IN THE SUPERIOR COURT FOR THE STATE OF DELAWARE

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

AFFIDAVIT OF ROBERT CLARKIN

STATE OF DELAWARE)

COUNTY OF NEW CASTLE)

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

1. After thirty-six years of public service, I retired from the Delaware Department of Labor, Division of Employment and Training as Deputy Director on March 31, 2010. My health care needs for the last ten years have been covered by Medicare Parts A and B, supplemented with the State supported Special Medicfill Medicare Supplement Plan and the CVS/SilverScript (formally Express Scripts) Medicare Part D prescription drug coverage plan. I am more than grateful for the healthcare insurance coverage, and peace of mind, that the state of Delaware has afforded me, and to my family, during my years of active state employment, my retired pre-Medicare eligibility years, and my Medicare eligible years to date.

"EXCITED" LETTER FROM THE STATE

2. In early June, 2022, I received a letter (dated June 1) from the State of Delaware. The letter sounded like I had won the lottery proclaiming: "On behalf of the Statewide Benefits Office and the Office of Pensions, we are **EXCITED** to share positive changes for Medicare-eligible retirees!" Subsequent language notified me as follows: "The State of Delaware will transition medical plan coverage from the current Special Medicfill Supplement Plan to Freedom Blue PPO, a Medicare Advantage Plan (also known as a Medicare Part C plan) administered by Highmark Blue Cross Blue Shield Delaware, for coverage to begin January 1, 2023." The letter went on to give "several reasons" to answer their own question posed as "Why is this a positive change?" They did not say anything possibly negative about the change. Instead, SBO Director Faith Rentz and Pension Administrator Joanna Adams, who jointly signed the letter, "reassure(d)" me that "we have your best interest in mind." I now know that this patronizing assurance was not at all the case.

3. Many questions entered my mind because over the years I have learned some things about Medicare Advantage, and I was concerned. So, I got to work and started looking for answers by combing through the State's website and the Federal Medicare website. After days of intensive research, I discovered many things that left me shocked. Both about the new plan itself - which is not a positive change at all as it turns out - and how the State made the changes in secret.

MY FAMILY'S CONCERNS AND THE HARM TO US

4. Retirees like me are now presented by the State with a choice: leave "traditional" Medicare Part A and B and be automatically enrolled in a Medicare Advantage plan, or opt out and lose your State health care benefits all together — **a take it or leave it proposition with both options terrible**.

5. To make matters even worse, I have been advised by the State Pension Office that my daughter, who currently has State funded healthcare through a Comprehensive Blue Cross Blue Shield plan, will also lose her coverage if I do not accept the Medicare Advantage plan. So we feel stuck.

THE REALITIES OF THE FINANCIAL CONSEQUENCES

6. I am a seventy-five year old State pensioner on a fixed income with a dependent daughter. My wife is also a State pensioner on a fixed income. We are confronted with the same inflation pressures and rising costs of health care that confronts the State. If I had a graphic presentation of an actuarial study of my 30 year, unfunded healthcare costs, I am sure it would look very similar to the State's. And just imagine how my fixed income would be negatively impacted if my wife and I opt out of the Medicare Advantage plan.

7. We would have to purchase Medicare supplement coverage for myself, Medicare supplement coverage for my wife, Medicare Part D prescription coverage for myself, Medicare Part D coverage for my wife, and healthcare coverage that

includes prescription coverage for my daughter. This would be a problem financially. The total "State Share" for my family coverage as indicated on my monthly Pension Direct Deposit Advisory Notice for the month of September is $1,724.29. This equates to $20,691.48 a year. If my wife and I opt out of the Advantage plan option, where do retirees on a fixed income find an additional $20,691.48 every year to replace the total loss of all of my family health insurance. This would wipe out almost all of my Social Security.

8. I am a cardiac patient who takes medications for Coronary Artery Disease and Atrial Fibrillation. My wife has rheumatoid arthritis that is in remission due to weekly injections. Through July, 2022, our combined Medicare Part D total drug costs are $53,698.48. Thankfully, the State's prescription plan covers most of these costs. However, if we opt out of the Advantage plan and lose our prescription plan we must cover the entire cost of two new prescription plans. How cruel of the the State to not provide a standalone prescription plan option.

9. The new "benefits of "Silver Sneakers!" and "meals after surgery" are trivial and meaningless to me. What *will* be meaningful is when a medically necessary procedure my wife or I really need, like a CT scan or MRI, is denied or delayed.

PRIOR AUTHORIZATIONS

10. What probably concerns me the most about the move to the Freedom Blue PPO plan is the issue of "prior authorizations" and "pre-visit coverage decisions." I have been on Medicare with Medicfill as my supplemental plan for 10 years and I have never had to get prior authorization for any Medicare Part A or Part B hospital stay, physician visit, specialist visit, physical therapy visit, urgent care visit, lab work, or medical test. And I have never been faced with confusing and lengthy paperwork and billing. Everything has been very seamless with Medicare as the gatekeeper, setting the rules and reimbursement rates.

11. With the new plan, Highmark becomes the gatekeeper. For instance, the following was included on a slide during an August, 2022 Pension Office orientation presentation: "Prior Authorizations may apply to certain services such as Inpatient Hospital services, Skilled Nursing Facility Stays, and Advanced Images (e.g., CT/PET Scan). Contracted "In Network" providers are responsible to submit to Highmark for approval. When seeking care from non-network providers, members ask for a pre-visit coverage decision to confirm that the services that you are getting are covered and medically necessary."

12. The above quote includes just three categories of services requiring prior authorization. As of September 30, 2022, the Frequently Asked Questions on the State's Highmark Medicare Advantage website include 21 categories of services

requiring pre authorization. On September 29, 2022, the State made the Advantage plan contract with Highmark public. The contract includes Exhibit 3, Highmark Prior Authorization List (Effective 10/1/22) which includes 41 pages of items requiring prior authorization. No, that is not a typo, the list has expanded from three items to 41 pages of items in just one month. Now you know why prior authorization concerns me!

THE NEW NETWORK STRUCTURE

13. And yet another issue that is also very concerning is whether or not our current doctors are in the Freedom Blue PPO network. The State maintains that "93-95% of Medicare providers in Delaware have agreed to be in the network." I am unsure what that exactly means. The State in its communications about the new plan seems always to be parsing its words carefully so that it is hard to know the implications of what the State is saying.

14. After hearing that a number of our doctors were not aware of the plan, my wife contacted Highmark to find out if they accepted the plan. She spent an hour on the phone with the Highmark concierge who had difficulty locating our doctors. Finally, after expressing it was difficult to navigate their online directory, he offered to send a paper copy of their provider directory which we did not know existed.

15. My wife and I have searched through the paper Provider Directory he sent in an attempt to determine our doctor's in-network status. To date, our trusted

family doctor is not in the network, my wife's trusted OB/GYN doctor is not in the network, the hospital that my wife's OB/GYN doctor is affiliated with is not in the network, my wife's trusted out-of-state endocrinologist is not in the network, and the hospital that my wife's endocrinologist is affiliated with is not in the network. And, in the future, if my wife requires specialized treatment for OB/GYN issues that she is currently being monitored for, we want the freedom and flexibility to seek the best treatment available at neighboring Philadelphia hospitals that do not appear to be in the Freedom PPO network.

MY WORRIES ABOUT PRIVATIZED MANAGED CARE REPLACING OUR TRADITIONAL MEDICARE

16. I have nothing but good experiences with traditional Medicare Parts A and B supplemented with the current Medicfill program. But as I have come to understand from my many hours of research, I cannot expect the same with Medicare Advantage. With traditional Medicare as the primary provider of my coverage, and Medicfill as the secondary, the rules and coverage are set and managed by the Federal government and not by a for-profit insurance company. With the new Medicare Advantage plan, a for-profit insurance company (Highmark) will manage my care, with the inevitable goal of increasing my costs to decrease their costs, increasing my hurdles to obtaining medical services, and decreasing my benefits every year that the contract is renewed with the State.

17. My health care, as well as my wife's, is currently managed between us and our trusted family doctor of thirty years with no barriers to care such as prior-authorizations, pre-visit coverage decisions, in-network providers, out-of-network providers, and prior-authorization service lists. I want my doctors to spend their time wisely providing us with the best possible care and not wasting time fighting their way through a maze of artificial barriers, the intention of which is to delay services, deny services, and pass costs on to retirees.

18. My wife and I now worry a lot about how, as we get older, we will manage our way through all the inevitable paperwork and obstacles to care that will happen with the new Medicate Advantage plan. We dread the nightmare of appealing any possible denial of care. Preparing such an appeal would be time consuming and very difficult, if not impossible, as we try to understand the confusing language in the various Highmark documents that we have received.

MY WORRIES ABOUT THE STATE'S LACK OF TRANSPARENCY AND RAILROADING THIS CHANGE THROUGH

19. I no longer trust the State to watch out for my best interests as a retiree. My review of the minutes of State Employee Benefits Committee (SEBC) meetings revealed that the SEBC began discussing this change in late 2020 leading to the development of an RFP during February, 2021. The RFP was released in April, 2021; responses were received and evaluated during May — November, 2012, and during their February 28, 2022 meeting, the SEBC unanimously approved moving

Medicare pensioners to the Highmark Delaware Medicare Advantage Plan effective January 1, 2023. Nothing in the agendas for these meetings suggested that a fundamental change to our healthcare benefits was in the works.

20. My time-consuming research also made it clear to me that the SEBC, the SBO, and the Office of Pensions were aware of the planning and execution of this change for at least eighteen months prior to the June 1, 2022 mailing. But they made no attempt to reach out to me (or as far as I can tell to other retirees) to tell us about the planned changes, or to seek our input and opinions, or consider viable options. If I had been told of the consideration to move us all to a Medicare Advantage plan, I would have done my research then and made every effort to object.

21. I found the State's lack of real transparency and reasonable public notice to be very troubling and it makes me more distrustful of what the State has done. I have learned that at least two State committees have had something to do with retiree health care benefits: the SEBC and the RBSC. Of course, few people will even be aware of these committees or think to attend their meetings. But at least to investigate after the fact as I was left to do, timely, publicly posted minutes were crucial for me to learn what they do in their proceedings. But the minutes are delayed at least 30 days, and sometimes more. Minutes for the March 24, 2022 RBSC meeting were not posted at all until a draft was posted on September 16, 2022. And

I went through the agendas and found they were not informative at all. One would never know that a sea change was happening.

22. As to input, the public is allowed to make "public comment" towards the end of SEBC meetings. However, comment is limited to 3 minutes and SEBC members will not answer questions or enter into a dialogue. To me, these practices might meet the lowest level of transparency and public notice — but, they are a far cry from a sincere and timely effort to satisfy transparency and public notice.

CONCLUSION

23. I firmly believe that this move to a Medicare Advantage plan its harmful to me and my family (and other retirees). It harms us in so many ways and forces us to leave our tried and true Original Medicare benefits supplemented by the current Special Medicfill plan and enter the unpredictable world of prior-authorizations, prior-authorization lists, pre-visit coverage decisions, in-network versus out-of-network providers, and determinations of medically necessary services intended to delay services, deny services, and pass costs on to retirees.

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

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

Executed this 3rd day of October, 2022.

Robert Clarkin

SWORN TO AND ASCRIBED before me this 3d day of October, 2022.

Notary Public Del Bar Id. 2256

Pursuant to 29 Del. C. § 4323(a)(3)

v. 10/3/22 1653

STATE OF DELAWARE

June 1, 2022

P2~1**********5-DIGIT 19808
Robert Clarkin
122 Dunbarton Dr
Wilmington, DE 19808-1356

Pensioner ID: [redacted]

Dear Robert Clarkin:

On behalf of the Statewide Benefits Office and the Office of Pensions, we are EXCITED to share positive changes for Medicare-eligible retirees! The State of Delaware will transition medical plan coverage from the current Special Medicfill Medicare Supplement Plan to Freedom Blue PPO, a Medicare Advantage Plan (also known as a Medicare Part C plan) administered by Highmark Blue Cross Blue Shield Delaware, for coverage to begin January 1, 2023.

Why is this a positive change? There are several reasons.

1. The monthly cost of the Medicare Advantage Plan is less than half of the current cost while providing the same level of medical plan benefits as the Special Medicfill plan it replaces.
2. The Medicare Advantage Plan offers exceptional service through an expanded concierge service team and additional benefits, such as Silver Sneakers and at home meals following discharge from a hospitalization.
3. The Medicare Advantage Plan offers a simplified process because you no longer need to carry your Medicare card in addition to your Highmark medical plan ID card.
4. There will be no change to your prescription coverage as SilverScript, the State of Delaware Medicare Part D prescription drug coverage administered by CVS Caremark, will continue as our pharmacy plan for all Medicare retirees.

The primary purpose of this letter is to inform you of the upcoming change and reassure you that we have your best interest in mind. Below are several things to remember:

- There will be no action required by you. Our staff will manage the transition, so no action is necessary if you are currently enrolled in Special Medicfill with Prescription.

View reverse side for more information →

- You will receive multiple mailings from now until the end of the year regarding this transition. Many more details will be available in the future mailings coming from us and Highmark Blue Cross Blue Shield Delaware.
- Please look for the State of Delaware Medicare Advantage branding on all mailings. You will likely be inundated with marketing materials in the upcoming months trying to sell additional coverage. For your convenience, all mailings from the State of Delaware and/or Highmark Blue Cross Blue Shield Delaware regarding the change to Medicare Advantage will have the State seal and this easily identifiable branding on the envelope.

Getting to know your Medicare Advantage Plan as a State of Delaware Pensioner

- Highmark Blue Cross Blue Shield Delaware has created a dedicated Medicare Advantage concierge call center to answer your questions regarding the Freedom Blue PPO Medicare Advantage Plan. Please feel free to call Highmark at **1-888-328-2960** for assistance with any questions you may have.

We want to reassure you that we are working hard to ensure the transition is smooth and worry-free. Remember, there will be additional information mailed to you over the next several months. In the meantime, enclosed in this mailing is a Frequently Asked Questions document and a chart from Highmark Blue Cross Blue Shield Delaware, comparing the Freedom Blue PPO benefits to the current Special Medicfill Plan. As a reminder, Highmark Blue Cross Blue Shield Delaware has a dedicated Medicare Advantage concierge call center ready to answer your questions at **1-888-328-2960**. The Office of Pensions can also be reached at 1-302-739-4208 or 1-800-722-7300 to answer any questions regarding your benefits. Information and updates can also be viewed at DelawarePensions.com.

Sincerely,

Faith L. Rentz
Statewide Benefits Office Director

Sincerely,

Joanna M. Adams
Pension Administrator