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Transaction ID 68499067
Case No. N22C-09-526 CLS

IN THE SUPERIOR COURT FOR THE STATE OF DELAWARE

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

PLAINTIFFS' MOTION TO AMEND AND SUPPLEMENT THEIR COMPLAINT

Pursuant to Superior Court Civil Rules 15(a) and (d), Plaintiffs hereby move to amend and supplement their Complaint to moot certain pleading arguments in Defendants' Brief In Opposition to Plaintiffs' Petition for Attorneys' Fees. Specifically, Plaintiffs seek to plead: (1) a request in the prayers for relief for attorneys' fees; and (2) a Paragraph 106 in Count III regarding the declaratory judgment for Count II. The requested pleading is attached as Exhibit 1; the changes are noted in the redline against the original Complaint attached as Exhibit 2.

ARGUMENT

Attorneys' Fees

Defendants argue in opposition to Plaintiffs' Petition for attorneys' fees that Plaintiffs waived the right to seek fees because they did not plead such a request in

the Complaint (AB 1, 9-10). They first raised this argument in an email on November 18 responding to the Court's questions about the status of the case. This came *three weeks after* the parties' moved forward to come to agreement on a stipulation to bring the case to conclusion with a final judgment and briefing on attorneys' fees (and cross motions for summary judgment on a portion of Count III dealing with mailings to retirees). Exhibit 3. And four days after Plaintiffs filed their opening brief on November 14.

Plaintiffs then asked Defendants if they would agree to Plaintiffs' amending and supplementing the Complaint to plead fees. Defendants did not agree and declined to give reasons why they might be prejudiced. Exhibit 4.

Rule 15(a) provides that Plaintiffs may amend their Complaint by leave of Court "and leave shall be freely given when justice so requires." Rule 15(d) allows Plaintiffs to file a supplemental pleading setting forth transactions or occurrences after the Complaint. "The purpose of Rule 15 is to encourage the disposition of litigation on its merits." *Cordrey v. Doughty*, 2017 WL 4676593, at *3 (Del. Super.). The touchstone is whether Defendants would be prejudiced. *Cook v. J and V Trucking Company*, 2020 WL 5846630, at *2 (Del. Super.) ("in the absence of prejudice to another party, the trial court is required to exercise its discretion *in favor of granting leave* to amend"); *Cordrey v. Doughty*, 2017 WL 4676593, at *3 (Del. Super.) ("It is the general policy in this jurisdiction to freely permit amendments to

pleadings unless the opposing party would be seriously prejudiced by the amendment."). Under Rule 15(d), "there is no apparent reason why the same liberality should not apply to a motion to supplement." *Citron v. Lindner*, 1985 WL 44689, at *1 (Del. Ch.).

Defendants are not possibly prejudiced:

(1) The parties' stipulation for the remaining proceedings was, for all intents and purposes, a *de facto* pretrial order reflecting Plaintiffs' request for fees. As such, the Court can treat that submission as such and find that no further action is needed. *Chrysler Corp. v. Chaplake Holdings, Ltd.*, 822 A.2d 1024, 1038 (Del. 2003) ("In this case, the pretrial stipulation executed by Chrysler, which became an Order of the Court pursuant to Superior Court Civil Rule 16, served to amend the pleadings . . . ."); *Vaughn v. Rispoli*, 804 A.2d 1067 (Del. 2002) (Table) ("At the court's discretion, the parties may amend pleadings at a pretrial conference and a pretrial order 'shall control the subsequent course of action.' Super. Ct. Civ. R. 16."). Plaintiffs are only moving to amend to moot Defendants' procedural argument.

(2) Defendants have known since October 27 that Plaintiffs were seeking fees and did not object. Indeed, they pressed for an expedited briefing schedule before entry of final judgment on Counts I and II.

(3) Defendants have actually filed a brief with three affidavits in opposition. Thus, Defendants were fully able to respond.

Plaintiffs seek to amend and supplement the Prayers for Relief with a paragraph 3 as follows (supplementation is to avoid any arguments by Defendants against Plaintiffs' reliance on the State's execution of the HMAP contract on September 28, after the Complaint was filed):

> ¶3 "for attorneys' fees as elaborated in Plaintiffs' papers filed in support of their Petition for Attorneys'

> Fees, including based on 29 Del.C. §10005(d), the common benefit achieved, and Defendants' vexatious conduct, including their execution of the Contract with Highmark for Medicare Advantage after notice the Complaint was filed seeking a stay of execution of the Contract."

Declaratory Judgment for Count II

Plaintiffs seek this amendment to moot Defendants' argument in its Opposition to Plaintiffs' Petition for fees that the "complaint lacks any count seeking a declaration that a FOIA violation occurred." (AB 11). Granting the amendment will allow the Court to focus on the merits. *See Cordrey*, 2017 WL 4676593, at *3.

That a declaratory judgment is sought as relief for Count II is clear from ¶93 of Count II: "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.'" But to moot Defendants' pleading argument, the amendment would add a Paragraph 106 to Count III (Declaratory Relief) that "Plaintiffs seek a declaratory judgment that the action of the SEBC in restructuring the healthcare of State retirees and adopting Medicare Advantage was unlawful and is void in violation of FOIA and the APA."

There can be no prejudice to Defendants. As they admit, Count II "alleges that the Defendants violated the APA *by virtue* of violating FOIA" when adopting the Medicare Advantage regulation (Defendants Motion to Dismiss at ¶6 (Trans. ID 68263720) (emphasis in original). Moreover, the parties' November 18 Stipulation

recognizes that the Court's Decision on the motion to stay (e.g., *Decision* at 3, 11 n.10) constitutes the Court's findings of fact and conclusions of law on Count II (hence the regulation is unlawful under FOIA given the flawed agenda) and effectively decides Count II in Plaintiffs' favor (so voiding the regulation for that reason). (Transaction ID 68405138).

CONCLUSION

For these reasons, Plaintiffs respectfully request that the Court grant them leave to file the Amended Complaint attached as Exhibit 1 hereto.

Dated: December 2, 2022

/s/ David A. Felice

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CERTIFICATE OF SERVICE

I, David A. Felice, hereby certify that on December 2, 2022, I caused a true and correct copy of *Plaintiffs' Motion to Amend and Supplement their Complaint* to be served via File& ServeXpress upon the parties listed below:

Patricia Davis
Adria Martinelli
Jennifer Singh
Department of Justice
Carvel State Office Building
820 N. French Street, 6th Floor
Wilmington, Delaware 19801

Max B. Walton
Shaun Michael Kelly
CONNOLLY GALLAGHER LLP
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Dated: December 2, 2022

/s/ David A. Felice
David A. Felice (#4090)
Bailey & Glasser, LLP

IN THE SUPERIOR COURT FOR THE STATE OF DELAWARE

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

[PROPOSED] ORDER APPROVING PLAINTIFFS' MOTION TO AMEND AND SUPPLEMENT THEIR COMPLAINT

Plaintiffs' Motion to Amend and Supplement their Complaint, having been presented and considered by the Court,

IT IS HEREBY ORDERED this ____ day of _____, 2022, that Plaintiffs' Motion is GRANTED. Plaintiffs will file their Amended Complaint within three (3) days of the date of this Order.

_____
Judge

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Transaction ID 68499067
Case No. N22C-09-526 CLS

EXHIBIT 1

IN THE SUPERIOR COURT FOR THE STATE OF DELAWARE

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

AMENDED AND SUPPLEMENTAL COMPLAINT[1]

Plaintiffs RiseDelaware Inc. ("RiseDelaware"); Karen Peterson; and Thomas Penoza (collectively, "Plaintiffs"), by and through their undersigned counsel, bring this Amended and Supplemental Complaint against defendants Secretary Claire DeMatteis, in her official capacity as Secretary of the Delaware Department of

[1] Amended and supplemented only to the extent set forth in Plaintiffs' Motion to Amend and Supplement.

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.[2] 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

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

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.

- 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[3] – 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;

[3] 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.

- 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). *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.[4]

- $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 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.[5] However, as Defendants eventually acknowledge

[4] *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.

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

"[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 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).[6]

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

[6] 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).

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 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[7] – 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, 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

[7] 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).

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.

Causes of Action

COUNT ONE

(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).

106. Plaintiffs seek a declaratory judgment that the action of the SEBC in restructuring the healthcare of State retirees and adopting Medicare Advantage was unlawful and is void in violation of FOIA and the APA.

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;

(3) for attorneys' fees as elaborated in Plaintiffs' papers filed in support of their Petition for Attorneys' Fees, including based on 29 Del. C. §10005(d), the common benefit achieved, and Defendants' vexatious conduct, including their execution of the Contract with Highmark for Medicare Advantage after notice the Complaint was filed seeking a stay of execution of the Contract; and

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

Dated: December ___, 2022

/s/ Draft
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EXHIBIT 2

IN THE SUPERIOR COURT FOR THE STATE OF DELAWARE

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

AMENDED AND SUPPLEMENTAL COMPLAINT[1]

Plaintiffs RiseDelaware Inc. ("RiseDelaware"); Karen Peterson; and Thomas Penoza (collectively, "Plaintiffs"), by and through their undersigned counsel, bring this Amended and Supplemental Complaint against defendants Secretary Claire DeMatteis, in her official capacity as Secretary of the Delaware Department of

[1] Amended and supplemented only to the extent set forth in Plaintiffs' Motion to Amend and Supplement.

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.[2] 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

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

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.

- 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[3] – 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;

[3] 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.

- 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). *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.[4]

- $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 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.[5] However, as Defendants eventually acknowledge

[4] *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.

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

"[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 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).[6]

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

[6] 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).

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 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[7] – 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, 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

[7] 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).

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.

Causes of Action

COUNT ONE

(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).

106. Plaintiffs seek a declaratory judgment that the action of the SEBC in restructuring the healthcare of State retirees and adopting Medicare Advantage was unlawful and is void in violation of FOIA and the APA.

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 attorneys' fees as elaborated in Plaintiffs' papers filed in support of their Petition for Attorneys' Fees, including based on 29 Del. C. §10005(d), the common benefit achieved, and Defendants' vexatious conduct, including their execution of the Contract with Highmark for Medicare Advantage after notice the Complaint was filed seeking a stay of execution of the Contract; and

~~(3)~~(4) for such other relief as this Court deems just and appropriate.

Dated: ~~September 25,~~December ___, 2022

/s/ ~~*David A. Felice*~~*Draft*

David A. Felice (#4090)
Bailey & Glasser, LLP

Of Counsel:
Sara Haviva Mark ~~(*pro hac vice* to be filed)~~

Steve Cohen ~~(*pro hac vice* to be filed)~~
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111 Broadway, Suite 1804
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Red Clay Center at Little Falls
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Telephone: (302) 504-6333
Facsimile: (302) 504-6334
Attorneys for ~~Plaintiff~~Plaintiffs

Jacob S. Gardener ~~(*pro hac vice* to be filed)~~
Walden Macht & Haran LLP
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Telephone: (212) 335-2030

EFiled: Dec 02 2022 05:12PM EST
Transaction ID 68499067
Case No. N22C-09-526 CLS

EXHIBIT 3

David A. Felice

From: Davis, Patricia (DOJ) <PatriciaA.Davis@delaware.gov>
Sent: Friday, October 28, 2022 11:59 AM
To: David A. Felice; Sara Mark
Subject: RE: Two additional thoughts
Attachments: Final Order DRAFT 54(b).docx

Counsel: Sorry for the multiple emails today. I really don't want to have to write an appeal this weekend. Attached is a version of the proposed order that would be a 54(b) final order on only counts one and two, leaving you to litigate count three and your attorneys fee petition later.

Let me know if this is acceptable.

Thanks,
Patty

Patricia A. Davis
Patricia A. Davis
State Solicitor
820 N French Street, 6th Floor
Wilmington, DE 19801
(302) 257-3233 Phone

From: Davis, Patricia (DOJ)
Sent: Friday, October 28, 2022 8:41 AM
To: David A. Felice <DFelice@baileyglasser.com>; Sara Mark <sara@pollockcohen.com>
Subject: Two additional thoughts

Counsel: Two thoughts after our discussion yesterday:

1) The Supreme Court recently affirmed that where the trial court reserves jurisdiction to consider an application for attorneys' fees, the appeal is interlocutory. *See CCSB Fin. Corp. v. Deann M. Totta*, No. 289, 2022, at 3 (Del. Sept. 12, 2022) (attached). By insisting on the right to petition for fees, you're precluding my appeal on a final judgment, which was supposed to be the point of this. I note that the GoFundMe was over 77k dollars yesterday.

2) The wording of Count 3 precludes us from stipulating to an order on that count. The court never addressed it, likely because you sought a judgment that the Secretary "failed to execute her duties in violation of 29 *Del. C.* § 9604(8)," which reads "The duties of the Secretary of Human Resources under this chapter shall include

(8) Communication to State employees of all State employee benefits coverages and any additions or changes of benefits affecting State employees." But your allegations are only as to pensioners. I can't stipulate to entering a judgment on that count, when you made no allegations about state employees and the court never addressed whether this also meant "pensioners" like your Plaintiffs all purport to be.

Happy to discuss if you have any case law to contrary.

Thanks,
Patty

Patricia A. Davis
Patricia A. Davis
State Solicitor
820 N French Street, 6th Floor
Wilmington, DE 19801
(302) 257-3233 Phone

IN THE SUPERIOR COURT OF THE STATE OF DELAWARE

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

[PROPOSED] PARTIAL FINAL JUDGMENT PURSUANT TO RULE 54(B) ON COUNTS I AND II OF THE COMPLAINT AND STAY OF PROCEEDINGS

WHEREAS, Plaintiffs RiseDelaware Inc., Karen Peterson and Thomas Penoza (collectively "Plaintiffs") filed suit on September 25, 2022 (the "Complaint") seeking a stay of implementation of the Delaware State Employee Benefits Committee's ("SEBC") decision to transition the state pensioner healthcare benefits plan to a custom-designed Highmark Medicare Advantage Plan for State of Delaware retirees (the "Benefits Plan");

WHEREAS, Plaintiffs' Complaint contends that the Benefits Plan constitutes a regulation subject to the Delaware Administrative Procedures Act, Title 29, Chapter 101 of the Delaware Code ("APA");

WHEREAS, Plaintiffs sought a stay of execution and any further implementation of the Benefits Plan pursuant to Section 10144 of the APA;

WHEREAS, the SEBC and all other Defendants assert that the SEBC's Benefits Plan for the award of healthcare benefits is not subject to the APA, and therefore a stay of the Benefits Plan is not authorized under the APA;

WHEREAS, on October 19, 2022, the Court granted "Plaintiffs' Motion for Stay of All State Retirees Holding Supplemental Health Plans to use Medicare Advantage" and by written decision, stayed implementation of the Benefits Plan (hereafter the "Decision");

WHEREAS, the Decision is attached hereto as Exhibit A and is incorporated herein by reference;

WHEREAS, the Decision holds that the implementation of the Benefits Plan "is a regulation under the APA," and the Decision issued the stay requested by Plaintiffs pursuant to Section 10144 of the APA;

WHEREAS, the Decision requires the Defendants to ensure that healthcare insurance and benefits available to state retirees prior to October 3, 2022, or in which they were enrolled prior to that time, remain in full force and effect;

WHEREAS, the SEBC has complied with the Court's directive and extended such benefits for the calendar year 2023; and

WHEREAS, the Decision effectively grants Plaintiffs the complete relief sought in Counts I and II of the Complaint, and the Parties agree that pursuant to Rule 54(b) a final, appealable Order should be entered in this case on Counts I and II of the Complaint.

NOW, THEREFORE, IT IS HEREBY ORDERED AND DECREED THAT:

1. For the reasons outlined in the Decision, final judgment is entered against Defendants and in favor of Plaintiffs on Counts I and II of the Complaint.

2. Pursuant to Rule 54(b), there is no just reason for delay of entry of judgment on Counts I and II of the Complaint.

3. The Benefits Plan enacted by the SEBC, "requiring retirees to move from their State-subsidized Medicare Plan to Medicare Advantage plan or stay with traditional Medicare and give up their State-subsidized benefits . . . is a regulation under the APA."

4. The stay entered by the Court's Decision pursuant to Section 10144 of the APA, requiring "the defendants to ensure that healthcare insurance and benefits available to State retirees prior to October 3, 2022, or in which they were enrolled prior to that time, remain in full force and effect" shall remain in place through the open enrollment period to select insurance and benefits for the 2023 policy year. Thereafter, the stay shall automatically terminate.

5. All proceedings concerning Count III of the Complaint are hereby stayed until resolution of any subsequent appeal on Counts I and II.

6. Plaintiffs expressly preserve an opportunity to file a petition seeking attorneys' fees. Defendants preserve their contention that Plaintiffs are not entitled to an award of attorneys' fees and preserve all defenses related to such petition. Any petition shall be filed after the stay imposed by paragraph 5 above is lifted.

7. Upon entry of this Final Judgment and Order on Counts I and II, each party shall be permitted to appeal as authorized by law. Nothing in this Order shall be deemed a waiver of any applicable right of appeal nor shall it be deemed to preclude any arguments on appeal that were raised in the underlying proceedings.

IT IS SO ORDERED AND JUDGMENT IS ENTERED on this ___ day of October 2022.

The Honorable Judge Calvin L. Scott Jr.

EFiled: Dec 02 2022 05:12PM EST
Transaction ID 68499067
Case No. N22C-09-526 CLS

EXHIBIT 4

David A. Felice

From: Max B. Walton <mwalton@connollygallagher.com>
Sent: Monday, November 21, 2022 5:18 PM
To: David A. Felice; Davis, Patricia (DOJ); Shaun Kelly; Martinelli, Adria (DOJ)
Cc: Sara Mark
Subject: RE: RiseDE v DeMatteis, et al N22C-09-526 CLS

CAUTION: External Email

David:

Defendants oppose any attempt to amend the complaint to add a claim for attorneys' fees at this late stage. You will need to seek leave to amend if you seek to amend. We disagree on the prejudice contention and many other points below, but we will save those arguments for a later time.

Thanks,

Max

CONNOLLY GALLAGHER LLP

Max B. Walton
CONNOLLY GALLAGHER LLP • www.connollygallagher.com
• 267 East Main Street • Newark, DE 19711
☎302-888-6297 ℡302-757-7299 ✉mwalton@connollygallagher.com

From: David A. Felice <DFelice@baileyglasser.com>
Sent: Monday, November 21, 2022 2:08 PM
To: Max B. Walton <mwalton@connollygallagher.com>; Davis, Patricia (DOJ) <PatriciaA.Davis@delaware.gov>; Shaun Kelly <skelly@connollygallagher.com>; Martinelli, Adria (DOJ) <Adria.Martinelli@delaware.gov>
Cc: Sara Mark <sara@pollockcohen.com>
Subject: RE: RiseDE v DeMatteis, et al N22C-09-526 CLS

Max:

Your email to the Court Friday for the first time asserts that Plaintiffs waived their request for attorneys' fees by not pleading it in their complaint. We believe the issue was fairly raised in the stipulation addressing the parties' cross motions for summary judgment. Nonetheless, the touchstone of whether to allow an amended complaint (if that is

even needed at this point) is prejudice to the Defendants. Here, there can be no prejudice to Defendants as defense counsel have been on notice since at least October 27 that we were seeking fees. Defendants never raised an issue in all that time of our needing to amend the complaint, and indeed, proceeded to negotiate with us for many rounds on a stipulation of how to bring the proceedings to closure at the trial court level, including with briefing on Plaintiffs' request for an award of attorneys' fees, so they could appeal.

Please let me know if you will insist that Plaintiffs move to amend even though the claim for fees and facts are laid out in our moving papers and you waited three weeks to assert the argument of waiver. And if so, whether Defendants will oppose the motion and on what grounds. Thank you.

David

David A. Felice
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From: Max B. Walton <mwalton@connollygallagher.com>
Sent: Friday, November 18, 2022 3:00 PM
To: Emerson, Lisa K (Courts) <Lisa.Emerson@delaware.gov>; David A. Felice <DFelice@baileyglasser.com>; Davis, Patricia (DOJ) <PatriciaA.Davis@delaware.gov>; Shaun Kelly <skelly@connollygallagher.com>; Martinelli, Adria (DOJ) <Adria.Martinelli@delaware.gov>
Cc: Watson, Shawan (Courts) <Shawan.Watson@delaware.gov>; White, Tamu (Courts) <Tamu.White@delaware.gov>
Subject: RE: RiseDE v DeMatteis, et al N22C-09-526 CLS

Dear Judge Scott –

In response to Ms. Emerson's November 15, 2022 e-mail, Defendants state:

EFiled: Dec 02 2022 05:12PM EST
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Case No. N22C-09-526 CLS

IN THE SUPERIOR COURT FOR THE STATE OF DELAWARE

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

NOTICE OF PLAINTIFFS' MOTION TO AMEND AND SUPPLEMENT THEIR COMPLAINT

PLEASE TAKE NOTICE that Plaintiffs' Motion to Amend and Supplement their Complaint will be presented to the Court on December 20, 2022 at 9:00 a.m.

Dated: December 2, 2022

/s/ David A. Felice
David A. Felice (#4090)
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Telephone: (302) 504-6333
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Attorneys for Plaintiffs

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