment in the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan mean I am giving up Medicare?**
No. Once eligible and enrolled in Medicare Parts A and B and as long as you continue to pay your Part B premiums, you **NEVER** lose Medicare. Enrollment in the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan simply means that Highmark Delaware assumes responsibility to provide all Medicare Part A and Part B services as long as you continue to pay your Medicare Part B premium.

6. **When will I receive more information about the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan?**
More information on the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan, including a Summary of Benefits, will be mailed from Highmark BCBS Delaware in late **September**. Information and updates on this important change in State of Delaware Medicare benefits effective January 1, 2023, can also be viewed at the Highmark BCBS Medicare Advantage website (https://dhr.delaware.gov/benefits/medicare/medicare-advantage.shtml).

7. **Do I need to contact the Office of Pensions to enroll in Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan if I am currently enrolled in the Highmark BCBS Delaware Special Medicfill Medicare Supplement Plan with Prescription?**
No. State of Delaware Medicare eligible pensioners and dependents who are enrolled in the Highmark BCBS Delaware Special Medicfill Plan with prescription will automatically transition to the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan (with prescription through SilverScript) effective **January 1, 2023**.

8. **Do I need to take action if I am currently enrolled in the Highmark BCBS Delaware Special Medicfill Medicare Supplement Plan without Prescription?**
Yes, State of Delaware Medicare eligible pensioners and dependents who are enrolled in the Highmark BCBS Delaware Special Medicfill Plan **without** prescription will receive Open Enrollment packets from the Office of Pensions in September 2022, containing information about enrollment in the Highmark BCBS Delaware Freedom Blue PPO Plan (with prescription through SilverScript) for the January 1, 2023 plan year.

9. **Why is the premium for the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan so much less than the Highmark BCBS Delaware Special Medicfill Medicare Supplement Plan?**

Pensioners who pay a monthly premium will see their amount of premium decrease under the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan (with prescription through SilverScript). The Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan monthly premium will be $216.18, effective January 1, 2023, less than half of the current Special Medicfill Supplement Plan with Prescription premium of $459.38. Pensioners who retired on or prior to July 1, 2012, will continue to pay $0. Pensioners who retired after July 1, 2012, will pay $10.80 monthly.

The Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan is able to be more affordable than other options like the Highmark BCBS Delaware Special Medicfill Medicare Supplement Plan with a strong focus on preventive care and care management program engagement with members and their providers delivering a coordinated approach to care resulting in lower premiums and higher quality outcomes. All health care costs are brought under one centralized plan that offers a number of advantages for a member's health outcomes and cost of care, including:

1. A broad network of high-quality physicians that share a commitment to preventive care and screenings.
2. Unique care and disease management programs that offer a nurse care coordinator, health information, and support to help members reach health goals (these programs are not part of the Original Medicare program).
3. Tools and resources to help navigate care to support members receiving appropriate care in the appropriate setting.

10. **Can I choose not to enroll in the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan (with prescription through SilverScript)?**

Yes. Pensioners will have the option to opt out of the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan (with prescription through SilverScript) during the annual State of Delaware Medicare Open Enrollment. Contact the Office of Pensions for instructions on the opt out process and to fully understand the implications of opting out of coverage through the State of Delaware for both the pensioner and eligible dependents.

IMPORTANT: Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan (with prescription through SilverScript) will be the **only** State of Delaware Medicare health plan option effective **January 1, 2023** and will replace the current Highmark BCBS Delaware Special Medicfill with and without prescription plans. Pensioners should **not** elect to opt out of the Freedom Blue PPO Medicare Advantage Plan (with prescription through SilverScript) if you **only** have health and prescription coverage through the State of Delaware. Pensioners who elect to opt out of the Freedom Blue PPO Medicare Advantage Plan will not receive the value of the plan's premiums for use in covering medical and prescription out-of-pocket expenses or for use in purchasing Medicare coverage in the individual market. In addition, the pensioner's eligible dependents may lose eligibility for health plan coverage through the State of Delaware. Please ensure that opting out of coverage through the State of Delaware is truly the best decision for you and your family by contacting the Office of Pensions at **1-302-739-4208** or **1-800-722-7300**.

11. **When is the annual State of Delaware Medicare Open Enrollment?**

The annual State of Delaware Medicare Open Enrollment is **October 3 - 24**, **2022** for benefits effective January 1, 2023. All State of Delaware Medicare eligible pensioners and dependents will receive more information from the Office of Pensions and Highmark BCBS Delaware in September 2022.

12. **If I choose not to enroll in the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan (with prescription through SilverScript) for the plan year that begins January 1, 2023, will I have another opportunity to enroll?**

State of Delaware pensioners will have the opportunity to enroll or disenroll in the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan once annually during the State of Delaware Medicare Open Enrollment period held in October for benefits effective the following January. State of Delaware pensioners who decide to enroll in the

Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan during the 2023 Open Enrollment for the 2024 plan year will not be required to go through medical underwriting or refused enrollment because of pre-existing conditions.

13. **As a State of Delaware benefit-eligible Medicare pensioner, may I enroll in "any other" individual or group Medicare Advantage or Medicare Part D prescription coverage in addition to the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan (with prescription through SilverScript)?**
The Centers for Medicare & Medicaid Services (CMS) only allows enrollment in **one** qualified Medicare Advantage and corresponding Part D prescription drug plan. Enrollment in another plan will terminate coverage with the State of Delaware Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage plan and SilverScript prescription drug plan. If you are enrolled in another Medicare Advantage or Medicare Part D prescription drug plan, contact the Office of Pensions Office to discuss your options. Pensioners who are enrolled in the Highmark BCBS Delaware Special Medicfill without Prescription Plan will receive enrollment information from the Office of Pensions with instructions in September 2022.

14. **My Medicare spouse is currently enrolled in other Medicare coverage available to them through a former employer and as required by the State of Delaware Spousal Coordination of Benefits (SCOB) Policy. Is my spouse eligible to enroll in the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan (with prescription through SilverScript)?**
Effective January 1, 2023, the State's Spousal Coordination of Benefits Policy will be modified to permit a Pensioner whose spouse is Medicare eligible and also offered either a Medicare Advantage plan or cash in lieu of coverage, to choose either the coverage available through the spouse's former employer or the State of Delaware Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan (with prescription through SilverScript). Spouse's enrolled in an employer sponsored Special Medicfill plan through a former employer should contact the Office of Pensions at **1-302-739-4208** or **1-800-722-7300** to discuss how the SCOB policy applies.

15. **I am a State of Delaware pensioner or spouse that is also enrolled in Tricare for Life. Am I eligible for enrollment in the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan (with prescription through SilverScript)?**
Yes. State of Delaware pensioners and spouses may be enrolled in both Tricare for Life and the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan (with prescription through SilverScript). Tricare will always pay after payment has been made by Highmark BCBS Delaware.

16. **What ID cards will I use for services beginning January 1, 2023?**
Enrollment in a Medicare Advantage plan means you will no longer have to present your red, white, and blue Medicare card for care. Pensioners enrolled in the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan (with prescription through SilverScript) will receive a new Medicare Advantage PPO ID card from Highmark BCBS Delaware in December 2022. Be sure to use only this new medical plan ID card for all medical care starting January 1, 2023.

    Pensioners currently enrolled in the current Highmark BCBS Delaware Special Medicfill Plan with prescription will continue to use their current SilverScript ID card for prescriptions. Pensioners who are not currently enrolled in the Highmark BCBS Delaware Special Medicfill Plan with prescription and elect to enroll in the BCBS Delaware Freedom Blue PPO Medicare Advantage Plan will receive an ID card from SilverScript in December 2022.

17. **What if I will become Medicare eligible on or after January 1, 2023?**
State of Delaware pensioners and dependents who become Medicare eligible on or after January 1, 2023, will receive additional information from the Office of Pensions approximately four months in advance of their 65th birthday.

18. **Can I keep my current doctors?**
The Highmark BCBS Delaware Freedom Blue PPO Plan allows pensioners and their spouses to use in network (contracted) as well as out of network (non-contracted) doctors and hospitals as long as those providers are eligible to participate in Medicare. Pensioners will receive information on how to find out if providers accept Medicare, within

the enrollment materials sent by Highmark BCBS Delaware during or before the State of Delaware annual Medicare Open Enrollment this October. Pensioners may contact Highmark BCBS Delaware at **1-888-328-2960 (TTY call 711), seven days a week, 8 a.m. to 8 p.m.** with questions about their doctors' participation in the Highmark BCBS Delaware Freedom Blue PPO Plan network.

19. Do I need a Primary Care doctor?
No. A primary care doctor is not required with enrollment in the Highmark BCBS Delaware Freedom Blue PPO Plan, but highly encouraged to help coordinate your health care needs.

20. Do I need a referral when scheduling care with a specialist?
No. Referrals are not required for specialist care under the Highmark BCBS Delaware Freedom Blue PPO Plan. You can see any specialist you want.

21. What if my provider refuses to accept the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan?
The Highmark BCBS Delaware Freedom Blue PPO Plan allows pensioners and their dependents to receive care from contracted and non-contracted doctors and hospitals across the U.S. if those providers are eligible to receive and accept Medicare payment. If your doctor does not join the Highmark BCBS Medicare Advantage network, you are eligible to see that doctor as an out-of-network provider, and the doctor will be reimbursed at 100% of the Medicare approved amount (up to the Medicare limiting amount for providers that do not accept Medicare assignment), as long as the doctor is eligible to participate in Medicare and accepts the plan. Please note, while most non-contracted providers agree to accept the Highmark BCBS Freedom Blue Medicare Advantage PPO plan, they have the option to refuse to see patients enrolled in the plan. Highmark has been building the Freedom Blue PPO network over the last two years and is making every effort to recruit providers treating State of Delaware Highmark BCBS Delaware Special Medicfill members. An extensive provider outreach and education plan is underway to ensure minimal disruption to State of Delaware Medicare pensioners and dependents when the plan becomes effective on January 1, 2023.

Pensioners may contact Highmark BCBS Delaware at **1-888-328-2960 (TTY call 711), seven days a week, 8 a.m. to 8 p.m.** if your provider indicates they are not accepting the Highmark BCBS Freedom Blue Medicare Advantage PPO plan so that Highmark may outreach to the provider to review accepting the plan and review other provider options as needed. **More details on how to engage with your provider if they are not contracted will be available in September 2022 at the [Highmark BCBS Medicare Advantage website](https://dhr.delaware.gov/benefits/medicare/medicare-advantage.shtml) (https://dhr.delaware.gov/benefits/medicare/medicare-advantage.shtml).**

22. Do I need prior approval for care or specific services?
In some cases, yes. Your doctor may need to get approval or a prior authorization from Highmark BCBS Delaware before you receive certain types of services that are not an emergency such as inpatient hospital care, home health care, home infusion therapy, organ transplants, diabetes supplies and services, durable medical equipment, intensive cardiac rehabilitation, non-emergent and air ambulance transportation, opioid treatment program/services, outpatient substance abuse services, Part B drugs, Physical/Occupational/Speech Therapy, Pulmonary Rehabilitation Services, supervised exercise therapy, outpatient hospital/ambulatory surgery center care, mental health care, skilled nursing facility care, dental services, chiropractic care, outpatient diagnostic tests/labs, and some radiology services (for example, CT, MRI, MRA and PET scans).

The Centers for Medicare and Medicaid (CMS) define the timeline for prior authorization requests. Standard requests (when received with complete information) must be completed in no more than 14 days; 72 hours for Part B drugs. Fast coverage decisions (when the standard deadline could cause serious harm to health or hurt ability to function) must be completed in no more than 72 hours; 24 hours for Part B drugs. Your doctor can help with any prior authorization necessary. Your enrollment materials coming this fall will further explain services that need prior approval.

Highmark BCBS has confirmed that Medicare Advantage prior authorization requests are prioritized to ensure compliance with CMS requirements and statistics follow below.

Calendar Year 2021

Approval Rate – 92%	Turn Around Times for Expedited Cases – 1.39 Days
Denial Rate 8%	Turn Around Times for Standard Cases – 4.59 Days

Calendar Year 2022 (Through May 31, 2022)

Approval Rate – 92%	Turn Around Times for Expedited Cases – 1.57 Days
Denial Rate 8%	Turn Around Times for Standards Cases – 4.05 Days

More details and additional FAQs on prior authorization will be available in September 2022 at the Highmark BCBS Medicare Advantage website (https://dhr.delaware.gov/benefits/medicare/medicare-advantage.shtml).

23. Are the covered services in the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan the same as the covered services in the Highmark BCBS Delaware Special Medicfill Medicare Supplement Plan?

Yes. State of Delaware pensioners will receive the same covered services including coverage outside of the U.S. and medically necessary home health services under the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan. Details on the new plan were mailed to State of Delaware pensioners from Highmark BCBS Delaware in mid-July 2022. More details including a Summary of Benefits will be coming from Highmark Delaware in late September 2022 and will be posted at the Highmark BCBS Medicare Advantage website (https://dhr.delaware.gov/benefits/medicare/medicare-advantage.shtml).

24. I do not live in the Delaware area. How can I and my dependents find out if our doctors are in or out of the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan network and who we and our doctors should contact for approval of services requiring prior authorization?

The Highmark Freedom Blue Medicare Advantage PPO plan provides access to any doctor, specialist, hospital, or other medical provider who is eligible to participate in Medicare. Pensioners can choose from a national network of Blue Cross Blue Shield Medicare Advantage PPO providers close to home and anywhere in the U.S. as well as doctors and hospitals outside of the network as long as the providers accept Medicare and accept the Blue Cross Blue Shield Medicare Advantage PPO plan (when outside of DE, PA, NY or WV, please let the provider know you are enrolled in a Blue Cross Blue Shield Medicare Advantage PPO plan as they may not recognize Highmark DE BCBS). Benefits and coverage levels are the same for medically necessary covered benefits in and out of the network.

To locate contracted in network providers, a member can contact the Highmark Freedom Blue Medicare Advantage PPO Concierge Service team at **1-888-328-2960 (TTY call 711)**, seven days a week, 8 a.m. to 8 p.m. to confirm in network providers nationally as well as for assistance using the BCBS national Medicare Advantage PPO provider search tool located on the Highmark DE website. Please refer to instructions on how to complete an online provider search included in the Highmark Freedom Blue PPO Open enrollment guide that will be sent in late September from Highmark BCBS Delaware.

For services that require a prior authorization approval, this request would be submitted directly to Highmark BCBS Delaware (not the local Blue plan) if a member is seeking services when outside of the Highmark footprint. When seeking services from out-of-network non contracted providers, the provider can submit a pre-visit coverage decision request directly to Highmark to confirm the service is a covered benefit and medically necessary. Also, a member can contact Highmark – **1-888-328-2960** to also request the pre-visit coverage decision for non-emergency services if their provider does not submit the pre-visit coverage decision on their behalf.

More details and additional FAQs on prior authorization will be available in September 2022 at the Highmark BCBS Medicare Advantage website (https://dhr.delaware.gov/benefits/medicare/medicare-advantage.shtml).

25. **Are hearing aid discounts available to State of Delaware pensioners?**
Yes. State of Delaware pensioners have several options to obtain hearing aid discounts when enrolled in the following benefit plans:
- **Highmark BCBS Delaware Health Plan Members** – have access to Blue365, which offers discounts on certain services including hearing aids. The specific hearing aid vendors are Beltone, Hear USA, Start Hearing and TruHearing. Each offer a specific discount on hearing aids and other hearing services. Contact Highmark BCBS Delaware at **1-888-328-2960 (TTY call 711).**
- **Delta Dental Members** – have access to preferred pricing on hearing aids through Amplifon. Call Amplifon at 888-779-1429 and a dedicated representative will assist you with the program and help you pick a provider, make an appointment, and receive your discount. Amplifon offers 62% average savings off retail hearing aid pricing with a best price guarantee of 5%.
- **Dominion National Members** – have access to preferred pricing on hearing aids through Amplifon. Call Amplifon at 855-565-1072 and a dedicated representative will assist you with the program to provide access to custom hearing solutions, risk free 60-day trial, and aftercare program. Amplifon offers savings averaging 64% off the retail price on more than 1,400 hearing aid options with access to over 5,000 credentialed provider locations across the country.
- **EyeMed Members** – are eligible for hearing aid discounts through Amplifon. EyeMed members have access to discounts on thousands of hearing aids, locations nationwide, free batteries and a 3-year warranty and loss and damage coverage. Members can call 877-203-0675 to find a hearing care provider in their area.

For more information on hearing loss resources, visit our website (https://dhr.delaware.gov/benefits/hearing-loss/medicare.shtml).

26. **How much is the State of Delaware paying Highmark BCBS Delaware for each pensioner and covered family member who enrolls in the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan?**
The Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan assumes responsibility for providing all benefits covered under Original Medicare Part A and Part B plus all the additional benefits beyond Medicare covered by the 2022 Highmark BCBS Delaware Special Medicfill Medicare Supplement Plan with Prescription, under one single retiree medical plan creating a superior member health experience while simplifying plan administration. State of Delaware Medicare pensioners and dependents benefit from a much larger overall relationship that Highmark Delaware has with the State of Delaware across the State's large population of active employees and dependents and pre-65 retirees and dependents, driving cost savings across all plans offered.

Medicare Advantage plans receive funding from CMS for the original Medicare benefits as well as the opportunity to earn quality bonus revenue through the Medicare Star rating program. The Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan leverages these revenue streams to deliver savings to the State of Delaware in the form of plan lower premiums while maintaining the current level of covered benefits State of Delaware pensioners and dependents enjoy today.

27. **What happens to the savings the State of Delaware will receive as a result of the lower premium being paid for pensioners and dependents enrolled in the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan?**
The current Highmark BCBS Delaware Special Medicfill Medicare Supplement with and without Prescription Plans offered by the State are part of a self-insured health program with the State bearing 100% of the risk and paying the full cost of all claims incurred by enrolled members as well as administrative fees paid to Highmark BCBS Delaware, the State's Third-Party Administrator (TPA). Unlike pension benefits that require a specific monthly pension benefit payment, with respect to health care benefits, the State Medicare health and prescription plan premium represents an implied value of health care benefits incurred by the State per covered individual as determined annually by the State Employee Benefits Committee (SEBC). The State's aggregated costs for the health care of all pensioners, active employees and dependents is included in the State's annual budget. The employer-sponsored Medicare Advantage Plan is a fully insured plan with premiums paid by the State of Delaware to Highmark BCBS Delaware and the risk borne by Highmark BCBS Delaware. To the extent there are any differences between the aggregate

premiums paid by the State to Highmark BCBS Delaware for the Medicare Advantage Plan versus the aggregate claims and fees the State might have had to pay in prior years under the Highmark BCBS Delaware Special Medicfill Medicare Supplement plan, those savings (or costs) would be reflected in the State's annual budget.

In addition, to the extent there may be savings, those savings will also help to assure the long-term sustainability of these very important benefits. The State of Delaware's current unfunded actuarial liability for future retiree health care benefits exceeds $10 billion – many multiples higher than the rest of the State's entire combined debt for roads, schools, state facilities, infrastructure and even pension benefits. Absent any changes to retiree health care benefits or how those benefits are funded, this unfunded liability is expected to triple over the next 30 years. The Retirement Benefits Study Committee (RBSC) has been meeting since 2019 to meaningfully address this unfunded liability. By migrating to the fully insured Medicare Advantage plan, the unfunded liability would be expected to only grow to $19.8 billion, a nearly 55% decline in the estimated growth rate. To protect our State of Delaware pensioners, in June 2022, the Delaware General Assembly approved language in the State's Fiscal Year 2023 budget placing 1% of the prior year's budget into the Other Post-Employment Benefits Trust (OPEB) Fund for retiree health care. Analysis prepared for the RBSC shows that the combination of migrating to a medical only Medicare Advantage plan and improved funding for the OPEB Fund could reduce the unfunded liability to a far more manageable amount of $3.1 billion by the Year 2050 – assuring that pensioners and their dependents continue to receive premium health care services at an affordable cost.

28. Where can I access and read a copy of the contract between the State of Delaware and Highmark BCBS Delaware for the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan?

The Medicare health plan contract award was approved by the State Employee Benefits Committee (SEBC) on February 28, 2022. The contract is being amended to address issues and concerns raised from the public comments received during and since the August Education Sessions. The contract will be made publicly available as soon as possible.

29. Given that Highmark BCBS Delaware will take over management of Medicare Parts A and B beginning January 1, 2023 as part of a 3-year contract, will Highmark BCBS Delaware be required to match any changes in Medicare Parts A and B coverage?

Highmark BCBS Delaware **Freedom Blue PPO Medicare Advantage Plan** assumes responsibility to provide all Medicare Part A and Part B benefits as well as the additional medical services, benefits, and out-of-pocket coverage that the State offers to Medicare pensioners and dependents. Administration of the Part D prescription benefits will continue to be handled by SilverScript. During the contract period, Highmark BCBS Delaware **Freedom Blue PPO Medicare Advantage Plan** will be required to cover all services approved and available under Medicare Parts A and B.

30. Are there any changes planned for the State vision and dental plans available to State of Delaware pensioners?

Vision and dental plan coverage is available to our State of Delaware Medicare pensioners through the same dental and vision plan options available to State of Delaware employees. Pensioners receive information during the May annual open enrollment to enroll, disenroll or make changes in dependent coverage in these plans administered by EyeMed, Dominion National and Delta Dental. The premiums, coverage and benefits for dental and vision coverage will remain the same during CY2023. State of Delaware pensioners will receive more information on the vision and dental plan offerings next Spring. Information on the dental and vision plans can be found online at [DHR - Division of Statewide Benefits (delaware.gov)](https://dhr.delaware.gov/benefits/medicare/index.shtml) (https://dhr.delaware.gov/benefits/medicare/index.shtml).

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Case No. N22C-09-526 CLS

EXHIBIT 2

Statewide Employee Benefits Committee

September 19, 2022

Medicare Advantage Transition

When will this change to a Medicare Advantage plan occur?

Beginning **January 1, 2023**, the State of Delaware Group Health Insurance Plan will offer one Medicare plan option - **Highmark Blue Cross Blue Shield (BCBS) Delaware's Freedom Blue PPO Medicare Advantage Plan (with Part D prescription through SilverScript).**

Medicare Advantage Summary

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 providers receiving the 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.

Why the change?

- State Employee Benefits Committee (SEBC) routinely reviews benefit options as required by procurement process
- Part of a broader review with the Retirement Benefits Study Committee (RBSC)
- New plan matches benefits and out-of-pocket costs for old plan, with added benefits and lower costs

What is a Medicare Advantage Plan?

- AKA Medicare Part C
- All-in-one alternative to Original Medicare
- Includes Medicare Part A (Hospital), Medicare Part B (Medical) and many include Medicare Part D (Prescription)
- Medicare approves and pays insurance company, which must follow Medicare rules

Is the new plan like other M.A. plans?

This plan is only available to SOD Pensioners and has been specifically designed to provide the same coverage as the old plan.

Are the requirements for Medicare Parts A and B changing?

Enrollment in the new plan does NOT impact eligibility or enrollment requirements for Medicare Parts A and B.

Does enrolllment in Medicare Advantage mean giving up Medicare?

Enrollment in MA means Highmark assumes responsibility for all Medicare Part A & B services as long as the pensioner pays their Part B premium.

Can a Pension er also enroll in other M.A. or Part D coverage?

Pensioners enrolled in another M.A. or Part D plan should contact the Pension Office.

Pensioners enrolled in Special Medicfill without Prescription will receive instructions from the Pension Office.

What if Medicare Part A or B coverage changes?

- The new plan will be required to cover all services approved and available under Medicare Parts A and B throughout the 3-year contract period.
- Prescription benefits will continue to be handled by SilverScripts.

Are covered services the same as the old plan?

The new plan has been specifically designed to cover the same services as the old plan and includes the same SilverScript prescription coverage.

Can Pensioners keep current doctors?

Pensioners can see in-network or out-of-network providers as long as they accept Medicare. Pensioners should call Highmark with questions about providers.

Is a Primary Care provider required?

It is highly encouraged to help coordinate health care needs, but a Primary Care doctor is not required.

Are referrals required to see a specialist?

Referrals are not required for specialist care. Pensioners can see any specialist they want.

(A referral is not the same as a prior authorization.)

What if a provider doesn’t accept the new plan?

- Pensioners can still see the provider as an out-of-network provider
- The plan will reimburse the provider at 100% of the Medicare approved amount
- Most providers accept the plan, and Highmark is outreaching to DE providers to minimize disruption
- Pensioners should call the Pension Office or Statewide Benefits Office if their provider says they are not accepting the new plan

Is prior approval for care or services required?

- **In some cases, yes.**
- The services requiring prior approval are detailed in the materials coming from Highmark
- Approval rate is 92%
- Turnaround times for expedited cases: under 2 days
- Turnaround times for standard cases: under 5 days
- Not required for emergency care
- Not applicable for outpatient services until May 1

What if the pensioners does not live in Delaware?

- The network is national
- Pensioners can see any provider who accepts Medicare
- Show the provider the ID card
- Call Highmark or use their online provider search tool for help finding a provider
- Providers send prior authorization requests and pre-visit coverage decisions directly to Highmark regardless of location

Can the pensioner choose not to enroll in the new plan?

Yes, pensioners can opt out during Open Enrollment by contacting the Pension Office, **BUT**…

- The new plan will be the ONLY SOD Medicare health plan option
- Pensioners should not opt out if SOD is their only coverage
- Pensioners will not receive the value of the premium for use in purchasing another plan
- Dependents might lose coverage eligibility

When is SOD Medicare Open Enrollment?

October 3 -24, 2022

for benefits effective

January 1, 2023

When will pensioners receive more information?

Open Enrollment packets from the Pension Office were mailed on September 15th.

More information, including a Summary of Benefits and a Medical Benefits Chart is coming from Highmark and will arrive in Pensioner mailboxes in late September. These mailings are already posted on the Highmark Medicare Advantage website.

Open Enrollment Sessions to be held in each county during Open Enrollment

If a pensioner does not enroll this year, will they be able to later?

- Opportunity to enroll or disenroll every year during Medicare Open Enrollment
- Pensioners who enroll during this year's Open Enrollment will not be required to go through medical underwriting or refused enrollment because of pre-existing conditions

If a spouse has other Medicare coverage from a previous employer, are they eligible for the new plan?

- If a spouse is Medicare eligible and offered a Medicare Advantage plan (or cash in lieu of coverage) by their former employer, they will be able to keep their current coverage or enroll in SOD's Medicare Advantage Plan.
- If a spouse is enrolled in an employer sponsored Special Medicfill plan through a former employer, contact the Pension Office to discuss options.

What ID cards will the Pensioner receive/use?

- No longer use red, white, and blue Medicare card
- Pensioners will receive a Highmark Advantage PPO ID card from Highmark in December 2022 to use for all medical care
- Use SilverScript ID card for prescriptions
  – Keep if Pensioner already has one
  – If not currently enrolled in Part D, Pensioner will receive one in December 2022

When will the contract be available?

- The contract and performance guarantees (PGs) are being finalized
- Both will be posted publicly once finalized
- PGs will include detailed monthly reporting on prior approvals and denials and appeals with financial penalties if not met

Why is the premium so much lower?

- Broad network of high-quality physicians share a commitment to preventive care and screenings
- Member engagement in care and disease management programs to help members reach health goals
- Tools and resources to help navigate care so members receive appropriate care in appropriate settings
- SEBC set the premiums for all State plans based upon projected health and prescription plan expenses.

Medicare Advantage Resources

Medicare Advantage Resources

- Statewide Benefits Office Highmark Delaware Medicare Advantage webpage (also accessible from the Office of Pensions site)
- Medicare Advantage October Open Enrollment Sessions
- Medicare Advantage Frequently Asked Questions
- Highmark Medicare Advantage Pre-OE Mailer
- Medicare Advantage Medical Benefits Chart
- State of Delaware Medicare Advantage Mailings/Events Timeline
- Pensioners may contact Highmark BCBS Delaware at **1-888-328-2960 (TTY call 711), seven days a week, 8 a.m. to 8 p.m.** with questions about the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage plan.
- Pensioners with questions about their enrollment or the State of Delaware Medicare benefits may also contact the Office of Pensions at **1-302-739-4208** or **1-800-722-7300**.

Thank You

Phone: 1-800-489-8933

Email: benefits@delaware.gov

Website: de.gov/statewidebenefits

Like us on Facebook: delawarestatewidebenefits

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Case No. N22C-09-526 CLS

EXHIBIT 3

MINUTES FROM THE MEETING OF THE STATE EMPLOYEE BENEFITS COMMITTEE
FEBRUARY 28, 2022

The State Employee Benefits Committee (the "Committee") met at 2:00 p.m. on February 28, 2022. The meeting was held at 97 Commerce Way, Suite 201, in Dover; however, in the interests of protecting the citizens of this State from the public health threat caused by COVID-19, this meeting was presented via WebEx, and participants were encouraged to attend virtually.

Committee Members Represented or in Attendance:

Director Cerron Cade, Office of Management & Budget ("OMB"), SEBC Co-Chair
Secretary Claire DeMatteis, Department of Human Resources ("DHR"), Co-Chair
The Honorable Colleen Davis, State Treasurer, Office of the State Treasurer ("OST")
The Honorable Trinidad Navarro, Insurance Commissioner, Department of Insurance ("DOI")
The Honorable Chief Justice Collins Seitz, Delaware Supreme Court
Controller General Ruth Ann Jones, Office of the Controller General ("OCG")
Secretary Molly Magarik, Department of Health & Social Services ("DHSS")
Mr. Jeff Taschner, Executive Director, Delaware State Education Association ("DSEA")
Mr. Keith Warren, Chief of Staff, Office of the Lieutenant Governor (Designee OBO The Honorable Bethany Hall-Long, Lieutenant Governor)
Ms. Ashley Tucker, Deputy State Court Administrator, Admin Office of the Courts (Designee OBO The Honorable Chief Justice Collins Seitz, Delaware Supreme Court

Others in Attendance

Director Faith Rentz, Statewide Benefits Office ("SBO"), DHR
Deputy Director Leighann Hinkle, SBO, DHR
Ms. Nina Figueroa, SBO, DHR
Deputy Attorney General Adria Martinelli, Dept. of Justice ("DOJ"), SEBC Legal Counsel
Mr. Chris Giovannello, Willis Towers Watson ("WTW")
Ms. Jaclyn Iglesias, WTW
Ms. Rebecca Warnken, WTW
Ms. Gabby Costagliola, WTW
Ms. Joanna Adams, Pension Administrator, Office of Pensions ("OPen")
Ms. Judy Anderson, DSEA
Ms. Wendy Beck, Highmark Delaware
Mr. Ken Bronke, Highmark Delaware
Ms. Christina Bryan, Delaware Healthcare Association
Mr. Randall Bryniarski, CVS Health
Ms. Rebecca Byrd, ByrdGomes
Ms. Michelle Carpenter, PHRST
Ms. Julie Caynor, Aetna
Ms. Marian Coker, Information Resource Specialist, Department of State
Dr. Jessilene Corbett, Deputy Secretary, DHR
Mr. Steven Costantino, Dir. Healthcare Reform, DHSS
Ms. Sue Dahms, Highmark Delaware
Ms. Cherie Dodge Biron, Deputy Principal Asst., DHR
Ms. Sara Dunlevy, CVS Health
Mr. John Ficaro, Aetna
Ms. Darcell Griffith, University of Delaware
Ms. Rishika Gupta, CVS Health
Ms. Jeanette Hammon, Sr. Fiscal Policy Analyst, OMB
Ms. Sandy Hart, IBM Watson Health
Mr. John Hintz, Christiana School District, retiree
Ms. Charlene Hrivnak, CVS Health
Ms. Katherine Impellizzeri, Aetna
Dr. Mark Jacobson, Highmark Delaware
Mr. Kollin Jensen, Teladoc Health
Ms. Heather Johnson, Controller, DHR
Mr. Jamie Johnstone, Deputy Principal Assistant, Dept. of Finance ("DOF")
Mr. Adam Knox, Highmark Delaware
Ms. Lisa Mantegna, Highmark Delaware
Mr. Walt Mateja, IBM Watson Health
Ms. Gisela McKenzie, University of Delaware

Mr. Sean McNeeley, Director of Bond Finance, DOF
Mr. Nick Moriello, Highmark Delaware
Ms. Kathy Nedelka, HRIS Specialist, PHRST, OMB
Ms. Brooke Nedza, Aetna
Ms. Evelyn Nestlerode, Deputy State Court Administrator, CFO, AOC
Mr. Michael North, Aetna
Ms. Megan Richards, Aetna
Ms. Paula Roy, Roy Associates
Ms. Elizabeth Sampo, Aetna
Mr. Bill Sarniak, Highmark Delaware
Ms. Carrie Schiavo, Delta Dental
Ms. Christine Schiltz, Parkowski Guerke & Swayze, P.A.
Mr. Robert Scoglietti, Deputy Controller General, OCG
Mr. Mike Shipley, Highmark Delaware
Mr. Charles Simons, Highmark Delaware
Ms. Jacqueline Faulcon, READAAMs. Martha Sturtevant, Exec. Sec., SBO, DHR
Ms. Carole Mick, SBO, DHR – Recorder

CALLED TO ORDER – DIRECTOR CADE, CO-CHAIR
Director Cade called the meeting to order at 2:00 p.m.

APPROVAL OF MINUTES – DIRECTOR FAITH RENTZ, DHR, SBO
A MOTION was made by Secretary Magarik and seconded by Controller General Jones to approve the minutes from the January 24, 2022, meeting of the State Employee Benefits Committee.
MOTION ADOPTED UNANIMOUSLY

DIRECTOR'S REPORT – DIRECTOR FAITH RENTZ, DHR, SBO

Medicare Part D – EGWP Transition Updates
Through 1/31/22, 70% (19,612) of the State's average eligible Medicare members (27,886) utilized the pharmacy benefit through CVS/SilverScript. Over 66,000 claims were processed at a total amount paid of $13.7M, almost$13M of this was paid by the State's plan (94%) and 6% paid by Medicare retirees. Call volume increased somewhat in early February; however, this has leveled off in the last 2 weeks. There were common themes in calls and customer service tickets being tracked by the SBO and Pension Office. The first common theme is Medicare Part B vs Part D Coordination for Immunosuppressants. Some members were denied coverage when transitioning to SilverScript, due to CMS records not being updated correctly. The SBO has been providing exception overrides while this information gets updated between CMS and SilverScript. Another issue concerning members is a copay increase due to members prescriptions not being on the drug formulary. Members can request SilverScript to cover a drug due to medical necessity. If a drug does become covered, it will be covered at the Tier Three Copay for Non-Formulary Drugs. SilverScript does offer preferred drug alternatives on the formulary. Formulary changes occur several times throughout the year due to re-contracting that the Pharmacy Benefits Manager (PBM) goes through with drug manufacturers, so members will see disruptions regardless of the change in PBM. Lastly, members are facing challenges with obtaining prior authorizations for prescriptions with the transition to SilverScript. Affected Medicare retirees were notified in early December about the transition to SilverScript and informed that they would need a new prior authorization and offered a 31-day transition fill for their first fill after January 1st, 2022. Medicare Part D members do have five levels of appeals to request consideration for prescription medication.

2021 HEALTH THIRD PARTY ADMINISTRATIVE SERVICE RFP RECOMMENDATIONS – MR. CHRIS GIOVANNELLO, WTW and MS. JACLYN IGLESIAS, WTW

Medicare Plan Option
Mr. Giovannello stated that in November the Proposal Review Committee (PRC) voted on the recommendations related to the Medicare plan options. The PRC determined that both Highmark Delaware and Aetna were qualified to administer both a Special Medicfill Medicare Supplement plan and a Group Medicare Advantage (Group MA) product to the Medicare pensioner population. The scoring of the two vendors ultimately determined that Highmark Delaware's Medicare Advantage product scored higher than Aetna's offering. The PRC

recommended that the State Employee Benefits Committee (SEBC) should reach a decision not later than March 31, 2022, in order to provide sufficient time for implementation of the plan option before the current Special Medicfill Medicare Supplement plan contract terminates on December 31, 2022.

Discussion was had regarding the options that have been proposed compared to what is currently being administered today, including review of the key components of group MA plans, the federal subsidies available to the GHIP under each option and considerations for including Part D drug coverage in a group MA offering.

Mr. Giovannello commented that compared to the current Medicfill plan there would not be any plan design changes if the State moved to a Group MA plan and the provider network would not change from a passive PPO network.

Mr. Taschner inquired which line item on the reported invoices would be eliminated if the Group Medicare Advantage with Prescription plan was selected. Mr. Giovannello responded all rebate payments that are related to the EGWP program, as well as EGWP related revenues (direct subsidy, coverage gap discount payment and federal reinsurance) would discontinue and any items that are related to the active/pre65 population would remain.

Mr. Giovannello summarized the key decision points for the SEBC: maintain Medicfill plan or move to Group MA product, effective 1/1/23 (or later); select Aetna or Highmark Delaware as the plan administrator; and include or exclude Part D drug coverage as part of the Group MA product.

Mr. Taschner expressed concern that moving to a Group MA product will reduce the revenue to the GHIP, considerably reduce the amount that the State must contribute to the GHIP, and the retiree population may have difficulty switching and understanding a transition to a Group MA offering. He asked Director Cade if there is a way to hold the actives/pre65 retirees harmless in order to make sure the move to a Group MA program does not result directly in a net increase to that group.

Director Cade commented that he shares Mr. Taschner's concerns that communication must be strategically implemented for the retiree population if the decision is to move forward with a Group MA product. However, there are not material changes to the plan. He commented that the vendors included transition credits in their proposals that could be used to cover the cost of communication and education materials and inquired what the dollar amount is that Highmark and Aetna offered as a transition credit. Ms. Rentz commented that she will follow up directly with committee members due to the proprietary nature of that information.

Mr. Giovannello concluded this portion of the presentation with a recap of the joint Subcommittees recommendation regarding a Medicare plan: Effective January 1, 2023, move to a Group MA plan, award administration of the plan to Highmark, and maintain existing self-funded EGWP coverage.

<u>*Active/Non-Medicare Plan Considerations*</u>

Ms. Iglesias explained that for the active/non-Medicare plan considerations for FY23, Subcommittee members discussed the following programs and formed recommendations for discussion during last week's meeting and is ultimately asking for the SEBC to take a vote based off Subcommittee member recommendations. These programs include the care management program option for each medical vendor, the PCP election/referral requirement of the Aetna HMO plan, and other FY23 opportunities for consideration.

Regarding the care management programs, Aetna has proposed two care management options for the State Group Health plan. Aetna's first program is called, "One Advisor", which targets more people, engages with them earlier, and uses more advanced technology. The second program is called, "One Flex", which targets fewer people, uses less advanced technology, however, is lower cost than "One Advisor". Both programs are new to the State Group Health plan, and both offer performance guarantees. Financially, the estimated cost savings for FY23

admin cost for the “One Advisor” would $0.6M and “One Flex” the estimated cost savings for FY23 admin cost is $1.7M. The combined Subcommittees met with Aetna in January to understand the key differences between the programs - focusing on the descriptions of each program, fees, performance guarantees, and outcomes achieved from case studies. Based on the deliberation among Subcommittee members, they ultimately agreed that the Aetna “One Advisor” program would be the best option for the State Group Health plan. They saw value in that the program would be able to identify more plan participants and engage with participants earlier, which would lead to a better member experience and improved health outcomes.

Highmark also proposed two care management options for the State Group Health plan. Highmark’s first program is called, “Well360 Clarity”, and is a new program that targets more people, is delivered in conjunction with a care management partner and offers more steerage of plan participants to high quality providers. The second option proposed is what the State Group Health plan has today and is called the “CCMU” (Custom Care Management Unit) program, which targets fewer people and includes clinical oversight provided by a different team of WTW resources on behalf of all mutual customers served by the CCMU. Financially, the estimated savings on FY23 admin fees for the “Well360 Clarity” would be $0.6M, whereas the CCMU would increase estimated FY23 admin fees by $0.1M. Both programs offer performance guarantees related to program outcomes. Highmark met with Subcommittee members in January to demonstrate the differences between the proposed programs and illustrate member scenarios under each option. After deliberation, the Combined Subcommittees agreed that the “CCMU” program would be better suited to continue supporting the State Group Health plan participants for FY23, with a willingness to consider reevaluating this decision throughout the subsequent years of the State’s contract with Highmark. Subcommittee members were concerned about adopting a program for which Highmark is using a new care management provider to deliver services to members and the lack of transparency into Highmark’s broader relationship with its care management provider, despite multiple inquiries requesting further details.

Pivoting to the next outstanding decision related to the Aetna HMO plan, today the State of Delaware’s Aetna HMO plan requires members to select a PCP upon enrollment and requires referrals for members seeking specialty care. In addition to maintaining the current HMO as it is administered today, Aetna’s proposal also included an option for the State to waive the current requirements for participants to select a primary care physician and obtain referrals. The Subcommittees discussed the possible implications of removing this requirement on plan costs and on GHIP revenue through enrollment migration from the PPO to the HMO plan (i.e., lost contribution of revenue for similar plan design, plus the potential impact on Highmark’s performance guarantees and other elements of Highmark’s financial proposal). Ultimately, Subcommittee members agreed that maintaining the requirement for the PCP selection and referrals is preferable to waiving this requirement.

Finally, Subcommittee members reviewed other FY23 opportunities that had previously been discussed at the Subcommittee level, but because no vote was taken at the December SEBC meeting, there was an opportunity to revisit the recommended options for consideration of whether these should be reintroduced at the SEBC level for evaluation and a potential vote. At last Thursday’s Subcommittee meeting, there was a discussion about how several updates to some FY23 opportunities had taken place since December and did not make them feasible for a vote in February or March in time to apply as savings against the FY23 deficit. These updates included discussion on foregoing any changes to telemedicine copays in FY23 with agreement to monitor ongoing utilization for the possibility of revisiting changes in the future, and discussion of the CVS Transform Diabetes Care program being considered alongside of other diabetes programs through the medical RFP, which will be discussed at the March Subcommittee meeting.

The CVS Drugs Savings Review program was also discussed on Thursday to gauge interest from Subcommittee members’ in maintaining the earlier recommendation to the SEBC to consider this program for FY23. The goals and key elements of the program were reviewed, which centers around identifying opportunities for improved prescribing practices and improved prescription drug utilization based on evidence-based medicine guidelines. This program involves outreach from CVS to prescribing physicians on behalf of specific members enrolled in the

State Group Health plan, with recommendations to those physicians on other opportunities to improve patient safety or help members save money on their prescriptions to potentially make changes for the betterment of the patient in their prescribing regimen. Providers would retain complete discretion over making any changes to their patients' prescriptions, so if a physician decides against making any changes to a member's prescription, then CVS will honor that physician's clinical opinion. This program has minimal member impact, which is only felt if the prescriber decided to change the patient's prescription drug regimen, underscoring the importance of provider engagement in driving the Return on Investment (ROI) and clinical impact of this particular program. It has a 3:1 minimum ROI guarantee (annual net saving range after member cost sharing $1M-$2.8). Discussion with the Subcommittee members about whether this program was truly voluntary for provider and recalled requirements to change prescriptions with the earlier PBM transition from Express Scripts to CVS. Ultimately, clarification was provided about the differences between those earlier situations where members may have had to change their prescriptions due to formulary differences and this program which would truly be voluntary for providers to determine whether a prescription would be changed. Further discussion also took place about the State of Delaware's ability to turn this program "On" or "Off" throughout the duration of the CVS contract if member experience wasn't meeting expectations. With this information provided, Subcommittee members remained in support of the SEBC considering the Drug Savings Review Program for FY23, with the additional caveat that monitoring should take place to ensure that the member experience, the provider community's engagement, and the program's first year results are all meeting expectations so that future years of the program could be reevaluated if those expectations are not met.

FINANCIALS – MR. CHRIS GIOVANNELLO, WTW

January Fund Report

The January Fund Report was reviewed. Mr. Giovannello clarified for Mr. Taschner the EGWP revenue items that would no longer be provided if the EGWP plan were to be removed. Overall, for the month of January, revenues came in close to what was expected. January claims ran favorable to budget, $80.5M paid vs $86.3M expected ($5.8M surplus). The January surplus was in part driven by the transition of the EGWP plan from Express Scripts to CVS Health effective 1/1/22, which led to lighter than expected pharmacy invoices during the month. Overall, year to date budget through January is a $35.1M surplus in claims. All in January fund experience generated net income of $2.9M and ending fund equity balance is $167.1M (variance to budget is $31.4M).

FY22 Q2 Financial Report

The quarterly financial report based on claims through December was reviewed; the report analyzes claims through the first six months of the plan year relative to the first six months of the prior fiscal year, and relative to budget. Gross claims for FY22 are trending higher when compared to FY21 (increased 3.7%). The total program cost is roughly flat (increased 0.5%), driven by overall favorable claims experience for the State of Delaware fund as well as increased pharmacy rebates. Per employee and per member per year program cost is down 0.2% and up 0.6% respectively. The FY22 actual experience relative to budget saw a decrease of 8.8% on total program cost and 8.6% on total per employee per year, and this was based on the favorable claims experience through December, as well as timing differences in the Fund and budget amounts relative to the vendor reports used in the quarterly financial report.

Mr. Giovannello pointed out that the loss ratios for Medicare retirees is 78%, for actives is 100%, and non-Medicare retirees is 134%. No concerns based on these ratios as it is typical to see pre-Medicare retirees generate more claims, and the budget rates for Medicare retirees are set higher than the cost of the program, as has been discussed previously with the SEBC.

Based on IBM Watson's quarterly dashboards, there was nothing unusual in the utilization data looking at the most recent 12 months ending December 2021 compared to the prior 12-month period. There are a few items that Mr. Giovannello did mention such as changes in well care and preventative visits (decreased 8.6% for well child and increase of 11.4% for preventative adult visits). Increased screening rates for colon cancer, breast

cancer, cervical cancer, and cholesterol. The State Group Health plan additionally saw an increase in the number of inpatient admissions and an increase in the severity of those admissions, which WTW is continuing to monitor. Pharmacy claims cost increased 7%, and utilization of all prescriptions increased 1.4%. Specialty medications make up 49% of pharmacy spend and saw a 0.9% increase in utilization.

Secretary Magarik queried, when a member is inpatient and utilizes medications dispensed by the hospital, whether that cost is incurred on the medical plan or on the pharmaceutical plan. Mr. Mateja confirmed that it is incurred on the medical plan.

FY23 GHIP Projections

The projections for FY23 have been updated to include $24 million in COVID-19 reimbursement funds. The payment for these claims is expected to be received during FY23 based on claims that were attributable to calendar year 2021. No additional COVID-19 funding relief is reflected in the projections as funding relief would offset COVID-19 related expenses.

Mr. Giovannello made note that the GHIP long-term projections have been updated to reflect all legislation signed into law and initiatives voted on by the SEBC as of February 24th, 2022. GHIP long term health care cost projections for FY23 are reflected with the following legislative impact factored in: Senate Bill 25, which pertains to chiropractor reimbursement not less than Medicare, went into effect January 1, 2022, and has been included in the projections for FY22 with an added cost of $0.5 million in FY22 and FY23. Other legislation either anticipated to be passed or passed with an effective date on or before the end of FY23 are not currently built into the projections. Most notably, Senate Bill 120, the primary care reimbursement bill, which Highmark estimates a fiscal year impact of $4.6M - $29.9M per year for the Highmark population only, is not built into the projections. Aetna has not provided a similar estimate. While these costs are not built into the projections, they should be considered when discussing potential rate action for FY23.

FY22 projection of $30.2 million surplus will be fully depleted during the subsequent plan year, resulting in a $62.7 million deficit projected for FY23. The one-time rate action needed to solve for the $62.7 million deficit in one year would be 8.67%. Smoothing the rate increase over three years to target $0 deficit by the end of FY25 requires an 8.98% annual rate increase in FY23-FY25. Discussion was had on the member impact scenarios tied to each rate action that illustrated the monthly and annual increases by medical plan and coverage tier.

Mr. Taschner asked about the 8.67% rate increase, per Mr. Taschner's analysis and calculation he found that 7.41% rate increase would be the rate action needed to solve for this deficit if the rate changed proportionally with the change in deficit; Mr. Taschner questioned how Mr. Giovannello reached the 8.67% rate increase. Mr. Giovannello responded that the calculation comes down to the subsidization that was previously discussed. The 8.67% rate increase is now based on moving to a Group Medicare Advantage plan and for the first six months of FY23, the State will have the increased subsidization of the current Medicfill rates on the pre-65 and active population rates. Then on January 1, 2023, the subsidization will decrease as the Medicfill rate for medical will convert to the fully insured rate. Historically WTW has not factored in the move to a Group Medicare Advantage Plan and the lost subsidy when presenting the rate increases needed to solve for the projected deficits. Additionally, in the scenarios where Medicfill would be maintained, the Medicfill subsidization would carry forward for the first six months of the fiscal year. Mr. Taschner asked if there is any way that a smoother transition of rates could happen as 7.41% is more favorable than 8.67% from a plan member increase standpoint. Director Cade responded that if the SEBC were just looking at FY23, then they might consider this, but the fact that they are considering the impact of this rate action on future deficits and rate actions makes the decision more complex. Further, there has not been a rate increase since FY17. That's theoretically the concern we run into that whenever we talk about a rate increase, we try to balance that with the impact it will have on employees, in real dollars. Even when we're just looking at this year, we're recommending a significant pay increase for State employees which should absorb a portion of the rate increase. Mr. Taschner acknowledged that he is not opposed to a rate increase as the State of Delaware has had a favorable five-year period and hasn't

raised the rates since FY17. Mr. Taschner indicated he was not convinced that the 8.67% rate increase is what is needed at this point.

Secretary DeMatteis commented that the overall cost of the rate increase to employees, even considering the Governor's proposed salary increases, ranges between $26 and $250 annually. Recognizing that rates are increasing along with inflation driving up all other costs as well, she suggested that the Committee think about the increase in terms of dollar amounts, not just percentages. Mr. Taschner reiterated his understanding that an increase is needed, but again not convinced that an 8.67% rate increase is the right amount. He referenced earlier discussions of potential savings with the SEBC in December 2021 related to the site of steerage in the range of $30-$33M. Mr. Taschner expressed concerns that if this rate increase is to take place, it will take the pressure off the potential to reduce overall plan cost in other potential areas of medical and pharmaceutical spend that would be beneficial to plan participants, the State and Delaware taxpayers. Ultimately, he wanted to focus on solutions that lower the overall cost of the plan rather than jumping to increasing rates by 8.67%.

Secretary Magarik commented that part of the challenge is that many of the other actions the SEBC could take to drive costs down (which they have discussed as a Committee) are many years into the future such as reference-based pricing. While several other measures have been taken, they seem to be largely incremental and don't dramatically affect the trend. Other remaining actions the Committee could take are not things that could be undertaken quickly enough to realize FY23 savings that would warrant putting off a rate increase. She acknowledged that she agreed with Mr. Taschner, that we must continue to put pressure on the vendors and look for ways to reduce overall plan cost because the cost of healthcare inflation is unyielding, but the SEBC also needed to implement a rate increase to solve for the FY23 deficit in the short term.

Director Cade added that the SEBC and its Subcommittees have looked at other cost reduction options at the end of last year, however no other options were enticing either because the effort to make the change wouldn't produce meaningful savings or because there were concerns about disruption to members. He agreed with Secretary Magarik that the conversation about medical cost reductions is one that must continue in the future and those solutions either will not yield immediate savings that would address the deficit in FY23 or FY24 or will produce near-term savings that are negligible. Mr. Taschner responded that he wants the SEBC to start making progress towards evaluating those future opportunities for longer-term savings and noted that even the site of care changes discussed in December could achieve some significant cost savings now if State Group Health Plan could drive the members to a different provider. Mr. Taschner added that, for example, while he understands that not every visit to an emergency room may be appropriate to redirect to an urgent care center, based on data presented at the December Subcommittee meeting, the GHIP could have saved $13.2M in FY21 if emergency room visits were redirected to urgent care, and that savings likely carries through year after year. He questioned what the SEBC needed to do to drive those emergency room visits to urgent care (i.e., those that can be moved into the urgent care setting) and for those non-emergent conditions that do get treated at an emergency care setting, whether there is a significant increase in cost compared to an urgent care setting and why is that. Mr. Taschner ultimately wanted to ensure that the SEBC doesn't lose sight of site-of-care steerage opportunities like that example and ensuring that what whatever the State is paying is the appropriate premium and driving cost down to the extent we can.

As there were no further comments on this topic, the presentation turned to the member impact scenarios associated with an 8.67% increase effective 7/1/2022. This reflects an employee contribution increase ranging between $2.41 - $23.66 per employee per month ($28.92 - $283.92 per year) and State subsidy increases of $57.88 - $156.14 per employee per month ($694.56 - $1,873.68 per year) effective 7/1/2022. The State picks up a much larger piece of this increase, so anytime that the SEBC opts to forego a potential premium increase, it more significantly reduces the revenue input by the State. To Mr. Taschner's point, regarding the dollar difference in the required premium increase after a move to Group MA vs. maintaining Medicfill, the value of the additional Medicfill subsidy is worth about 2% of the overall rate increase, which on the high side is worth about

$65 for an employee with Family coverage in the Comprehensive PPO plan, which is baked into the $283.92 increase.

Also discussed were the current premium rates for Medicfill that would remain in effect through the first six months of FY23, along with the premium rates under the Subcommittees' recommended plan option (Highmark group Medicare Advantage, medical only, retaining the CVS EGWP). With maintaining the EGWP Rx benefit under CVS, the premium rate for drug coverage will maintain some of the Medicfill subsidization that we're seeing happen today since the Rx rate is also higher than the cost of the plan. There would be no change to the structure in terms of how retirees contribute toward that premium. The presentation walked through an example of a pensioner that has retired after July 1, 2012. All Medicfill premium rates would reduce under the new rate structure.

Chief Justice Seitz left the meeting.

OTHER BUSINESS
No new business was presented.

PUBLIC COMMENT
A retiree expressed concern about the GHIP's recent transition to the new PBM. The retiree's specialty medication has been denied for medical necessity when it was previously covered under ESI's formulary. Insurance Commissioner Navarro commented that there is an appeal process through the State that the retiree could consider, and this isn't a challenge with the insurance company per se; rather, it has to do with the drug manufacturer may not be tied to SilverScript. The SBO could assist the retiree with obtaining information about the State's appeal process.

FY23 HEALTH PLAN PREMIUM RECOMMENDATIONS*
Medicare Plan Option – DIRECTOR CADE, CO-CHAIR
Subcommittees recommend moving to Group Medicare Advantage plan (medical only), effective 1/1/2023, administered by Highmark, and to continue offering drug coverage through CVS EGWP.

A MOTION was made by Secretary DeMatteis and seconded by Secretary Magarik to accept the Subcommittees' recommendation for moving to a Group Medicare Advantage plan (medical only), effective 1/1/2023, administered by Highmark, and to continue offering drug coverage through CVS EGWP.

MOTION ADOPTED UNANIMOUSLY
Ashley Tucker is voting on behalf of Chief Justice Seitz.
Keith Warren is voting on behalf of The Lieutenant Governor.

Care Management program decisions – DIRECTOR CADE, CO-CHAIR
HMO and CDH Gold plans: Subcommittees recommend Aetna One Advisor.

A MOTION was made by Secretary Magarik and seconded by Secretary DeMatteis to accept the Subcommittees' recommendation to adopt Aetna One Advisor ("Option 1") for the HMO and CDH Gold plans.

MOTION ADOPTED UNANIMOUSLY
Ashley Tucker is voting on behalf of Chief Justice Seitz.
Keith Warren is voting on behalf of The Lieutenant Governor.

Comprehensive PPO and First State Basic plans: Subcommittees recommend continuing with the Highmark CCMU.

A MOTION was made by Secretary DeMatteis and seconded by Secretary Magarik to accept the Subcommittees' recommendation to continue with the Highmark CCMU for the Comprehensive PPO and First State Basic plans, and in addition to this MOTION Highmark should provide additional transparency into its relationship with its care management partner for the Well360 Clarity care management program, which is not being recommended by the Subcommittees at this time but would potentially be considered in future years.

MOTION ADOPTED UNANIMOUSLY
Ashley Tucker is voting on behalf of Chief Justice Seitz.
Keith Warren is voting on behalf of The Lieutenant Governor.

Aetna HMO – DIRECTOR CADE, CO-CHAIR
Subcommittees recommend retaining the requirement for PCP selection and referrals.

A MOTION was made by Secretary DeMatteis and seconded by Secretary Magarik to accept the Subcommittees' recommendation for retaining the HMO plan's requirement for PCP selection and referrals.

MOTION ADOPTED UNANIMOUSLY
Ashley Tucker is voting on behalf of Chief Justice Seitz.
Keith Warren is voting on behalf of The Lieutenant Governor.

CVS Drug Savings Review Program – DIRECTOR CADE, CO-CHAIR
Subcommittees remain in support of the SEBC considering this program for FY23, but with continued monitoring of the member experience, physician engagement and program results throughout the first year of the program for reconsideration of continuing the program past FY23.

A MOTION was made by Secretary Magarik and seconded by Secretary DeMatteis to accept the Subcommittees' recommendation for adopting this program for FY23, but with continued monitoring of the member experience, physician engagement and program results throughout the first year of the program for reconsideration of continuing the program past FY23.

MOTION ADOPTED UNANIMOUSLY
Ashley Tucker is voting on behalf of Chief Justice Seitz.
Keith Warren is voting on behalf of The Lieutenant Governor.

FY23 Rate Action – DIRECTOR CADE, CO-CHAIR
Financial Subcommittee recommends an 8.67% rate increase effective 7/1/2022 to solve for the projected FY23 deficit of $62.7M

A MOTION was made by Secretary DeMatteis and seconded by Secretary Magarik to accept the Financial Subcommittee's recommendation of an 8.67% rate increase effective 7/1/2022 to solve for the projected FY23 deficit of $62.7M.

MOTION FOR DISCUSSION
Mr. Taschner stated that for the reasons he discussed earlier, he will be voting "No" because he is not convinced that an 8.67% increase is necessary though he does support some level of increase. He also voiced concerns about this being characterized as a "recommendation" from the Subcommittee since as he understood it, there was no vote taken by the Subcommittee but rather a discussion on this topic in which some Subcommittee members acknowledged the necessity of a rate increase, but others did not voice an opinion. He did not believe that there was an affirmative recommendation from the majority of Subcommittee members. Ms. Rentz responded that she has had additional discussions with the majority of Subcommittee members and a number of SEBC members since Thursday's meetings and addressed questions and concerns coming out of those

discussions. Additionally, as the SEBC is aware, the Subcommittees are not voting bodies and only put forth recommendations.

Controller General Jones acknowledged that Mr. Taschner's statement is right, that a large portion of the rate increase is still funded by the General Fund, when we talk about the State's share. Regarding the Governor's Recommended Budget including a one-time amount of $82.8M for the Group Health Insurance Plan, Controller General Jones inquired about the intent of how that funding would be used for the Plan. Director Cade responded that the one-time funding in the Governor's Recommended Budget would not be needed as that was a "worst case scenario" if nothing was solved by the SEBC. The concern, if the SEBC chose against implementing a rate increase in FY23 and tapped into the one-time funding, there would be a larger rate increase required to cover the deficit in FY24. Controller General Jones asked for confirmation that there is nothing in the Governor's Recommended Budget to cover the rate increase, to which Director Cade responded no, this is something that they will need to reconcile during mark-up.

Secretary Magarik indicated that we must be good stewards of taxpayers' dollars, however these scenarios continue to get worse if we don't take a rate action this year. Respectfully, if action is not taken to increase the rates by 8.67% for FY23 and take other actions to solve for savings longer term, the deficit will be dramatically worse in the future. Moving people away from emergency departments is not a quick fix and there are other actions that the SEBC can take. Secretary DeMatteis supports Secretary Magarik's comments and indicated that the deficit has also been mitigated by an influx of federal dollars associated with COVID treatment costs and therefore believes this is a responsible rate increase. Insurance Commissioner Navarro added that no one wants to implement a rate increase, but this action is the prudent thing to do at this point. Mr. Taschner commented that he is not against a rate increase, but not convinced the 8.67% is what is needed. Director Cade responded that at this point the State Group Health plan must act in order to be ready for Open Enrollment but agreed with Mr. Taschner that the rate increase has decreased consistently over the last several financial updates. Secretary DeMatteis added that the recommended salary increase also mitigates the impact of the rate increase, understanding that all costs are going up right now. Treasurer Davis expressed concern that any site of steerage changes must be made carefully to avoid any negative effects on a member's medical needs.

MOTION NOT ADOPTED UNANIMOUSLY – ALL IN FAVOR EXCEPT FOR MR. TASCHNER
Ashley Tucker is voting on behalf of Chief Justice Seitz.
Keith Warren is voting on behalf of The Lieutenant Governor.

ADJOURNMENT
A MOTION was made by Mr. Taschner and seconded by Secretary Magarik to adjourn the Public Session at 4:17 p.m.
MOTION ADOPTED UNANIMOUSLY

Respectfully submitted,

____
Carole Mick, Administrative Specialist III, Statewide Benefits Office, Department of Human Resources
Recorder, State Employee Benefits Committee, and Subcommittees

EFiled: Sep 25 2022 11:00PM EDT
Transaction ID 68158478
Case No. N22C-09-526 CLS

EXHIBIT 4

State Medicare Plan Options Briefing Document – April 25, 2022 SEBC

What did the SEBC approve at the February 28, 2022 Meeting?

The SEBC approved moving the Medicare pensioners to the Highmark Delaware Medicare Advantage Plan effective January 1, 2023. The Medicare Advantage Plan would replace the current Highmark Special Medicfill Medicare Supplement Plan in place through December 31, 2022.

What did the SEBC approve at the March 14, 2022 Meeting?

The SEBC approved rates for the following Medicare pensioner plan options effective January 1, 2023:

- Highmark Delaware Medicare Advantage with CVS/Silverscript Prescription Coverage – monthly premium $216.18
- Highmark Delaware Medicare Advantage without Prescription Coverage – monthly premium $0

These two plan options were proposed to replace the following plan options currently in place through December 31, 2022:

- Highmark Delaware Special Medicfill Medicare Supplement with CVS/Silverscript Prescription Coverage - monthly premium $459.38
- Highmark Delaware Special Medicfill Medicare Supplement without Prescription Coverage – monthly premium $260.44

What is the SEBC being asked with regards to the votes made at the February 28 and March 14, 2022 meetings?

The SEBC is being asked to consider no longer offering a Medicare pensioner plan without prescription coverage.

How many eligible State pensioners are currently enrolled in the Special Medicfill with or without prescription coverage and how many have waived coverage entirely?

OPen reporting reflects:

- 27,526 state pensioners and spouses are enrolled in the Special Medicfill with prescription coverage.
- 689 State pensioners and spouses are enrolled in the Special Medicfill without prescription coverage.
- 5,089 State pensioners and spouses are eligible for State Medicare coverage but are not enrolled.

What are the primary reasons why a state pensioner or spouse, eligible for State Medicare coverage, would not enroll in State Medicare coverage?

- The pensioners or spouse is not enrolled in Medicare Part A and B as required.
- The pensioner or spouse is employed or retired from another employer (other than the State) that offers coverage.
- The pensioner or spouse is not eligible for 100% of State share and the current cost of the State Medicare coverage is unaffordable.
- The pensioner or spouse has opted to purchase another Medicare Part D prescription plan.

Note: Currently, if a state pensioner or spouse enroll in another Medicare plan and are also enrolled in the State Medicare coverage, CMS coordination rules only impact enrollment in the State EGWP plan.

Research by the Statewide Benefits Office (SBO) and Office of Pensions (OPen) to support this request:

- As far back as 2002, the State has continuously offered Medicare Supplement plans with the option of selection with or without prescription coverage. The prescription coverage offered was the same coverage offered to active employees and non-Medicare pensioners.
- Open Enrollment plan booklets indicated the Medicare Supplement without prescription coverage plan option to be available for pensioners and spouses with other Part D prescription coverage.
    - Rates for the option without prescription were significantly less.
    - The without prescription option gave flexibility to State pensioners and spouses to purchase less costly prescription coverage.
    - There were no issues with CMS coordination with the State prescription coverage.
    - The without prescription option was appealing for State pensioners or spouses not receiving 100% of state share for their State Medicare coverage.
- Effective January 1, 2013, the State moved Medicare pensioners selecting the State's prescription coverage plan option to a Medicare Part D Employer Group Waiver plan (EGWP).
    - The EGWP plan allowed the State to obtain significantly more federal funding to offset current Medicare pensioner prescription expenses and reduce the State's unfunded Medicare retiree healthcare liability (aka OPEB).
    - State Medicare pensioners could no longer enroll in the State Medicare Supplement with prescription coverage and also be enrolled in another Medicare Advantage or Medicare Part D prescription plan. CMS rules prohibit enrollment in more than one Medicare plan.
    - During this time the Medicare marketplace was growing and expanding; many employers were moving away from offering any Medicare retiree benefits and directing former employees to purchase Medicare plans in the group and individual marketplace.
    - OPen saw an increase in pensioner coordination of benefits issues due to lack of understanding of various options available and CMS rules regarding Medicare options.
- When the State moves to the Medicare Advantage plan on January 1, 2023, the State for the first time, will offer only Medicare medical and prescription coverage to State pensioners and spouses.
    - Enrollment in any other Medicare medical and/or prescription coverage will impact enrollment in the State Medicare Advantage and Medicare Part D EGWP.
- Medicare pensioners are overwhelmed with marketing and information offering Medicare coverage. OPen expends considerable time and resources in advising State pensioners that they do not need to enroll in any other Medicare coverage, they should only enroll in the State Medicare coverage and in sorting out and correcting inadvertent enrollment and disenrollment caused by pensioners enrolling in multiple Medicare coverages.
- Most State pensioners continue to pay $0 for their Medicare coverage. Only pensioners who retired on or after July 1, 2012, pay a 5% pensioner contribution. Additionally, there are 1,507 Medicare pensioners enrolled and responsible for a portion of state share.
- OPen cannot quantify but believes there are a significant number of State pensioners and spouses enrolled in the State Medicare coverage without prescription simply because there is no cost to the pensioner; however, they are not actually using the benefit.
    - Using the IBM Watson database, SBO will provide the average per member per month medical costs for pensioners and spouses enrolled in the two current plan options for the last 3 plan years. This information will be presented at the April 25, 2022 SEBC meeting.

- OPen pays to the GHIP, monthly premiums for pensioners enrolled in the State Special Medicfill plan with or without prescription, regardless of whether the pensioner actually uses the benefit. OPen projects to pay $1.9M to the GHIP in FY22 for the 689 pensioners enrolled in the Special Medicfill without prescription plan.
- OPen and SBO predict that the significant reduction in the State Medicare plan rates effective January 1, 2023, will prompt State pensioners and spouses:
    - who are not currently enrolled or who are only enrolled in the Special Medicfill without prescription coverage to enroll in the State Medicare Advantage with prescription plan.
    - to consider choosing the State Medicare Advantage plan without prescription option if they have had a negative experience with the State transition of the Medicare Part D EGWP plan to CVS/Silverscript.
- Reducing the State Medicare plan options to only the Medicare Advantage plan with prescription coverage will reduce the State pensioner or spouse enrollment options through the State which will enable OPen to focus resources on:
    - Researching CMS reporting detailing State pensioners and spouses who have been disenrolled in the State Medicare coverage due to other Medicare coverage.
    - Outreaching to State pensioners and spouses who opt out of the State Medicare coverage to verify their understanding of the implications, confirm their intent to maintain other Medicare coverage or correct inadvertent disenrollment from the State Medicare coverage.

Next Steps:

- SBO requests input and questions from the SEBC related to the request to consider no longer offering a Medicare pensioner plan without prescription coverage effective January 1, 2023.
- The State Medicare Open Enrollment for the January 1, 2023 plan year has been tentatively set for October 3 – 24, 2022.
    - CMS requires a 21-day minimum enrollment period.
    - OPen will proactively work with Highmark, CVS/Silverscript and eligible State Medicare pensioners between the end of Open Enrollment and the plan year start date to address and correct errors in enrollment/disenrollment in State or other Medicare coverage.

EFiled: Sep 25 2022 11:00PM EDT
Transaction ID 68158478
Case No. N22C-09-526 CLS

EXHIBIT 5

AGENDA
STATE EMPLOYEE BENEFITS COMMITTEE MEETING
February 28, 2022 – 2:00 pm

Until further notice, in the interests of protecting the citizens of this State from the public health threat caused by COVID-19, all State Employee Benefits Committee meetings will continue to be conducted virtually without a physical location. Members of the public may participate virtually or by phone using the information provided. Meeting materials will be posted in advance on the Public Meeting Calendar and the SEBC webpage.

https://www.webex.com/
Meeting number (access code): 2690 883 8132 Meeting Password: SEBC
or Join by Phone Toll Free: 1-866-205-5379

1. Call to Order

2. Approval of January 24, 2022 SEBC meeting minutes*

3. Director's Report/Subcommittee/Legislative Updates

4. 2021 Health Third Party Administrative Services RFP Award Recommendations*

   a. Active/non-Medicare Care Management Programs
   b. Aetna HMO Model
   c. Medicare Plan Effective January 1, 2023

5. CVS Drug Savings Review Recommendation*

6. Financials

   a. January 2022 Fund Report
   b. FY22 Qtr 2 Financial Reporting
   c. FY23 GHIP Projections

7. FY23 Health Plan Premium Recommendations*

8. Other Business

9. Public Comment

10. Adjournment

Visit the SEBC website at dhr.delaware.gov/benefits/sebc for further details. Meeting materials are posted after each meeting.

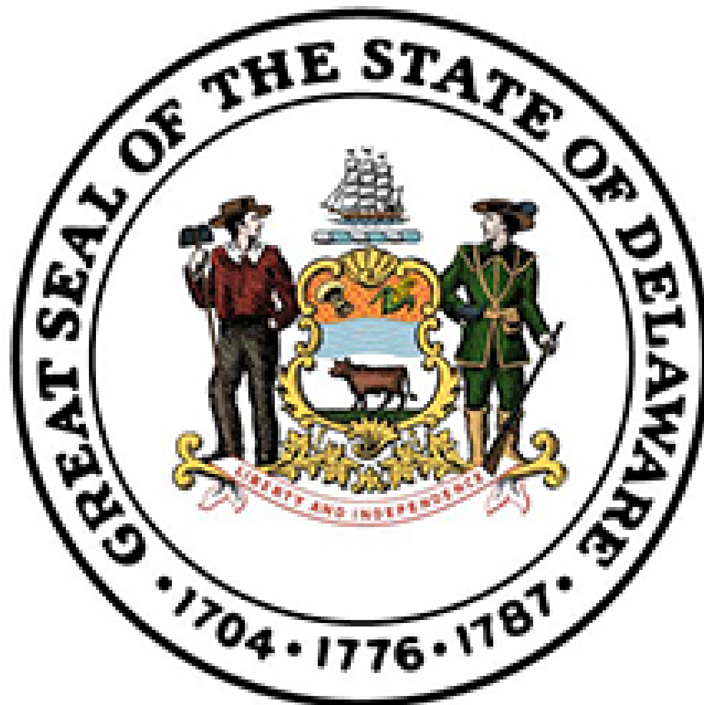
***Agenda items may require action and approval by the Committee.**
The Committee may move into Executive Session for the purpose of discussing confidential financial information and trade secrets or the content of documents excluded from the public record pursuant to 29 Del.C. §10004(b)(6), and to receive legal advice pursuant to 29 Del.C. §10004(b)(4) relating to pending or potential litigation. The Committee may move into Executive Session for one or more of these reasons.

EFiled: Sep 25 2022 11:00PM EDT
Transaction ID 68158478
Case No. N22C-09-526 CLS

EXHIBIT 6

Initial Report on Other Post-Employment Benefits (OPEB)

Retirement Benefits Study Committee



November 1, 2021

STATE OF DELAWARE
RETIREMENT BENEFITS STUDY COMMITTEE
PURSUANT TO EXECUTIVE ORDER 51

To: The Honorable John C. Carney, Jr., Governor
Members of the Delaware General Assembly
Members of the Delaware Economic and Financial Advisory Council (DEFAC)

From: Rick Geisenberger, Chair and Secretary of Finance
Cerron Cade, Vice Chair and Director of the Office of Management and Budget

RE: RBSC Initial Report (November 1, 2021)

The Retirement Benefits Study Committee (the "Committee") was established by Governor Carney in September 2019 and charged with studying options for reducing Delaware's unfunded liability for retiree health care benefits, also known as Other Post-Employment Benefits (OPEB).

The attached report is broken into four sections – Summary of Activity, Findings, Principles for Reform, and Recommendations. The Committee has held nine (9) public meetings. The Committee determined that pay-as-you-go costs of State retiree health care benefits are expected to continue to grow dramatically, placing stress on Delaware's state budget and credit rating. Delaware's retiree healthcare benefits and subsidies are higher than average, the State's OPEB liability relative to key metrics is materially higher than all other Triple-A rated states, and the State's OPEB liability will balloon to more than $36 billion by 2050 if no changes are made.

The Committee agreed on key Principles for Reform. For example, any reforms should provide retiree health care benefits for career employees that are affordable to the retiree, comparable to those offered by similar government employers, and can be sustainably maintained within the means of the State and its taxpayers, without placing pressure on public services or the State's financial strength and credit worthiness.

The Committee found that a combination of enhanced funding and benefit reforms provides the most effective reductions in future unfunded OPEB liability. The report makes specific recommendations to increase the OPEB Trust Fund and outlines several benefit reform ideas for continuing review by the Committee with an eye toward implementation in 2024 or thereafter.

The Committee will continue its work and will advance further detailed recommendations and implementation guidance in a subsequent report due March 31, 2022. A copy of this report and all materials reviewed by the Committee are available at:

https://finance.delaware.gov/financial-reports/committee-reports/retirement-benefit-study-committee/

CARVEL STATE OFFICE BUILDING, 820 N. FRENCH ST., 8TH FLOOR, WILMINGTON, DE 19801
TELEPHONE: (302)577-8979

RBSC Initial Report
Findings and Recommendations

November 1, 2021

Report Background

The Retirement Benefits Study Committee (RBSC, the Committee) was established and resumed by the following authority:

Executive Order 34, signed by Governor John Carney on September 13, 2019

Executive Order 51, signed by Governor John Carney on July 21, 2021

This report of findings and recommendations has been prepared for Governor Carney, the Delaware General Assembly and the Delaware Economic and Financial Advisory Council (DEFAC) in accordance with Executive Orders Number 34 and 51, which re-established the RBSC.

The Committee was charged with studying options for reducing the unfunded liability for Other Post-Employment Benefits (OPEB) and making recommendations to the Governor, General Assembly and DEFAC. This report fulfills the requirement to provide a report by November 2021. Subsequent reports are due in March 2022 and 2023.

Committee Membership

Rick Geisenberger, Chair and Secretary of Finance
Cerron Cade, Director of the Office of Management and Budget

Ruth Ann Jones, Controller General

Joanna Adams, Director of the State Office of Pensions

Faith Rentz, Director of the Office of Statewide Benefits and Insurance Coverage

Colleen Davis, State Treasurer

Rep. John L. Mitchell, appointed by the Speaker of the House of Representatives

Rep. Ruth Briggs-King, appointed by the Minority Leader of the House of Representatives

Sen. Trey Paradee, appointed by the President Pro Tempore of the Senate

Sen. David Lawson, appointed by the Minority Leader of the Senate

Michael Begatto, Executive Director, AFSCME, Council 81, appointed by the Director of the Office of Management and Budget

Jeff Taschner, Executive Director, Delaware State Education Association, appointed by the Director of the Office of Management and Budget

Aaron Klein, Chief Accounting Officer, Marlette Funding, appointed by the Secretary of Finance in consultation with the Delaware State Chamber of Commerce

Summary of Committee Activity

The Committee met nine times between September, 2019 and October, 2021 and reviewed over 300 pages of materials in addition to past reports, appendices, and actuarial and financial data. Materials were prepared by staff and the State's consultants including benefits consultant Willis Towers Watson, plan actuary Cheiron, and financial advisor PFM. The data reviewed has included:

- Plan benefits, statutory and administrative
- Plan actuarial information
- Plan demographics
- Medical benefit budgetary trends
- Bond rating agency assessments
- Comparative OPEB financial benchmarking
- Comparative OPEB benefits benchmarking
- Plan options
- Actuarial estimates of plan options
- Illustrative retiree impacts of potential changes
- Implementation considerations for plan options

The materials reviewed by the Committee and meeting minutes are available in full at: https://finance.delaware.gov/financial-reports/committee-reports/retirement-benefit-study-committee/

Summary of Committee Findings

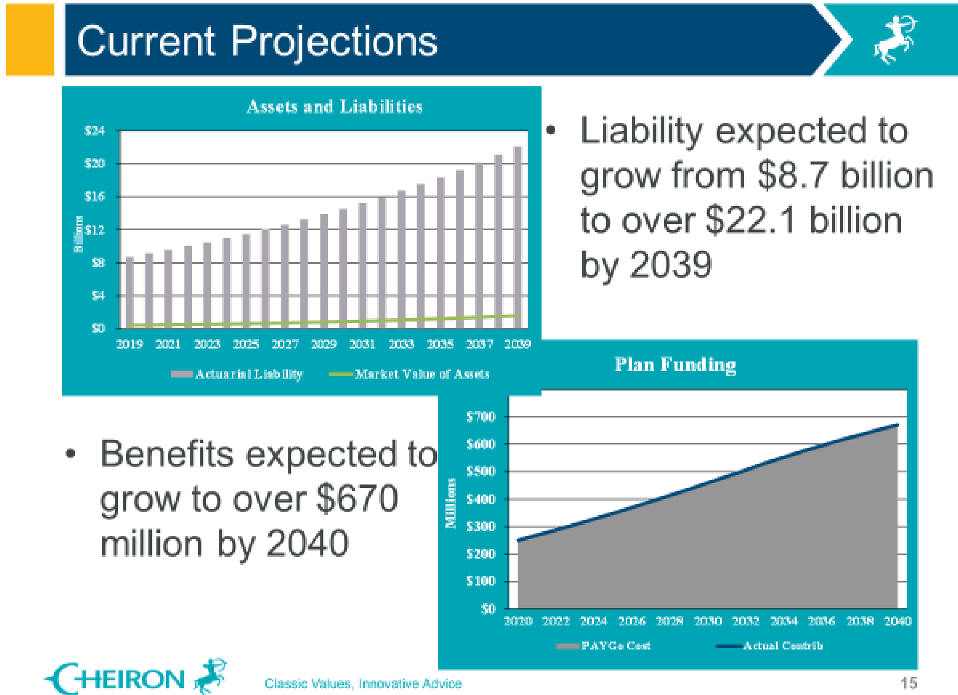
Key representative findings from the materials reviewed include:

1. A large and growing number of former State employees, and their spouses and beneficiaries, receive and rely upon OPEB benefits.

	2019	2020
Retirees, Beneficiaries and Spouses with Coverage	31,861	32,352

Source: 12/10/2019 and 7/26/21 presentations

2. The pay-as-you-go cost of retiree medical benefits has increased significantly and is projected to continue to grow much faster than inflation. The liability for OPEB is also projected to continue to grow dramatically, placing stress on the State's net position and financials.



Source: 11/12/19 presentation

3. At June 30, 2020, 19 percent of members receiving OPEB benefits were under age 65, but 30 percent of the liability was attributable to the cost of pre-Medicare coverage.

Key Results – State OPEB

Eligible Participants are those active employees or terminated vested in the State, Judges, or State Police Retirement Plans. Inactive participants are retirees, disableds, spouses, and surviving spouses with medical coverage.

	2019	2020 Total	2020 Pre-Medicare	2020 Medicare
Actives Actuarial Liability (AL)	$4,475	$ 5,179	$ 2,055	$3,124
Inactive AL	$4,255	$ 4,698	$931	$3,766
Total AL *(in millions)*	$8,730	$ 9,877	$ 2,987	$ 6,890
Market Value of Assets (MVA)	$410	$ 464		
UAL (Total AL – MVA) *(in millions)*	**$ 8,320**	**$ 9,413**		
MVA Funded Ratio (MVA/AL)	**4.7%**	**4.7%**		
Eligible Participant Counts*				
Active	38,497	39,308		
Terminated Vested	3,907	3,959		
Inactive	31,861	32,352		
Total	**74,265**	**75,619**		

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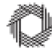
Slide content developed by Cheiron

Source: 7/26/21 presentation

4. Delaware's debt is rated AAA by the major bond rating agencies, the highest rating available. The State's net OPEB liability is significantly larger than other AAA-rated and regional states relative to key metrics such as state population, personal income, and gross state product.



AAA-Rated States: OPEB Funding Context

State	Moody's Adjusted Net OPEB Liability (ANOL) Per Capita FY2018	Moody's Adjusted Net OPEB Liability (ANOL) as a % of Personal Income FY2018	Moody's Adjusted Net OPEB Liability (ANOL) as a % of State GDP FY2018
DE	$7,450	14.5%	9.6%
TX	$2,515	5.1%	4.1%
MD	$1,774	2.8%	2.6%
GA	$747	1.6%	1.3%
VA	$727	1.2%	1.0%
MO	$634	1.4%	1.2%
SC	$529	1.2%	1.2%
FL	$352	0.7%	0.7%
TN	$225	0.5%	0.4%
MN	$109	0.2%	0.2%
IN	$70	0.1%	0.1%
IA	$58	0.1%	0.1%
UT	$31	0.1%	0.1%
SD	$0 (no employer funded OPEB)	--	--

Sources: Moody's Investors Service, "Medians – Adjusted net pension liabilities decline; OPEB liabilities vary widely," September 2019.

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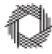
Source: 11/12/19 presentation

5. A majority of the AAA-rated states either do not provide any access to coverage for new hires, or provide access-only with no employer subsidy.



AAA-Rated States: Structure and Liability Management

No OPEB (All Retirees)	No OPEB (New Hires)	Retirees Pay 100% of Blended Premium (Implicit Subsidy)	Other Retiree Premium Cost Sharing Structures
SD	**TN** closed to new hires 7/1/2015 **UT** Closed to new hires 1/1/2006	FL IN IA MO MN	**GA** For individual coverage, retirees contribute 100% if <10 years of service (YOS); declining incrementally to a minimum of 25% with 30 YOS; for dependent, retirees contribute a minimum of 45% up to 100%, depending on YOS (increased from approx. 25% for all prior to 2012) **SC** Retirees hired since 2008 to contribute 50% of premium if 15-24 YOS, no contribution if 25 or more YOS (pre-2018 hires eligible after 10 YOS) **TX** Future retirees with <5 YOS as of 9/1/2014 to contribute 50% of premium if <15 YOS at retirement, 25% if 15-19 YOS, no contribution if 20+ YOS. Retirees pay 100% of dental. Grandfathered retirees have no medical contribution.

Notes:

- South Dakota had an implicit subsidy until 2014 adjustments shifted all retirees into a separately rated plan.
- Utah coverage for grandfathered employees is based on conversion of accrued, unused sick leave on retirement.
- Indiana has a defined contribution benefit that can be used to offset cost of 100% premium. State contributes $500-$1,400 to an employees account annually, with the amount varying by age, plus a larger one-time amount on retirement ($1,000*YOS) if minimum YOOS eligibility requirements are met.
- Tennessee hires prior to 2015 retiring from the State with 30 YOS to receive $50 subsidy per month; 20-29 YOS, $37.50; and 15-19 YOS, $25; retired teachers contribute 40% if <20 YOS, 30% if 20-29 YOS, 20% if 30+ YOS

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Sources: Review of states' respective annual CAFRs; The Pew Charitable Trusts' 50-State Survey of Retiree Health Care Liabilities - December 2018; The Pew Charitable Trusts' State Retiree Health Care Liabilities - May 2016; NASRA 2019 State OPEB Plan Design Summary; Moody's 9/17/19 Medians - Adjusted net pension liabilities decline; OPEB liabilities vary widely; National Conference of State Legislators 2010 and 2013 Pension and Retirement Plan Enactments in 2010 State Legislatures.

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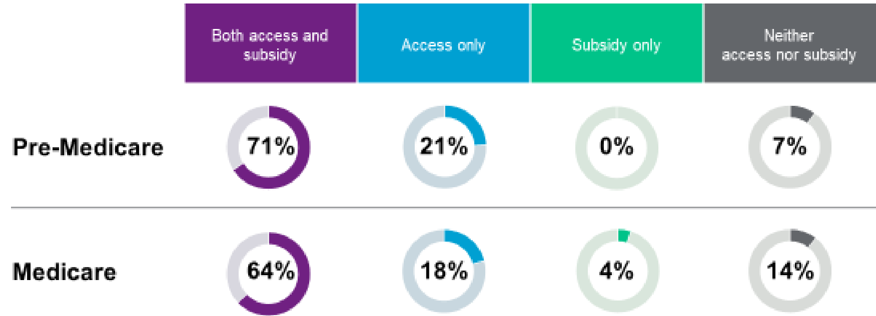
Source: 11/12/19 presentation

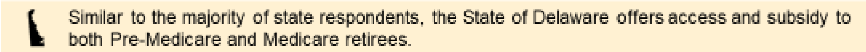
6. A survey of 27 responding state governments found that a majority do offer access and employer subsidies for pre-Medicare and Medicare-eligible retirees, similar to Delaware. However, roughly 30 percent do not subsidize retiree healthcare.

Access and/or subsidization of retiree medical programs

All States (including those not offering retiree medical)

Does your State provide access to coverage and/or financial support through an employer-sponsored plan or an exchange to pre-Medicare and/or Medicare retirees?





Similar to the majority of state respondents, the State of Delaware offers access and subsidy to both Pre-Medicare and Medicare retirees.

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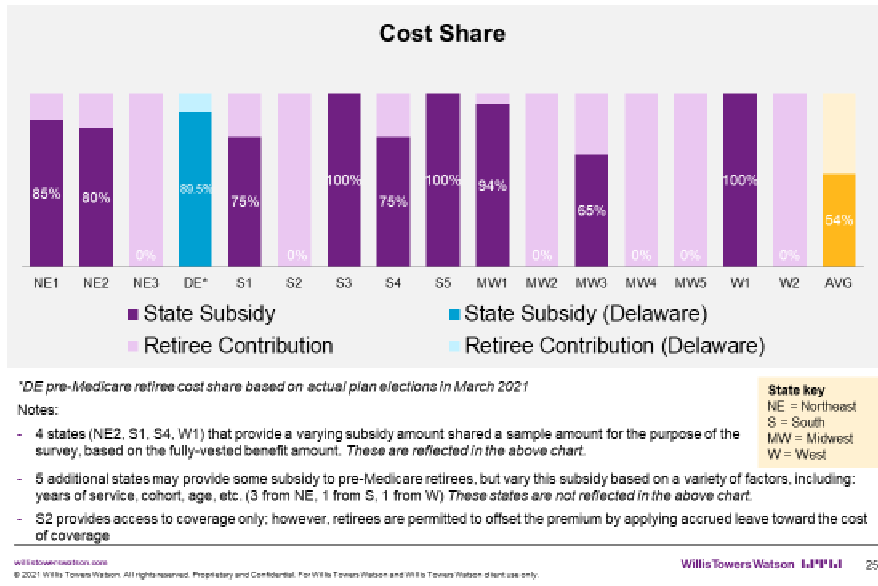
Source: 7/6/21 presentation

7. Among the state survey respondents that do subsidize retiree medical benefits, the State of Delaware employer subsidy was higher than the average on a percentage basis for both pre-Medicare and Medicare coverage.

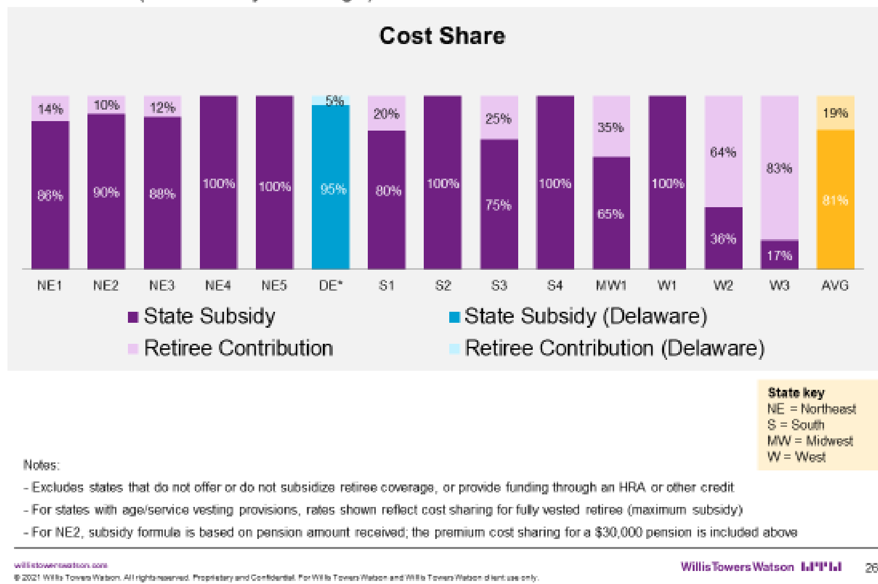
Pre-Medicare retiree subsidy

Cost share (retiree only coverage, for fully-vested retirees)



Medicare-eligible retiree subsidy

Cost share (retiree only coverage)



Source: 7/6/21 presentation

8. A number of benefit reform options would result in cost savings and reduction in liability including several options with minimal or modest impacts on retirees and members.

Presented to RBSC on March 9, 2020

Actuarial Value of Options Previously Explored

Scenario Label	Description	Immediate OPEB Liability Reduction	OPEB Liability Reduction Over 30 Years	Retiree/Member Impact
HRA (2% Increase)	Delaware eliminates Medicfill coverage and moves to individual marketplace structure – retirees receive annual HRA to purchase individual coverage comparable to the value of subsidy received by State of Delaware currently, *with 2% annual increase* to HRA amount provided in future years	$2.4b	$22.0b	● (green)
Active Spouses	Delaware reduces spousal subsidy by 50% for future retirees; no impact to current spouses of retirees	$0.9b	$5.9b	● (yellow)
Eligibility of State Share Schedule C	State Share eligibility schedule for those hired since 1/2007 to 20 years = 50%, 25 years = 75% and 30 years = 100%	$0.5b	$9.6b	● (yellow)
Eliminate Term Deferred Vested Benefits B	Effective 7/1/2020 future terminated vested participants would not have access to any state health benefits, those that are already terminated could still come back and have access to healthcare	$0.0b	$1.4b	● (green)
Set Minimum Age for healthcare	Minimum age to start healthcare would be age 60 for State Employees and Judges but Public Safety would be age 55	$0.7b	$6.8b	● (yellow)
Combination starting 1/1/2021*	-$5,100 HRA for Medicare retirees with 2% inflation -Vesting schedule C -Future Retiree Spouses would receive 50% of benefit -Eliminate Term Vested Benefits B -Minimum age for healthcare (60 and 55 for public safety) *with 0.5% funding	$3.75b	$28.4b	● ● (yellow, green)

Note: Health Reimbursement Arrangement (HRA) is a tax-free account that can be used to pay premiums for Medicare Parts A, B and D, Medicare Advantage plan and/or supplemental plan, as well as qualified out-of-pocket expenses (deductibles, copays, etc.)

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● Minimal negative impact ● Modest negative impact ● Significant negative impact

Source: 7/6/21 presentation

9. The survey findings indicate that benefit provisions would remain within typical ranges if reform options were implemented as considered in Delaware. Such options would require legislative action.

Revisiting Options with Updated Benchmarking and Market Data

	Prior and New Considerations	Benchmarking Results*	Requires legislative change?
Establish minimum age for eligibility	Previously evaluated (age 60 for State Employees and Judges but Public Safety would be age 55)	65% of states have a minimum age requirement (age 55 most common)	Y
State Share vesting schedule	Several options previously evaluated to increase years of service requirements for State Share schedule	74% of states have eligibility and/or subsidy provisions that vary by YOS, but provisions vary widely	Y
Reduce spouse subsidy by 50%	Previously evaluated for current and/or future retirees	Of those states that provide a subsidized benefit to retirees, half provide the same level of subsidy to retiree and spouses	Y
Eliminate Term Deferred Vested Benefits	Previously evaluated eliminating benefits for this group	50% of states allow deferred term-vesting, including most states surrounding Delaware	Y
Health Reimbursement Arrangement (HRA)	Previously evaluated with Individual Marketplace, with and without index; retirees can buy up/down for preferred coverage and accumulate savings for future years HRA could be offered with employer sponsored coverage – but given limited plan choice, administrative burden may outweigh benefits	4 states offer HRA with Individual Marketplace connector as only option, and 1 state offers as a choice No states offer retiree HRA with employer sponsored coverage	Y
★ Group Medicare Advantage (Group MA)	Last evaluated as part of 2016 Medical TPA RFP and did not yield material cost savings vs. current Medicfill. Since 2016, evolving MA market in Delaware may yield competitive carrier proposals for comparable level of medical coverage; Group MA proposals were solicited as part of 2021 Medical TPA RFP as a potential interim solution	24% of states offer Group MA options only, and 31% offer choice of Group MA and Medicare Supplement options	Y

★ New option for evaluation

*Based on 27 state respondents as of Sept 2020 (see full report for more details)

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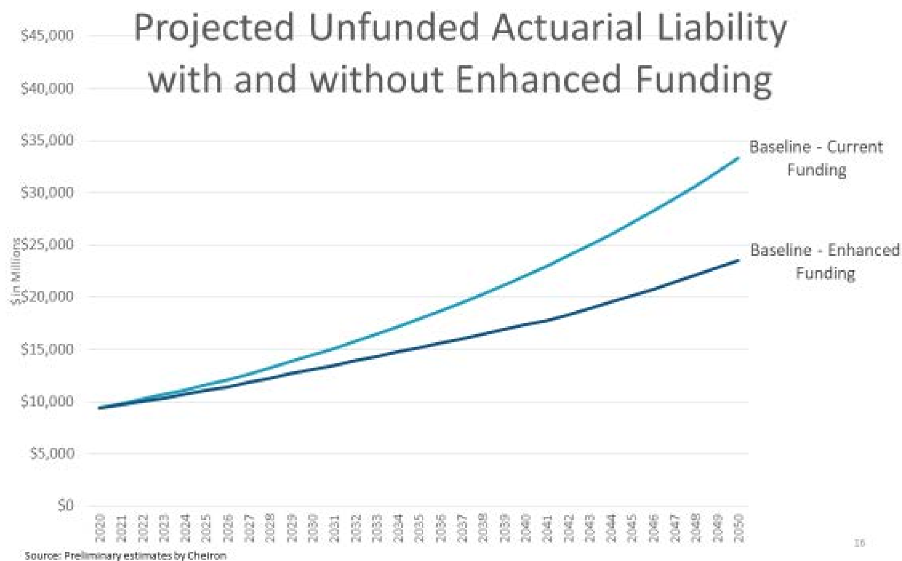
Source: 7/6/21 presentation

10. Increasing the OPEB Trust Fund pre-funding by a recurring contribution equal to roughly 1% of the State's operating budget would reduce the growth of the State's unfunded liability long-term, but the unfunded liability would continue to grow and remain substantial, absent benefit reforms.



Source: 8/30/21 presentation

11. Implementation of individual benefit eligibility reform options would also not prevent the total and unfunded liability from increasing. Combinations of enhanced funding and benefit reform would provide the most effective reductions in future unfunded liability.

Combinations of Benefit Modifications and Additional Funding Significantly Reduce OPEB Net Liability

		2050 Projection					
		Total Benefits	ADC	Accrued Liabilities	Trust Assets	Funded Ratio	Discount Rate
Current Funding	Baseline	$787	$2,486	$36,876	$3,535	9.6%	2.2%
	Eliminate Future Terminated Vesteds	$743	$2,383	$35,369	$3,535	10.0%	2.2%
	Graduated State Share Based on YOS	$787	$2,084	$31,326	$3,535	11.3%	2.2%
	Minimum Required Age 60/55	$690	$2,078	$31,866	$3,535	11.1%	2.2%
	HRA (2% Increase)	$566	$1,105	$16,963	$3,535	20.8%	2.2%
	Reduce Spousal Subsidy for Future Retirees	$681	$2,070	$31,626	$3,535	11.5%	2.2%
	Combination	$379	$636	$10,586	$3,535	33.4%	2.2%
$0 million/$47 million Funding	Baseline	$787	$2,024	$33,424	$9,917	29.7%	3.0%
	Eliminate Future Terminated Vesteds	$743	$1,880	$31,451	$9,917	31.5%	3.1%
	Graduated State Share Based on YOS	$787	$788	$17,185	$9,917	57.7%	7.0%
	Minimum Required Age 60/55	$690	$746	$16,831	$9,917	58.9%	7.0%
	HRA (2% Increase)	$566	$337	$11,055	$9,917	89.7%	7.0%
	Reduce Spousal Subsidy for Future Retirees	$681	$773	$16,882	$9,917	58.7%	7.0%
	Combination	$379	$142	$5,859	$5,670	96.8%	7.0%
	Group Medicare Advantage w EGWP for Rx	$712	$1,652	$28,027	$9,917	35.4%	3.3%

Source: Preliminary estimates by Cheiron

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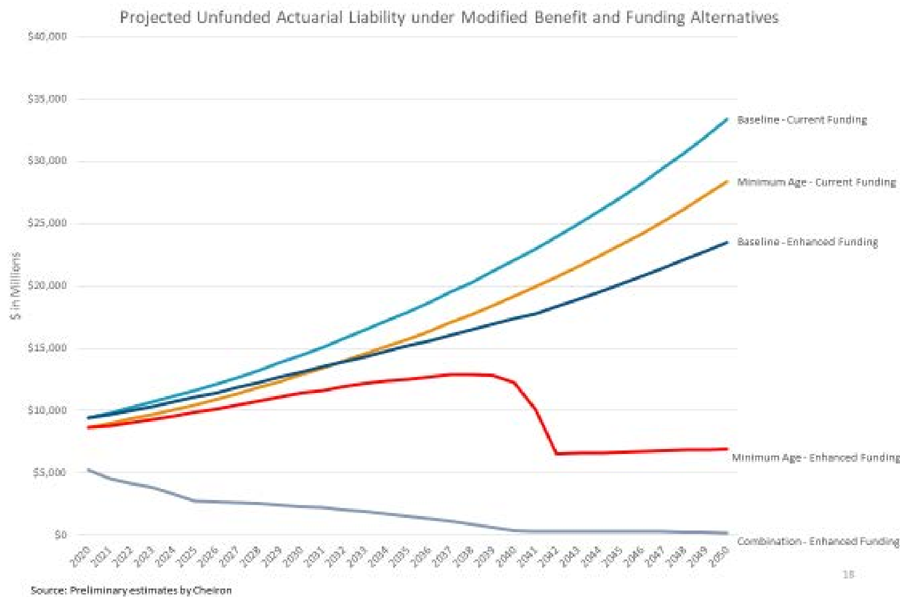
Combination of Benefit Modifications and Additional Funding Significantly Reduce OPEB Net Liability



Source: 8/30/21 presentation

Committee Principles for Reform

Based on the findings and plan options reviewed and the Committee's discussions, the following principles were developed:

I. Provide retiree health care benefits for career employees that are affordable to the retiree, comparable to those offered by similar government employers, and can be sustainably maintained within the long-term resources made available to the State by its taxpayers, without placing pressure on public services or the state's financial strength and creditworthiness.

II. Preserve benefit eligibility and comparable level of coverage for career employees that have already retired or are near retirement.

III. Provide a benefit that is transparent, understandable, predictable, and accessible.

IV. Provide quality customer service and education to assist retirees with structural changes or transitions.

V. Implement steps to reduce the unfunded OPEB liability through a combination of enhanced recurring funding above pay-go funding, benefit reforms, and increases in the actuarial discount rate as a result of such changes. The magnitude of benefit savings generated by reform should be of at least equal magnitude to enhanced funding within an actionable timeframe, e.g., within five to ten years of adopting reforms.

VI. Transition OPEB funding from pay-go funding to the pension funding model, which uses current taxpayer resources to pre-fund future liabilities as they are earned by employees, by enhancing the current budgetary pre-funding of 0.36% of payroll. Possible mechanisms would include an OPEB Trust Fund Carveout from the Budget Benchmark Appropriation and Index structure, and/ or a gradual scheduled increase in the percentage of payroll pre-funding amount, within actuarially determined levels.

VII. Target benefit reforms to be as minimally disruptive to career employees as possible, and to balance expected savings equitably in proportion to the costs and liabilities generated by retirees receiving pre-Medicare and Medicare medical benefits.

VIII. Through the combination of principles above, demonstrate meaningful improvement by reaching an actuarial funded ratio of OPEB liabilities of at least 60% by 2050, including funding 100% of the Actuarially Determined Contribution (ADC), and demonstrate interim progress toward that objective by reaching an actuarial funded ratio of at least 10% by 2033, and 50% of the ADC.

IX. Evaluate the current benefit and premium-sharing structure to identify opportunities to bring cost growth in line with inflation by introducing consumer choice and plan flexibility. This potentially includes such mechanisms as: providing retirees an indexed employer contribution to purchase coverage, such as in the individual Medicare marketplace; or, changing the statutory premium-sharing formula from a structure that defines and limits retiree contributions to one that limits employer contributions within fixed ranges as a percent of payroll, and requires changes in benefits and/ or retiree contributions when the ranges are exceeded.

X. Benefit reforms that would impact eligibility of active or future employees should be evaluated within the context of overall employee compensation and consider trends in salaries and other compensation.

Committee Recommendations

The Committee reviewed and discussed numerous options, many of which merit further study but require further analysis, documentation and data from the market before they are ripe for action by the Governor and General Assembly. At this time, in meeting the timeframe required by Executive Order 51, the Committee is prepared to recommend the following:

I. Transition OPEB funding from pay-go to pre-funding to reduce the unfunded liability over time, through the following mechanisms:

   a. A substantial increase in recurring funding by adopting an OPEB Trust Fund Carveout from the Budget Benchmark Appropriation and Index structure. The structure reviewed by the Committee consisted of a set-aside from available extraordinary revenues in a fiscal year equal to 1% of the operating budget.

   b. Increasing the OPEB Fund payroll rate adopted in the annual Budget Bill from the current 0.36% to an amount that provides a more material increase in Fund assets over time. This could be accomplished by maintaining the overall benefits payroll rate for FY22, 22.80% of payroll (inclusive of the pension liability, retiree health insurance costs, and OPEB fund), as a floor, such that any decreases in individual portions of the rate such as the pension rate would result in a corresponding increase to the OPEB Fund rate. Note that the FY20 gap between the actuarial expense of OPEB and the pay-go contribution plus the 0.36% pre-funding was equal to 15.34% of payroll, at the pay-go discount rate of 2.21%.

   c. Provide additional one-time contributions when circumstances such as one-time revenues or surpluses permit, similar to Section 16 (Escheat – Special Funds) of the FY 2022 Bond and Capital Improvement Act (SB 200).

II. 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.

c. Reduce the State share/ subsidy for spouses of retirees from 100% to 50% for future retirees after a certain effective date, for those that have not reached retirement eligibility status.

d. Modify the eligibility schedule for State share/ subsidy for those hired since 1/2007 to 20 years of service = 50%, 25 years = 75% and 30 years = 100%, after a certain effective date.

e. Establish a minimum age to enroll on the retiree medical plan of 60 for State Employees and 55 for employees subject to a mandatory retirement age, providing a deferred benefit for those that retire prior to the minimum. This would apply after a certain effective date, for those that have not reached retirement eligibility status.

f. Eliminate the ability to access retiree medical benefits for vested employees that terminate their State service without filing with the Pension Office for retirement. This would apply to employees that terminate after a certain effective date, and require employees in the future to retire from State service in order to receive the retiree medical benefit.

III. Advance further detailed recommendations and implementation guidance in the additional report required by March 31, 2022, under Executive Order 51. Based on Principle VII above, it is anticipated that detailed recommendations would include Recommendations I and II.a above, along with one or two options from among II.b-f.

SUPERIOR COURT
CIVIL CASE INFORMATION STATEMENT (CIS)

EFiled: Sep 25 2022 11:00PM EDT
Transaction ID 68158478
Case No. N22C-09-526 CLS

COUNTY: N CIVIL ACTION NUMBER:

Caption:

RISEDELAWARE INC.; KAREN PETERSON; and THOMAS PENOZA,
Plaintiffs,

vs

SECRETARY CLAIRE DEMATTEIS; DIRECTOR CERRON CADE; DELAWARE DEPARTMENT OF HUMAN RESOURCES; DELAWARE STATE EMPLOYEE BENEFITS COMMITTEE; and DELAWARE DIVISION OF STATEWIDE BENEFITS
Defendants.

Civil Case Code: CDEJ

Civil Case Type: Declaratory Judgment
(SEE REVERSE SIDE FOR CODE AND TYPE)

MANDATORY NON-BINDING ARBITRATION (MNA) ______

Name and Status of Party filing document:
RISEDELAWARE INC.; KAREN PETERSON; and THOMAS PENOZA, Plaintiffs

Document Type:(E.G.; COMPLAINT; ANSWER WITH COUNTERCLAIM)

Complaint

JURY DEMAND: YES ____ NO X

ATTORNEY NAME(S):
David A. Felice

ATTORNEY ID(S):
#4090

FIRM NAME:
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IDENTIFY ANY RELATED CASES NOW PENDING IN THE SUPERIOR COURT OR ANY RELATED CASES THAT HAVE BEEN CLOSED IN THIS COURT WITHIN THE LAST TWO YEARS BY CAPTION AND CIVIL ACTION NUMBER INCLUDING JUDGE'S INITIALS:

None

EXPLAIN THE RELATIONSHIP(S):

N/A

OTHER UNUSUAL ISSUES THAT AFFECT CASE MANAGEMENT:

Plaintiffs seek expedited treatment and a stay of the Department of Human Resources' Medicare Advantage decision that may be implemented as early as October 3, 2022

(IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH PAGE)

THE PROTHONOTARY WILL NOT PROCESS THE COMPLAINT, ANSWER, OR FIRST RESPONSIVE PLEADING IN THIS MATTER FOR SERVICE UNTIL THE CASE INFORMATION STATEMENT (CIS) IS FILED. THE FAILURE TO FILE THE CIS AND HAVE THE PLEADING PROCESSED FOR SERVICE MAY RESULT IN THE DISMISSAL OF THE COMPLAINT OR MAY RESULT IN THE ANSWER OR FIRST RESPONSIVE PLEADING BEING STRICKEN.

SUPERIOR COURT CIVIL CASE INFORMATION STATEMENT (CIS) INSTRUCTIONS

CIVIL CASE TYPE

Please select the appropriate civil case code and case type (e.g., **CODE** - **AADM** and **TYPE** - **Administrative Agency**) from the list below. Enter this information in the designated spaces on the Case Information Statement.

APPEALS
AADM - Administrative Agency
ACER - Certiorari
ACCP - Court of Common Pleas
AIAB - Industrial Accident Board
APSC - Public Service Commission
AUIB - Unemployment Insurance Appeal Board

COMPLAINTS
CABT – Abatement
CASB – Asbestos
CAAA - Auto Arb Appeal
CMIS - Civil Miscellaneous
CACT - Class Action
CCON – Condemnation
CCLD – Complex Commercial Litigation Division **(NCC ONLY)**
CDBT - Debt/Breach of Contract
CDEJ - Declaratory Judgment
CDEF - Defamation
CEJM - Ejectment
CATT - Foreign & Domestic Attachment
CFJG - Foreign Judgment
CFRD - Fraud Enforcement
CINT - Interpleader
CLEM - Lemon Law
CLIB - Libel
CMAL - Malpractice
CMED - Medical Malpractice
CPIN - Personal Injury
CPIA - Personal Injury Auto
CPRL - Products Liability
CPRD - Property Damage
CRPV - Replevin
CSPD - Summary Proceedings Dispute
CCCP - Transfer from CCP
CCHA - Transfer from Chancery

MASS TORT
CABI - Abilify Cases
CBEN - Benzene Cases
CFAR - Farxiga Cases
CHON - Honeywell Cases
CMON - Monsanto Cases
CPEL - Pelvic Mesh Cases
CPLX - Plavix Cases
CPPI - PPI Cases
CTAL - Talc Cases
CTAX - Taxotere Cases
CXAR - Xarelto Cases

INVOLUNTARY COMMITMENTS
INVC- Involuntary Commitment

MISCELLANEOUS
MAGM - AG Motion - Civil/Criminal Investigations *
MADB - Appeal from Disability Board *
MAFF - Application for Forfeiture
MAAT - Appointment of Attorney
MGAR - Appointment of Guardianship
MCED - Cease and Desist Order
MCON - Civil Contempt/Capias
MCVP - Civil Penalty
MSOJ - Compel Satisfaction of Judgment
MSAM - Compel Satisfaction of Mortgage
MCTO - Consent Order
MIND - Destruction of Indicia of Arrest *
MESP - Excess Sheriff Proceeds
MHAC - Habeas Corpus
MTOX - Hazardous Substance Cleanup
MFOR - Intercept of Forfeited Money
MISS - Issuance of Subpoena
MLEX - Lien Extension
MMAN - Mandamus
MWIT - Material Witness *
MWOT - Material Witness - Out of State
MRAT - Motion for Risk Assessment
MROP - Petition for Return of Property
MCRO - Petition Requesting Order
MROD - Road Resolution
MSEL - Sell Real Estate for Property Tax
MSEM - Set Aside Satisfaction of Mortgage
MSSS - Set Aside Sheriff's Sale
MSET - Structured Settlement
MTAX - Tax Ditches
MREF - Tax Intercept
MLAG - Tax Lagoons
MVAC - Vacate Public Road
MPOS - Writ of Possession
MPRO - Writ of Prohibition

MORTGAGES
MCOM - Mortgage Commercial
MMED - Mortgage Mediation
MORT - Mortgage Non-Mediation (Res.)

MECHANICS LIENS
LIEN - Mechanics Lien

*** Not eFiled**

DUTY OF THE PLAINTIFF

Each plaintiff/counsel shall complete the attached Civil Case Information Statement (CIS) and file with the complaint.

DUTY OF THE DEFENDANT

Each defendant/counsel shall complete the attached Civil Case Information Statement (CIS) and file with the answer and/or first responsive pleading.