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' OPENING BRIEF
IN SUPPORT OF THEIR MOTION TO STAY

Dated: October 4, 2022

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INTRODUCTION

For decades, the Medicare-eligible retired employees of the State of Delaware ("retirees") have received Medicare Supplemental insurance as a retirement benefit for their service to the State. Compl. ¶ 17. Retirees have relied upon, and have made decisions based upon, the expectation of these benefits. Predictability about their ability to see their doctors, ensure continuity of care, and live within their means is important to people who are retired and living on a fixed pension. In fact, many retirees factored these retirement benefits into their decision to work for the State.[1]

The State has now abruptly changed, and materially reduced, these healthcare benefits – benefits relied upon by approximately 30,000 Delaware retirees – by shifting *all* retirees to a Medicare Advantage Plan. The State itself described this sweeping policy shift as an "important change in State of Delaware Medicare benefits." Compl., Ex. 1 at 2. When enacting such fundamental regulatory change, agencies are bound by procedural requirements established to protect the democratic goals of open government and citizen participation. These requirements are enshrined in the Delaware Administrative Procedures Act and Freedom of Information Act and include the right of citizens to provide input during the

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[1] Affidavit of AnRea MacDonald ("MacDonald Aff.") ¶ 3; Affidavit of Diana Brubaker ("Brubaker Aff.") ¶ 3; Affidavit of Patricia Maichle ("Maichle Aff.") ¶ 3; Affidavit of Thomas Penoza ("Penoza Aff.") ¶ 2-4; Affidavit of Robert Clarkin ("Clarkin Aff.) ¶ 19-22; Affidavit of Karen Peterson ("Peterson Aff.") ¶ 17.

rulemaking process and to participate in meetings involving government actions that affect them. *See* 29 *Del. C.* §§ 9602(b)(4) , 10002(k), 10004, 10102(1).

This lawsuit is brought in response to Defendants' spectacular failure to comply with these statutory requirements. The State unlawfully promulgated this regulation moving all of its retirees onto the Highmark Medicare Advantage Plan without affording them, or other interested Delaware citizens, of their rights of notice and participation. In stark contrast to the transparent and inclusive process required, Defendants provided confusing, incomplete, and misleading information about the new healthcare plan. Indeed, only last week did Defendants finally make public full information of what the new plan entails – some of which is inconsistent with what Defendants represented, and much of which is alarming – and retirees now have until only October 24 to make this critical decision. Because of the State's failure to perform its statutory duties and ensure the procedural rights of retirees, the Court must stay implementation of this unlawful regulation.

PARTIES

Plaintiff RiseDelaware Inc. is a nonprofit corporation that was established and is managed by Delaware retirees to act as a sentinel on issues involving State healthcare benefits provided for Medicare-eligible Delaware retirees. Compl. ¶ 8. Its directors are Elisa Diller and John Kowalko – both state retirees. *Id.*

Plaintiff Karen Peterson is a Delaware retiree. Compl. ¶ 9. 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. *Id.* Peterson was also a State Senator from 2002 - 2016. *Id.* Plaintiff Thomas Penoza is a Delaware retiree. Compl. ¶ 10. 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, retiring in 2014 as the Director of Special Investigations. *Id.* Both Peterson and Penoza rely on their original Medicare benefits and strongly object to the Medicare Advantage plan. *Id.* at ¶ 9-10. As described in the Complaint, Peterson and Penoza have been harmed by Defendants' conduct, which violates their obligations under the APA and FOIA. *Id.* Had Defendants complied with these laws, Peterson and Penoza would have provided comments, attended relevant meetings, and otherwise participated in the regulatory process so that her voice could have been heard. *Id.*[2]

FACTS

Within the next 20 days, the State is requiring its 30,000 retirees to decide whether to enroll in the Highmark Advantage plan ("HMAP") or lose their state-funded health insurance. Compl., Ex. 1 at 3. They are being forced to do so on the

[2] *See also* Peterson Aff. ¶ 18; Penoza Aff. ¶ 10; Maichle Aff. ¶ 13; Clarkin Aff. ¶ 19-22.

basis of confusing, misleading, and incomplete information, and on an impossibly short timeline.[3] Had Defendants properly complied with their statutory obligations to provide notice, receive comment, and allow for participation, retirees could have voiced their objections to the plan and worked with the State on potential solutions. But Defendants did not. And now retirees are scrambling to understand their options and make an enormously consequential determination about their health and financial futures.

I. The State Employee Benefits Committee Promulgated a Regulation Which Fundamentally Changed Retirees' Healthcare Benefits

The State Employee Benefits Committee ("SEBC") was statutorily granted a host of powers and duties for the administration of benefits coverages for the State's employees and retirees.[4] These include "control and management of all employee benefit coverages including healthcare insurance" and "all other currently existing

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[3] Both the contract and the Evidence of Coverage for the HMAP were posted within the last week. *See generally* FreedomBlue Medicare Advantage Highmark BCBSD Inc. Group Account Agreement, Highmark Blue Cross Blue Shield Delaware, *available at*: https://dhr.delaware.gov/benefits/medicare/documents/ma-delaware-contract.pdf ("HMAP Contract"); January 1 – December 31, 2023 Evidence of Coverage at 27-28, 100, Highmark Blue Cross Blue Shield Delaware, *available at*: https://dhr.delaware.gov/benefits/medicare/documents/ma-evidence-of-coverage.pdf ("HMAP EOC").

[4] Defendants Claire DeMatteis and Cerron Cade are being sued in their official capacities as co-chairs of the SEBC. Defendants Delaware Department of Human Resources and the Delaware Division of Statewide Benefits are assisting with the implementation of the SEBC's regulatory change to HMAP.

and future employee benefits coverages"; the "selection of all carriers or third-party administrators necessary to provide coverages to State employees"; and, critically, the "[a]uthority to adopt rules and regulations for the general administration of the employee benefit coverages." 29 *Del. C.* § 9602(b)(1),(2) & (4); Compl. ¶ 42-43.

Pursuant to this authority, the SEBC promulgated a regulation that upended the decades-long rule of providing Medicare supplemental insurance to State retirees. Compl. ¶ 17. This directive requires Medicare-eligible state retirees to participate in a Medicare Advantage plan or lose their state-funded health insurance beginning in January 2023. Compl., Ex. 1 at 3. This new plan is called the Freedom Blue PPO Medicare Advantage Plan, and it will be administered by Highmark Blue Cross Blue Shield Delaware. *Id.* The State Office of Pensions is named as Defendants' point of contact for retirees' questions about plan enrollment and benefits. Compl., Ex. 1 at 1.

Given the lack of proper process and transparency, it is still difficult for Plaintiffs to piece together exactly what happened and when. However, from the minutes of a February 2022 SEBC meeting, it appears that this unprecedented policy shift to Medicare Advantage had long been discussed and had already reached the time for final decision by the date of that meeting. Compl. ¶ 45. At that meeting, a motion was made and adopted unanimously to require Delaware's retirees to

participate in the HMAP or lose their state-funded healthcare.[5] Compl. ¶ 47-48. The SEBC did not appear to consider the Retirement Benefits Study Committee's ("RBSC") recommendations to contemplate a Health Reimbursement Arrangement ("HRA") option; delay implementation to 2024 to allow for continued review and analysis; or solicit retiree participation in the regulatory process. Compl. ¶ 53-57.

This sweeping directive will shift *all* of the State's 30,000 retirees onto a fundamentally different and materially worse health insurance plan. It also imposes new rules and responsibilities on healthcare providers and the insurance company.[6] Compl. ¶ 20. Despite this foundational change in healthcare policy –which affects tens of thousands of retirees, and enacts a new regulatory regime on the healthcare industry – the SEBC promulgated this far-reaching new rule without notice, comment, or the other procedural protections required by law. Compl. ¶ 44-47.

Defendants also failed to provide adequate notice in the agendas of the meetings where this critical regulation was being considered and evaluated. Neither the public agenda for the February 28, 2022 SEBC meeting, nor any agendas prior

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[5] It is still not certain that this rule was in fact enacted at that meeting. On September 12, 2022, Office of Management and Budget Director Cerron Cade stated that the HMAP was "not adopted in early February, but voted on in early June." Compl. ¶ 51.

[6] Doctors and hospitals must now abstain from administering various tests and treatments pending insurance company authorization; and the insurance company must now provide all benefits covered under Medicare Parts A and B. Compl. ¶ 20.

to that date, gave any indication to retirees that the SEBC was considering this transformational requirement. Compl. ¶ 48-50. Indeed, it seems impossible to dispute that retirees were deprived of their right to meaningful participation in these meetings.

II. The Forced Choice between the Highmark Medicare Advantage Plan or the Loss of State-Funded Benefits

A. Highmark Medicare Advantage Plan

If the State's plan is allowed to proceed, Delaware's approximately 30,000 retirees will be forced to decide between the HMAP and the loss of state-funded health insurance benefits by October 24. Compl., Ex. 1 at 3. This is a Hobson's choice: accept materially worse health insurance coverage[7] or give up your hard-earned state retirement benefit.

1. Prior Authorization

For those who might choose the HMAP, they will be subject to a variety of new coverage limitations, including the particularly harmful "prior authorization" process. Compl. ¶ 22. Prior authorization is a process by which Highmark, a for-profit insurance company, will step in between the patient and her doctors, and

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[7] Not all retirees will even have this choice. The HMAP explicitly will not enroll retirees or their dependents who are diagnosed with End Stage Renal Disease. HMAP Contract at 3. Diane Brubaker's husband suffers from such disease, and it appears he will not even have the option to participate in the plan. Brubaker Aff. ¶ 7.

decide whether a diagnostic test or medical procedure is "medically necessary." *Id.* Because unlike traditional Medicare which does not employ prior authorization outside of durable medical equipment such as motorized wheelchairs, in Medicare Advantage plans, the private insurance company does not have to provide coverage unless and until it determines that a procedure ordered by one's doctor is "medically necessary." *Id.*

One need not be a healthcare expert to understand the dangers of substituting one's personal doctor's medical judgment with that of a private insurance company. The harmful consequences of prior authorization have been well-documented and are outlined generally in the Complaint. *See*, *e.g.*, Compl. ¶ 23-24.

In addition to the serious medical consequences of a prior authorization denial, there are also significant economic costs. Compl. ¶ 25. Indeed, the Evidence of Coverage for the HMAP, made available to retirees only days ago, finally makes clear that retirees will have to shoulder the financial burden of services not deemed "medically necessary." HMAP EOC at 27-28, 100 (highlighting that it is "important" to ask for a "pre-visit coverage decision" before seeing an out-of-network provider because "[w]ithout a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost."); *id.* ("In the network

portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan.").

In the Frequently Asked Questions document provided by Defendants to retirees regarding HMAP, there are 21 categories of services listed that require prior authorization. Compl. ¶ 31. In the contract recently executed with Highmark, there are *forty-one* pages of services that are subject to prior authorization, which include approximately *1,690 procedures and 340 drugs*. HMAP Contract at Exhibit 3.

Significantly, if those 1,690 procedures and 340 drugs services prove insufficient to meet Highmark's needs, the contract includes a disclaimer: "The Health Plan's prior authorization list is subject to change, and *the Health Plan has the authority to add or remove items, procedures and/or services from the prior authorization list at its sole discretion*." HMAP Contract at 4 (emphasis added). Unlike much of the information provided about the plan, this language is clear—the list of services for which prior authorization is required is far from final, and it is hardly alarmist to worry that this list will only continue to increase over time.

2. Provider Network and Out-of-Pocket Costs

Two other troubling features of the HMAP are the potential limitations of the provider network and retirees' subsequent out-of-pocket costs for care. While Defendants have promised that a majority of Delaware's healthcare providers will accept the new plan, it is difficult to rely on these representations. That is not only

because it is well-documented that Medicare Advantage provider networks are significantly more limited than traditional Medicare. Compl. ¶ 27 ("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")). But also because Defendants have admitted that "[providers] have the option to refuse to see patients enrolled in the plan." Compl. ¶ 35.

As such, it is 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. *Id.* This injects enormous uncertainty into the continuity of their care, and much anxiety that one's medical treatment may be delayed by a midstream refusal by their doctor to participate in the HMAP. MacDonald Aff. ¶ 7; Brubaker Aff. ¶ 9; Maichle Aff. ¶ 6-8; Penoza Aff. ¶ 10, 14-15; Clarkin Aff. ¶ 13-15; Peterson Aff. ¶ 7-13.

For retirees who now live outside of Delaware, or see doctors outside of the State, concerns about provider coverage are especially acute. National surveys have demonstrated the inadequacies of Medicare Advantage provider networks across the country. Compl. ¶ 36 ("Medicare Advantage networks included *less than half* (46%) of all physicians in a county, on average."). Information coming in from retirees confirms these limitations on providers who will accept the HMAP. MacDonald

Aff. ¶ 7; Brubaker Aff. ¶ 9; Maichle Aff. ¶ 6-8; Penoza Aff. ¶ 10, 14-15; Peterson Aff. ¶ 7-13.

A significant, related risk retirees face concerns their exposure to provider charges, or "out-of-pocket" costs. While the communications provided by Defendants to retirees were unclear on this topic (*see* Compl. ¶ 32), the just-signed contract with Highmark has an entire section dedicated to "Out-of-Area Services." HMAP Contract, at 10. In it, the potential out-of-pocket costs are made clear by Highmark, with the heading "Member Liability Calculation." This liability is calculated as "[t]he cost of the service, on which member liability (copayment/coinsurance) is based, will be either:

- The Medicare allowable amount for covered services, or
- The amount either Health Plan negotiates with the provider, or the Host Blue negotiates with its provider on behalf of Health Plan Members, if applicable. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable amount." *Id.*

This provision makes clear that retirees will be liable for out-of-pocket costs for any amount charged by a provider above the Medicare allowable amount or for an even bigger out-of-pocket cost where the negotiated rate with that provider is lower than the Medicare allowable amount. This arrangement is significantly different from the current Medicfill plan, where a vast majority of providers accept Medicare and so are fully covered by the Medicare approved amount. Compl. ¶ 33. And, this is in addition to any out-of-pocket costs discussed above, where services provided by

either in-network or out-of-network providers are determined not to be "medically necessary." Compl. ¶ 34.

Because many State retirees live on fixed pensions and receive treatment on a regular basis due to their advanced age or disabilities, these out-of-pocket costs will create significant financial hardship. MacDonald Aff. ¶ 11; Brubaker Aff. ¶ 10; Maichle Aff. ¶ 9, 11. And, this hardship may force a reduction in spending in other critical areas of their lives – like rent, groceries, or other necessities. *Id.*

Moreover, for some retirees, the harm may extend beyond the financial to the healthcare decisions themselves, as the potential of out-of-pocket costs may cause them to forego that care. *See*, *e.g.*, Gretchen Jacobson et al., *When Costs Are a Barrier to Getting Health Care: Reports from Older Adults in the United States and Other High-Income Countries*, The Commonwealth Fund (October 1, 2021), *available at*: https://www.commonwealthfund.org/publications/surveys/2021/oct/when-costs-are-barrier-getting-health-care-older-adults-survey (12% of elderly U.S. adults reported postponing, delaying, or avoiding care due to out of pocket costs; 7% did not visit a doctor to report a medical care; 8% skipped treatment; 9% did not fulfill a prescription or skipped medication); Jeanne Madden, et al., *Affordability of Medical Care Among Medicare Enrollees*, JAMA Health Forum (December 10, 2021), *available at*: https://jamanetwork.com/journals/jama-health-

forum/fullarticle/2787080 (8.3% of elderly Medicare enrollees delayed care due to cost and 7.4% had problems paying medical bills).

B. Loss of State-Funded Benefits

While the very real harms, risks, and uncertainties posed by the HMAP are daunting, the option to forego state-funded benefits has its own significant costs. In order for retirees to obtain Medicare Supplemental insurance – to maintain the coverage promised by the State – they will have to buy it on the open market. Defendants appear not to have provided any information on how retirees may be able to approach this process – which has caused additional anxiety and distress for retirees – but Plaintiffs and other retirees have attempted to acquire the necessary information. From this research, it is unclear whether retirees will be able to duplicate the healthcare and prescription benefits that they currently receive. Even if they are able to do so, the costs of such open-market insurance range from hundreds to thousands of dollars a month depending on age, gender, smoking habits and other health status factors. MacDonald Aff. ¶ 9; Penoza Aff. ¶ 12-13; Clarkin Aff. ¶ 7-8; Peterson Aff. ¶ 16. *See also* Medicare.gov, *Supplemental Insurance (Medigap) plans in Delaware*, *available at*: https://www.medicare.gov/medigap-supplemental-insurance-plans/#/m/plans?fips=10001&zip=19901&year=2022&lang=en. In addition to coverage for themselves, retirees will also have to find and pay for health insurance

for their dependents, who may have their own set of health challenges. MacDonald Aff. ¶ 8; Maichle Aff. ¶ 3-4; Penoza Aff. ¶ 14; Clarkin Aff. ¶ 5-7; Peterson Aff. ¶ 18.

Moreover, since many retirees live on fixed incomes, the cost of Medicare Supplemental insurance may be prohibitive, or as discussed above, detract from spending on other necessities. MacDonald Aff. ¶ 9; Penoza Aff. ¶ 12-13; Clarkin Aff. ¶ 7-8; Peterson Aff. ¶ 16-18.

III. Inability to Make an Informed Decision in the Next 20 Days

As described in the Complaint, Defendants' communications to retirees about the HMAP have confused, misinformed, and misled retirees about the decision they must make within the next 20 days. Compl. ¶ 30 (representations about "prior authorization" buried beneath references to "medically necessary" services or benefits); Compl. ¶ 32-34 (few, if any, mentions of "out-of-pocket" costs); Compl. ¶ 35-36 (uncertainty about which providers accept Highmark Advantage, and which have or will "refuse" to see retirees with the plan).

Retirees across the State are confused about which of their providers accept the HMAP and whether their continuity of care will be lost. MacDonald Aff. ¶ 6-11; Maichle Aff. ¶ 10-13; Penoza Aff. ¶ 10, 13-16; Clarkin Aff. ¶ 13-15; Peterson Aff. ¶ 10-13. They are fearing that the services they need will be subject to prior authorization, and if so, that they may not be deemed "medically necessary."

MacDonald Aff. ¶ 7, 11; Brubaker Aff. ¶ 9; Maichle Aff. ¶ 6; Penoza Aff. ¶ 7-10; Clarkin Aff. ¶ 10-12; Peterson Aff. ¶ 6-9. They are worrying about the out-of-pocket costs for services not found to be "medically necessary," or of seeing out-of-network providers. *Id.* Simply put, as a result of the State's abject failure to properly communicate the terms of the HMAP to retirees, they are now left wholly unable to make an informed decision about whether to join the HMAP or to opt out.

Adding to this unacceptable level of uncertainty, the contract with Highmark was executed *less than a week ago*. Retirees have only just been able to review the final terms of the HMAP and the scope of coverage, some of which appears to be different from Defendants' communications about the plan. For example, the 21 categories of services subject to prior authorization described in the Frequently Asked Questions, is now known, in reality, to encompass 1,690 procedures and 340 drugs. HMAP Contract at Exhibit 3. With this highly relevant and consequential information just now being shared with retirees – and with that information subject to future change in light of the open-ended disclaimer – it is nearly impossible to make an informed decision about whether to join the plan or opt-out within the next 20 days.

Moreover, Defendants' failure to provide clear, complete and accurate information about the HMAP has created a high level of confusion and anxiety for retirees, who are being forced to make this important healthcare decision without

adequate information, and who are also faced with the potential of a drastic change to their healthcare. MacDonald Aff. ¶ 4; Maichle Aff. ¶ 10-13; Penoza Aff. ¶ 10; Clarkin ¶ 16-18; Peterson Aff. ¶ 7, 14-15. This anxiety and distress has only been exacerbated by the impossibly short timeline within which to make this critical decision. *Id.* Absent this Court's intervention, these retirees will be forced to make a life-changing decision about their healthcare without the information and time required and deserved.

ARGUMENT

This Court is empowered to stay enforcement of an "agency regulation or decision" if it "finds, upon a preliminary hearing," that: (1) "the issues and facts presented for review are substantial"; and (2) "the stay is required to prevent irreparable harm." 29 *Del. C.* § 10144. Both prongs are satisfied here.[8]

I. THE CENTRAL ISSUE IN THIS CASE—WHETHER THE SEBC VIOLATED THE APA—IS SUBSTANTIAL

This case involves the SEBC's decision to drastically change the rules governing State-funded health insurance for tens of thousands of elderly and

[8] Unlike a preliminary injunction motion, a motion for stay pending review under § 10144 does not "allow for the balancing of [Plaintiffs'] interests against those of [Defendants]." *Liselyn Enterprises v. Brady*, 1989 WL 100399, at *3 (Del. Super.). If it did, however, the balance would tip heavily in Plaintiffs' favor. For Defendants, a stay simply means a brief continuation of the status quo that has existed for decades (and which the RBSC recommended, *see* Compl. ¶¶ 52-60). By contrast, a denial of the present motion would unleash incalculable harm on the health, financial interests, and procedural rights of tens of thousands of elderly and disabled retirees.

disabled retirees. The relevant facts are indisputable. Earlier this year, the SEBC issued an unprecedented directive requiring all Medicare-eligible retired State workers to be removed from traditional Medicare and placed into a Medicare Advantage plan (the "HMAP") by October 24. Although the HMAP is designed to save the State money, it is materially inferior in critical ways to the health insurance that retirees have received for decades: traditional Medicare plus supplemental coverage. Most notably, under the HMAP (unlike traditional Medicare), there is a limited network of healthcare providers, and the insurance company will deny coverage for tests and procedures ordered by one's doctor if it does not deem them medically necessary. If retirees choose to opt out of the HMAP—in order to keep their doctors, preserve their continuity of care, and avoid newly imposed and dangerous prior authorization hurdles—they will lose their State-funded health insurance entirely. This is a radical shift in healthcare policy that will adversely affect retirees.

The ultimate issue in this case is whether, by adopting this new healthcare policy without affording the public an opportunity to review or comment on it, the SEBC violated its obligations under Delaware's Administrative Procedure Act ("APA"). The answer is yes.[9] However, for purposes of the present motion, the

[9] Because the new policy was not adopted in compliance with the APA, it is unlawful and thereby void. *Delaware State Sportsmen's Ass'n v. Garvin*, 2020 WL 6813997, at *8 (Del. Super.).

Court need not determine whether the SEBC violated the APA. The Court's limited task here is simply to decide whether, based upon a "preliminary" analysis, this issue is "substantial." As explained below, it unquestionably is.

A. The "Substantial" Standard is a Low Bar

The APA does not define "substantial." However, this Court has repeatedly construed this standard to mean something different from—and far less demanding than—likely success on the merits.[10] *See*, *e.g.*, *Delmarva Power & Light Co. v. Pub. Serv. Comm'n of State*, 1997 WL 855702, at *3 (Del. Super.) (describing the operative question under § 10144 as "whether a substantial issue has been presented," not whether the movant can show a "probabilit[y] of success as one would on a petition for a preliminary injunction"); *Bell-Atl.-Delaware, Inc. v. Pub. Serv. Comm'n of State*, 1996 WL 659487, at *2 (Del. Super.) (stating that when analyzing "whether the issues and facts to be reviewed are substantial," it would "not [be] appropriate for [the Court] to attempt to measure the probability of success"); *Patel v. Milfor, Inc.*, 2018 WL 1009168, at *2 (Del. Super.) (finding issue presented for review to be "substantial" without finding that movant was likely to succeed on the merits); *Blinder, Robinson & Co. v. Bruton*, 1987 WL 14750, at *8 n.1 (Del. Ch.)

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[10] The "substantial" standard is low enough that in at least one case, the State conceded that it was satisfied even though the State disputed the merits of the plaintiff's claim. *See E. Shore Env't v. Solid Waste Auth.*, 2001 WL 913994, at *1 (Del. Super.).

(noting that test for stay pending review under § 10144 is "less demanding" than that for preliminary injunctive relief).[11]

Although there appears to be little caselaw addressing the meaning of "substantial" in the context of § 10144, courts have shed helpful light on that term in analogous contexts. For instance, courts have construed the phrase "substantial basis in law" to "simply ask[] whether a claim is frivolous or not." *US Dominion, Inc. v. Fox News Network, LLC*, 2021 WL 5984265, at *19 (Del. Super.), *appeal refused*, 270 A.3d 273 (Del. 2022). And when describing whether an appellate question is "substantial" for purposes of bail pending appeal, courts have held that "substantial" means something only slightly more demanding than non-frivolous. *See United States v. Smith*, 793 F.2d 85, 89 (3d Cir. 1986) (interpreting "substantial" to merely mean "of more substance than would be necessary to a finding that it was not frivolous"). In the evidentiary context, courts have described "substantial" as "more than a scintilla, if less than a preponderance." *Citizens for Smyrna-Clayton First*, 2002 WL 31926613, at *4 (Del. Ch.), *aff'd*, 818 A.2d 970 (Del. 2003). Finally, Black's Law Dictionary defines "substantial" to mean, in relevant part, "[r]eal and

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[11] *But see State Dep't of Transp. v. Keeler*, 2010 WL 334920, at *1 (Del. Super.) (analyzing whether the movant had a "reasonable" probability of success on the merits); *Hannan v. Delaware Bd. of Med. Licensure & Discipline*, 2018 WL 1037463, at *3 (Del. Super.) (denying stay motion because movant had "little, if any, chance of success on the merits").

not imaginary; having actual, not fictitious, existence"; "[i]mportant, essential, and material; of real worth and importance"; and "[c]onsiderable in extent, amount, or value; large in volume or number."

Thus, in sum, the standard here is not whether Plaintiffs are likely to prevail (although they are). Rather, it is whether the issue before the Court—*i.e.*, did the SEBC violate the APA—is important and debatable. As explained below, it undoubtedly is.

B. Plaintiffs' Complaint Presents a Substantial Issue Regarding Whether the SEBC Violated the APA

Plaintiffs are challenging the process by which the SEBC changed the rules regarding retiree healthcare, a change the State itself describes as "important."[12] Without providing the required notice and opportunity to be heard, the SEBC materially diminished the healthcare rights of all Medicare-eligible State retirees. Under the SEBC's new regulation, these retirees will no longer be entitled to State-funded health insurance coverage through traditional Medicare, a benefit they have relied on for decades. This is a drastic change for tens of thousands of elderly and disabled individuals, all of whom were denied their statutory right to review and comment on the SEBC's decision before it was made. If this does not qualify as a "substantial" issue, it is difficult to imagine what would.

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[12] Compl., Ex. 1 at 2.

The SEBC's overhaul of retiree healthcare is unlawful because the SEBC failed to comply with the APA. The APA provides a vital check on the power of the administrative state by protecting the right of ordinary citizens to review and weigh in on agency policy before they become bound by it. Specifically, the law states that when state agencies adopt regulations, they must first comply with the procedural requirements of Title 29, Chapter 101 of the Delaware Code. 29 *Del. C.* § 10113(a). These requirements include, *inter alia*: (i) filing notice of the regulation with the Register of Regulations; (ii) receiving written comments from the public; (iii) holding public hearings; (iv) allowing for a period of public comment lasting at least 30 days; and (v) issuing findings and conclusions. *Id*. at §§ 10115-18. Agencies must also provide adequate notice of meetings under the Freedom of Information Act, which is incorporated by reference into the APA through 29 *Del. C.* § 10141(e).

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). On February 28, 2022, without complying with any of the APA's procedural requirements, the SEBC adopted the regulation at issue here upending retiree healthcare benefits.

Presumably, Defendants will attempt to argue that the SEBC was not required to comply with the APA because its healthcare overhaul was not a "regulation." They would be wrong.

The APA defines "regulation" broadly 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."[13] 29 *Del. C.* § 10102(7). This expansive definition reflects "[t]he statutorily delineated policy of the APA show[ing] that it is intended to govern *all actions* by agencies." *Christina Educ. Ass'n v. Delaware State Bd. of Educ.*, 1994 WL 637000, at *4-5 (Del. Super.) (emphasis added).

Importantly, the APA's definition of "regulation" is not restricted to matters that an agency itself considers to be a regulation. Thus, an agency cannot evade the APA's requirements by simply not labeling a regulation as such. As explained in the authoritative Delaware Manual for Drafting Regulations, "*[a]ll directives*

[13] The APA does not define the individual terms included in the definition of "regulation." However, the Revised Model State Administrative Procedure Act provides the following definition of "rule," which is applicable here: "the whole or a part of an agency statement of general applicability that implements, interprets, or prescribes law or policy or the organization, procedure, or practice requirements of an agency and has the force of law." *See also* RULE, Black's Law Dictionary (11th ed. 2019) ("Generally, an established and authoritative standard or principle; a general norm mandating or guiding conduct or action in a given type of situation.").

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."[14] *See Baker v. Delaware Dep't of Nat. Res. & Env't Control*, 2015 WL 5971784, at *13 (Del. Super.), *aff'd*, 137 A.3d 122 (Del. 2016) (holding that agency action that meets the broad definition of regulation "must be subject to the rigors of the APA whether they are located in documents captioned 'Regulations' or whether they are contained in some other document"); *Christina Educ. Ass'n*, 1994 WL 637000, at *4 (holding that action designated by agency as a "calendar change" was a *de facto* regulation). In other words, a directive's effect on individuals renders an action a regulation, not the terms of art used by an agency.

A regulation can be as simple as "requir[ing] . . . that certain solid waste and dry waste be disposed at a DSWA Solid Waste Facility," *E. Shore Env't v. Solid Waste Auth.*, 2001 WL 913994, at *1 (Del. Super.), or "provid[ing] for days for teachers to attend educational activities," *Christina Educ. Ass'n*, 1994 WL 637000, at *4. It can also be the setting of Medicare reimbursement rates, *see* 29 *Del. C.* § 5203(c)(3), which happens to be one of the many regulatory features of the SEBC's comprehensive healthcare overhaul. *See* Compl. ¶ 49 & n.5.

[14] Delaware Administrative Code Drafting and Style Manual, § 2.6, available at https://regulations.delaware.gov/agency/docs/draftingmanual.pdf.

This healthcare overhaul meets the definition of a "regulation" for several reasons: it imposes new "rules," "standards," "procedures," and "requirements" on retirees, healthcare providers, and insurance companies, among others; it alters the "rights" of retirees; and it represents a major change in healthcare "policy."[15] *See* Compl. ¶¶ 16-21, 44, 48, 79-80; *see also Retail Liquor Dealers Ass'n of Delaware v. Delaware Alcoholic Beverage Control Comm'n*, 1980 WL 273545, at *1 (Del. Ch.) (holding that state agency's action qualified as a regulation "inasmuch as it was a policy decision"); *Garvin*, 2020 WL 6813997, at *9 (concluding that agency language restricting rifles and ammunition for deer hunting qualified as a "regulation" because it was "a statement of 'policy'" as well as "one of 'requirement'"). In addition, the switch to a new Medicare Advantage plan serves as a "guide for the decision of cases" thereafter by various agencies, including the

[15] Although it would be too burdensome to catalogue all of the ways in which these quoted terms apply, we offer a few illustrative examples of the new "rules" imposed by the SEBC: Medicare-eligible retirees must enroll in the HMAP by October 24, or else they will lose their right to State-funded health insurance; these retirees must refrain from receiving, and doctors and hospitals must refrain from administering to them, tests and treatments subject to prior authorization unless and until the insurance company gives that authorization; Medicare-eligible retirees seeking care from out-of-network doctors must pay the difference between the Medicare-approved reimbursement rate and the rate set by the insurance company; Highmark Blue Cross Blue Shield Delaware must, for the first time with respect to Medicare-eligible State retirees, assume responsibility for providing all benefits covered under Medicare Parts A and B, and must do so pursuant to the rates set by the SEBC; and other insurance companies competing for Delaware's Medicare business must offer a Medicare Advantage plan.

Office of Pensions, regarding retirees' healthcare enrollment, eligibility, and benefits.

In short, the SEBC's sweeping healthcare overhaul squarely qualifies as a regulation, thus triggering the procedural protections of the APA. Because the SEBC did not follow these procedures, this regulation is unlawful. At the very least, the question of lawfulness is "substantial," which is all that is required here. Importantly, Plaintiffs are not aware of any legal authority holding that agency action similar to the SEBC's need not comply with the APA. That, by itself, compels a finding that the issue here is substantial. *Smith*, 793 F.2d at 89 (holding that a legal question is inherently "substantial" if the party's argument is not foreclosed by "controlling precedent"). Not only does the caselaw not foreclose Plaintiffs' argument, it strongly supports it.

II. PLAINTIFFS WILL SUFFER IRREPARABLE HARM ABSENT A STAY

If the State's implementation of this new HMAP is not stayed, tens of thousands of elderly and disabled retirees, including Plaintiffs, face irreparable harm in numerous ways. "Harm is irreparable unless alternative legal redress is clearly available and is as practical and efficient to the ends of justice and its prompt administration" as the requested stay. *In re Del Monte Foods Co. S'holders Litig.*, 25 A.3d 813, 838 (Del. Ch. 2011) (internal quotations and brackets omitted).

After depriving retirees of their statutory right to review and weigh in on the decision to radically change their healthcare, the State is now forcing them to make the following choice by October 24: either be automatically enrolled in the HMAP or opt out and pay thousands of dollars to retain traditional Medicare supplemental insurance. As explained below, both options entail irreparable harm.[16]

Notably, this exact same choice was forced on retirees in New York a year ago, and a court there issued preliminary and permanent injunctive relief based on the same irreparable injuries identified below. *See NYC Org. of Public Service Retirees Inc. v. Campion*, 2021 WL 4920705, at *2 (Sup. Ct., N.Y. Cty.).

A. Retirees will Suffer at Least Three Types of Irreparable Harm Regardless of Their Enrollment Decision

Retirees will suffer at least three types of irreparable harm regardless of whether they choose to enroll in or opt out of the HMAP.

First, all retirees will be irreparably harmed by the violation of their procedural rights under the APA if Defendants are allowed to proceed with their new healthcare policy. It is well-established that where, as here, members of the public are denied a statutorily protected opportunity to review or comment on proposed agency action before it is implemented, the harm they suffer is irreparable. *See*, *e.g.*, *Blue Cross & Blue Shield v. Elliott*, 1977 WL 23810, at *1 (Del. Ch.) (staying

[16] The irreparable harm discussed below is supported by the affidavits submitted along with Plaintiffs' motion.

Insurance Commissioner order "direct[ing] Blue Cross and Blue Shield to reduce proposed weighted average rate increases" based on irreparable harm from, *inter alia*, "alleged deficiencies in the notice of hearing preceding such order"); *Louisiana v. Horseracing Integrity & Safety Auth. Inc.*, 2022 WL 2960031, at *13 (W.D. La.) (holding that the "alleged violations of the APA, which did not allow sufficient time for public comments, constitute irreparable injury"); *Texas v. Becerra*, 577 F. Supp. 3d 527, 559 (N.D. Tex. 2021) (holding that party suffers "irreparable injury by being denied its procedural right [under the APA] to comment on the Rule"); *Alaska v. Lubchenco*, 2012 WL 13035040, at *2–3 (D. Alaska), *aff'd*, 723 F.3d 1043 (9th Cir. 2013) (holding that defendant's failure to "provide the public with a sufficient opportunity for review and comment on the [environmental assessment] . . . caused irreparable harm to the Plaintiffs' and the public's procedural rights").

Had retirees been given the statutorily required notice and opportunity to review and comment on the SEBC's regulation before it was adopted, large numbers would have vehemently objected at public hearings and submitted written materials explaining why the proposed regulation was misguided and unfair. The SEBC, in turn, would have been required to consider this input and explain whatever decision it made. This process might have led to a different outcome, including adoption of the sensible proposals made by the RBSC. *See* Compl. ¶¶ 52-60. Absent a stay, we will never know.

Second, because of the inadequate and misleading information provided to retirees about the HMAP—including which healthcare providers will participate in it—retirees cannot make an informed decision about whether to enroll in the plan by the State-imposed deadline of October 24. Forcing these elderly and disabled retirees to make such a consequential healthcare decision without adequate information is an additional form of irreparable harm. *See NYC Org.*, 2021 WL 4920705, at *2 (stating that retirees would suffer irreparable harm by having to make healthcare enrollment decision when information regarding new Medicare Advantage plan and doctor participation was still unclear); *Woodward & Lothrop, Inc. v. Schnabel*,593 F. Supp. 1385, 1394 (D.D.C. 1984) ("Given the current state of information now before the shareholders, proceeding with the vote would itself cause an irreparable injury to the shareholders who would be compelled to make a vital investment decision based on incomplete and potentially materially misleading information.").

Lastly, retirees are already experiencing and, absent a stay, will continue to experience anxiety over the drastic and unprecedented change to their healthcare benefits, which many are still struggling to understand. Such distress among senior citizens and the disabled—many of whose health and financial conditions are precarious—is another recognized form of irreparable harm. *See*, *e.g.*, *United*

Steelworkers, 836 F.2d at 8; *Angotti*, 2006 WL 1646135, at *16; *Laforest v. Honeywell Intern., Inc.*, 2003 WL 23180220, at *2 (W.D.N.Y.).

B. Enrolling in the HMAP will Cause Irreparable Harm

Those who enroll in the HMAP will experience a number of adverse changes to their healthcare benefits. First, because of the HMAP's prior authorization requirements, they will be prohibited from receiving various tests and treatments ordered by their doctors unless and until the private insurance company administering the plan deems them medically necessary. Countless studies, including one recently conducted by the U.S. Department of Health and Human Services, have demonstrated that such prior authorization protocols cause life-threatening denials of, and delays in, medical treatment. *See* Compl. ¶¶ 22-24. Courts "routinely" find irreparable harm where, as here, there is a risk of "delay in or inability to obtain medical services." *Wilson v. Gordon*, 822 F.3d 934, 958 (6th Cir. 2016) (collecting cases); *see also Mamula v. Satralloy, Inc.*,578 F. Supp. 563, 577 (S.D. Ohio 1983) (holding that "delay in obtaining medical attention or [] not receiving any medical attention" constitutes irreparable harm).

Second, in contrast to traditional Medicare—which is accepted by virtually all doctors and hospitals around the country—a large number of healthcare providers

will not participate in the HMAP. *See* Compl. ¶¶ 26-27, 35-36.[17] The State has not identified which healthcare providers will—and which will not—participate. And there is no way for retirees (or the State) to accurately predict that information at the moment since the details of the plan, and the contract authorizing it, were only just finalized on September 28.[18] There is simply no way for a retiree to make an informed decision about whether to accept the HMAP (or opt out) without knowing if their doctor is going to accept this new plan.

For those retirees who choose to enroll in the HMAP, but whose doctors or hospitals later refuse to accept it, they will have to scramble to switch healthcare providers. This will be incredibly disruptive, particularly for those in the middle of a course of treatment. Such disruption to the continuity of care, which is especially important to the thousands of Medicare-eligible (*i.e.*, elderly and/or disabled) individuals at issue in this case, has been found to constitute irreparable harm. For example, in *Plattsburgh City Retirees' Ass'n v. City of Plattsburgh*, the court granted interim relief to Medicare-eligible retirees because their "change in coverage [from one health insurance plan to another] may necessitate a change in healthcare

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[17] In New York City, which recently attempted to switch its retirees into a Medicare Advantage plan, scores of healthcare providers refused to accept the plan. *See NYC Org.*, Index No. 158815/2021 (Sup. Ct., N.Y. Cty.), NYSCEF Nos. 46-56, 102-04, 124.

[18] *See* https://dhr.delaware.gov/benefits/medicare/documents/ma-delaware-contract.pdf.

providers and a change in course of treatment." 2016 WL 1424371, at *5 (Sup. Ct., Clinton Cty., N.Y.). Similarly, in *Matter of Sheriff Officers Ass'n, Inc. v. Nassau County*, the court granted interim relief because "monetary damages are an inadequate substitute for the anticipated disruption in the continuity of medical care that may result" from a change in health insurance. 2012 WL 2367795, at *4 (Sup. Ct., Nassau Cty., N.Y.).

If retirees who are enrolled in the HMAP find that their doctors will not accept it, but continue being treated by them anyway in order to maintain continuity of care, they will incur significant out-of-pocket costs. *See* Compl. ¶¶ 32-34. These costs are irreparable because damages are not available under the APA. *Stritzinger v. Barba*, 2018 WL 4189535, at *2 (Del. Ch.) (unavailability of damages remedy renders financial harm irreparable); *City & Cnty. of San Francisco v. U.S. Citizenship & Immigr. Servs.*, 981 F.3d 742, 762 (9th Cir. 2020) (finding "economic harm . . . sufficient to constitute irreparable harm because of the unavailability of monetary damages"); *Ghadiri v. Tops Auto Supply Inc.*, 2020 WL 5775832, at *4 (C.D. Cal.) (finding irreparable harm because, *inter alia*, "damages are unavailable under the ADA").

Moreover, because many of these retirees live on fixed pensions and receive treatment on a regular basis due to their advanced age and/or disabilities, such increases in healthcare expenses will create significant financial hardship. Some

retirees will have trouble paying their rent; others will be forced to reduce spending on food and clothing; and still others will have to skimp on prescribed medications and other necessities. Courts have widely found such harm to be irreparable. *See, e.g.*, *United Steelworkers of America, AFL-CIO v. Textron, Inc.*, 836 F.2d 6, 8 (1st Cir. 1987) (explaining that irreparable harm is commonly found when retired union members—"most [of whom] live on fixed incomes" and "are not rich"—must pay for healthcare expenses "out of money that they need for other necessities of life"); *Angotti v. Rexam, Inc.*, 2006 WL 1646135, at *15 (N.D. Cal.) (finding irreparable harm to retirees because their increased healthcare costs would cause them to "cut back on spending for grocery trips and visiting family").

Out-of-pocket costs will also inevitably cause some to forego visits to the doctor, which is yet another form of irreparable harm. *See, e.g.*, *Zotto v. Scovill, Inc.*, 1985 WL 14176, at *2 (D. Conn.) (finding irreparable harm because retirees might "forego needed medical treatment if they were required to pay for it"); *Mamula v. Satralloy, Inc.*, 578 F. Supp. 563, 577 (S.D. Ohio 1983) (finding irreparable harm based on the fact that some retirees may "forego needed medical attention" due to cost concerns).

C. Opting out of the HMAP Will Cause Irreparable Harm

Not surprisingly, a number of retirees will choose to opt out of the HMAP because of its prior authorization requirements and limited network of healthcare

providers. Although these retirees should be able to obtain some type of Medicare supplemental insurance on the open market, there is no guarantee they will be able to duplicate the healthcare and prescription benefits they currently receive, and, regardless, they will have to pay for such insurance, which will cost thousands of dollars a year. They will also have to find and pay for health insurance for their dependents, who will lose State-funded coverage as a result of the opt-out decision. As noted previously, such financial harm is inherently irreparable because monetary damages are unavailable here.

Further, because many retirees live pension-check-to-pension-check with serious medical conditions, these new financial burdens will require them to limit spending on other necessities, which, as mentioned above, is a widely recognized form of irreparable harm. *See, e.g.*, *Angotti*, 2006 WL 1646135, at *15 (finding irreparable harm to individuals "who must pay an additional $261.14 for supplemental insurance and therefore have [to] cut back on spending for grocery trips and visiting family"); *Angotti v. Rexam Inc.*, 2006 WL 3043130, at *13(D. Minn.) (finding irreparable harm based on retirees having to pay $100 a month for insurance); *Helwig v. Kelsey-Hayes, Co.*, 857 F. Supp. 1168, 1179–80 (E.D. Mich. 1994) (enjoining defendant from raising health insurance costs, even though some retirees were likely well-off, because others were former secretarial and clerical workers who likely faced financial hardship); *Schalk v. Teledyne, Inc.*, 751 F. Supp.

1261, 1267–68 (W.D. Mich. 1990), *aff'd*, 948 F.2d 1290 (6th Cir. 1991) (finding additional yearly medical expense of $592 to $1,900 would impose irreparable harm on fixed-income retirees).

In conclusion, a stay is necessary to prevent Plaintiffs and their fellow retirees from suffering myriad forms of irreparable harm.

CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that this Court grant their motion and stay implementation of the HMAP, including the October 24 enrollment deadline, pending a final trial on the merits.

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