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Case Number 178,2023D

IN THE SUPREME COURT OF THE STATE OF DELAWARE

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 Below/ Appellants/Cross Appellees, v. RISEDELAWARE INC., KAREN PETERSON, and THOMAS PENOZA, Plaintiffs Below/ Appellees/Cross Appellants.	No. 178,2023D On Appeal from the Superior Court of the State of Delaware C.A. No. N22C-09-526 CLS

APPELLEES' ANSWERING BRIEF ON APPEAL AND CROSS-APPELLANTS' OPENING BRIEF ON CROSS APPEAL

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NATURE OF PROCEEDINGS

This litigation arose out of the State's secretive and abrupt effort to upend the long-standing Medicare benefit enjoyed by over 30,000 State of Delaware employees in retirement ("Retirees"). That benefit—a Medicare Supplement for traditional Medicare called "Medicfill"—ensures that Retirees can see the doctors of their choice, that their doctors will be the ones who determine their healthcare, and that Retirees can live affordably. Many employees factor this promised benefit as a tradeoff to work for the State with its lower salaries and they rely on it when deciding to retire.

Unfortunately, and to Retirees' grave detriment, that healthcare arrangement was about to be involuntarily taken away. In February 2022, the State Employee Benefits Committee ("SEBC"), steered by its defendant co-chair leaders (Defendants DeMatteis and Cade), acted surreptitiously and unilaterally to switch Retirees to an entirely different plan—Medicare Advantage. That material change would inflict drastic, adverse consequences on Retiree healthcare rights. Unlike traditional Medicare, Medicare Advantage is privatized and puts an insurance company in charge of patient healthcare. Those healthcare insurers have an exceptional profit incentive to restrict, delay, and deny healthcare when Retirees are most vulnerable and in greatest need.

When enacting such fundamental governmental policy changes, agencies are legally required to observe the procedural safeguards established in the Delaware Administrative Procedures Act ("APA") and Freedom of Information Act ("FOIA"). These codified safeguards of Title 29, designed to uphold the democratic values of open government and citizen participation, include open government meetings conducted with proper notice and that afford citizens the opportunity to provide input during rulemaking.

The SEBC abysmally failed to comply with those statutory mandates. Without notice or opportunity for input, the SEBC unlawfully promulgated what amounted to a regulation (though not in name) that peremptorily moved all Retirees to Medicare Advantage. Following that secretive action, the defendant co-chairs intentionally delayed informing Retirees of that change, and then cloaked their delayed disclosure with false and misleading glowing descriptions of Medicare Advantage to forestall pushback. They almost succeeded before Retirees could see what was happening and take legal action. Plaintiffs, who represent the interests of the 30,000 Retirees, managed only by the skin of their teeth to successfully halt the switch at the eleventh hour before it became a *fait accompli*.

Because of the SEBC's failure to honor its duties and comply with statutory safeguards, the Superior Court, in a well-founded "Stay Order" entered on October 19, 2022, stayed Defendants' implementation of any Medicare Advantage

plan and required that current Retirees be kept on their existing benefit during the stay. That stay—which Defendants never sought to have lifted below—is, Plaintiffs submit, now permanent and beyond legal challenge. Further, Defendants also waived below their right to challenge the underlying factual findings of the Stay Order by voluntarily foregoing any right to a merits trial. Consequently, those factual findings stand on and govern this appeal.

Of critical consequence for their appeal, Defendants do not challenge the Superior Court's final May 22, 2023 Order on which their appeal is founded. That "Final Order" determined that the parties had settled the case without need for further Court adjudication, a consequence of which was that the Stay Order was never lifted and remains in force. Defendants' Opening Appeal brief is devoted to attacking the Stay Order. The absence of any challenge to the May 22 Final Order itself, however, is fatal to their appeal—and to any challenge of the earlier Stay Order. The Stay Order is beyond appeal, but if it is considered, it should unquestionably be affirmed on the merits.

Plaintiffs' lawsuit was indisputably successful. It achieved a highly significant benefit for some 30,000 current Retirees of stopping Defendants from switching them to Medicare Advantage. That switch would have caused irreparable harm to Retirees by depriving them of their long-standing healthcare benefit, as established by unrebutted Retiree testimony and determined by the Superior Court. With the

Stay Order remaining in force, both current and future Retirees are protected from being forcibly thrust into Medicare Advantage.

The Superior Court commendably recognized the irreparable harm in the SEBC's denial of Retirees' statutorily protected right to provide input on the attempted switch to Medicare Advantage. Events post-dating the Stay Order validate that recognition. In January 2023, the Delaware General Assembly established an advisory committee (the "RHBAS"), led by the Lieutenant Governor and two legislators, to recommend appropriate Retiree healthcare benefits. The RHBAS, in numerous meetings over many months, has welcomed extensive public comments. With the help of informed public input, the RHBAS has made important recommendations—most notably, that the SEBC in the next bidding cycle take Medicare Advantage off the table for Retirees—current and future.

The achievement of the momentous common benefit from the Stay Order warrants an award of attorneys' fees, especially given the extremely troublesome conduct of Defendants DeMatteis and Cade in attempting to foreclose relief for Retirees from the other two branches of State government. Those officials campaigned, employing flagrant misrepresentations, to block legislative support for Retirees and to thwart any potential lawsuit by Retirees seeking to stop the implementation of Medicare Advantage. The Superior Court, however, without

considering these facts, held that the Plaintiffs were not entitled to an award of attorneys' fees.

On their cross appeal, Plaintiffs respectfully submit that the Superior Court's erroneous denial of fees should be reversed and remanded with instructions to award fees. The Superior Court (twice) declined to evaluate the merits of the fee application and erroneously refused to consider the equitable bases for awarding fees. The lawsuit has been funded (albeit quite incompletely) only through donations from a comparative few of the many thousands of affected individuals because Plaintiffs lack the ability to reach out to most of them. As a result, a very small fraction of Retirees are "footing the bill" for the Defendants' misdeeds.

SUMMARY OF ARGUMENT

1. Denied that the Stay Order was erroneous in any respect and denied that it should be reversed.

A. Defendants have voluntarily relinquished any entitlement to challenge the Stay Order on the merits. They waived any right to challenge its facts when they waived trial. At the proposed final judgment stage, Defendants never asked the Superior Court to lift or modify the Order's stay of implementation of Medicare Advantage. B301–05. On appeal, Defendants do not challenge on the merits any aspect of the Superior Court's May 22, 2023 "Order on Final Judgment" ("Final Order") which determined that the parties had settled the case without need for further Court adjudication, a consequence of which was that the Stay Order was never lifted and remains in force. Therefore, Defendants are legally foreclosed from challenging the Stay Order, including its determination that the Defendants violated the APA and its injunction against implementation of Medicare Advantage. Accordingly, Defendants' appeal should be dismissed without reaching the merits of their claim that the Superior Court committed error in entering the Stay Order.

B. If this Court decides to reach the merits, it should affirm and uphold the Stay Order. And given Defendants' waiver below, the stay itself should not be lifted in any event. As the Superior Court found and the Defendants did not dispute below, the SEBC's adoption of Medicare Advantage constituted a policy change that falls

squarely within the statutory definition of a "regulation." The SEBC was therefore required to observe the mandates of the APA when adopting Medicare Advantage.

Defendants' legal arguments—that other statutory provisions or case law negate or excuse the SEBC from the APA's mandates—fail at the threshold. Defendants erroneously conflate the act of the SEBC—changing the paradigm of Retirees' healthcare plan from Medicfill to Medicare Advantage—with the act of the SEBC's selection of a carrier to furnish or implement the new healthcare plan. Those are qualitatively distinct acts, with the former being subject to the APA's requirements for rulemaking.

Nothing in *Free-Flow Packaging Int'l, Inc. v. Sec'y of Dep't of Nat. Res. & Envtl. Control of State*, 861 A.2d 1233 (Del. 2004) (hereinafter "*Free-Flow*") is to the contrary. *Free-Flow* excuses from APA compliance *only* agency conduct that mechanistically carries out a specific and detailed directive of the General Assembly. The General Assembly did not dictate that the SEBC switch Retirees to Medicare Advantage. The Court below was correct in rejecting this argument.

Defendants' other argument, based on canons of statutory construction, is equally without merit. No canon supports the extreme notion advocated by Defendants that the SEBC's legislatively-derived authority to enter into a contract implementing a regulation overrides all other statutory obligations, including the APA, that govern the adoption of the regulation.

SUMMARY OF ARGUMENT ON CROSS APPEAL

1. The Superior Court reversibly erred by refusing to consider the merits of, and thereby denying, Plaintiffs' Petition for Attorneys' Fees ("Fee Petition") in its February 6, 2023 and May 22, 2023 orders. The Superior Court abused its discretion by declining to exercise its jurisdiction to apply established equitable principles to the found facts of this case. Plaintiffs achieved an undeniable common benefit for 30,000 Retirees by obtaining a court order preventing the State from switching its longstanding traditional Medicare supplement benefit to Medicare Advantage. Plaintiffs saved Retirees from the irreparable harm found by the Superior Court of being forced to the "choice" of going on Medicare Advantage or forfeiting a State-subsidized benefit for traditional Medicare. *Decision* at *4, A099–100.[1] Achievement of that common benefit, and in protection of Retirees' statutory right to review and comment on proposed agency action, deserves fee recognition all the more because of Defendants' obstreperous and improper attempts to obstruct Retirees' efforts to obtain relief from the SEBC's illegal acts. Finally, if Defendants press their frivolous pleading-waiver argument on this cross appeal and so as to moot that issue, Plaintiffs ask this Court to reverse, as an abuse of discretion, the Superior Court's denial of Plaintiffs' motion to amend the Complaint to plead fees.

[1] Citations to "Decision" are to the October 19, 2022 Stay Order, *RiseDelaware Inc. v. DeMatteis*, 2022 WL 11121549 (2022), found in its original form at A089–102.

STATEMENT OF FACTS

A. The SEBC's Improper Adoption Of Medicare Advantage Under Defendant State Officials' Leadership

1. Background

a. The Parties

The five Appellants, Defendants below, are:

(a) the State Employee Benefits Committee ("SEBC") which is tasked by its enabling statute, 29 *Del. C.* § 9602, with control and management of State employee benefits (*see also* 29 *Del. C.* § 5210);

(b) the two individual defendant co-chairs of the SEBC, Claire DeMatteis, Secretary of DHR (the Department of Human Resources) and Cerron Cade, Director of OMB (the Office of Management and Budget) (jointly "State Officials"); and

(c) DHR and its division, the Statewide Benefits Office ("SBO"), named in the Complaint as Division of Statewide Benefits.

The SEBC is a defendant because it is the agency responsible for the adoption of the healthcare overhaul at issue. The State Officials are defendants because they lead the SEBC and steered its unlawful actions.[2] They are also responsible for

[2] The other seven members of the SEBC at the pertinent times for this lawsuit were: a State Administration official, three elected officials, two appointees (not in the Administration), and a citizen representing one of four state employee organizations (picked on a rotating basis). 29 *Del. C.* § 9602(a). In 2023, a retiree appointed by the governor was added, along with a second organizational member, increasing the SEBC from 9 to its present 11 members. *Id.*

improper attempts to thwart this lawsuit. DHR and its division, the SBO, are defendants because of their roles under the direction of Secretary DeMatteis.

The three Appellees, Plaintiffs below, are: (a) RiseDelaware Inc. ("RISE"), a nonprofit established to act as a sentinel on issues involving State healthcare benefits for Retirees; and (b) Retirees Karen Peterson and Thomas Penoza who devoted many years to State service. B004–55 ¶¶ 8–9.

b. Retirees' Healthcare Benefit

Traditional Medicare, funded by the federal government, is simple in theory: Part A covers hospital care and Part B covers doctors. Medicare pays Part A hospital care (after a deductible) and 80% of bills under Part B. The remaining 20% is paid for by the individual or supplemental insurance ("Medicare Supplement plans").

Delaware Retirees for decades have had a Medicare Supplement plan largely or entirely paid for by the State as a retirement benefit from their State employment. They rely on the promise of that benefit in deciding to work for the State and in deciding to retire. B137 ¶ 3 (Brubaker Aff.), B156 ¶ 3 (MacDonald Aff.), B163 ¶ 3 (Maichle Aff.), B168–69 ¶¶ 2–4 (Penoza Aff.), B183 ¶ 17 (Peterson 1st Aff.).

Medicare Advantage (called Part C) essentially substitutes for Parts A and B with plans run by private insurance companies. The federal government pays a set annual amount per individual per year to the insurance companies, who in turn decide on what they will pay the hospitals and doctors.

For both traditional Medicare and Medicare Advantage, individuals pay a standard monthly premium to the federal government of $165, unless adjusted for income. Premiums for both Supplement and Advantage plans are paid for by individuals or former employers. But typically, premiums are much cheaper for Medicare Advantage plans because they profit from often-hidden costs that crop up when seniors go to obtain care. *See* B179–81 ¶¶ 9–10 (Peterson 1st Aff.); B394 ¶ 8 (Peterson 3d Aff.).

The theory behind the adoption of Medicare Advantage 25 years ago was a win-win-win public-private partnership with insurance companies as the managers of care to keep older people healthier and reduce costs. But, in reality, seniors on Medicare Advantage receive worse care because of restrictive doctor networks and the use of massive so-called "prior authorizations,"[3] with resulting costly and dangerous delays and denials of care for patients.[4]

In short, the only winners in this privatized managed care Medicare Advantage scheme have been the profit-incentivized private insurance industry and the employers who offload their retired employees to such plans.

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[3] Traditional Medicare has "virtually no" prior authorizations. B348. The contract with Highmark has over 41 pages of prior authorizations, numbering over 2,000 B146-47 ¶ 12 (Clarkin 1st Aff.), B411 ¶ 13 (Clarkin 2d. Aff.).

[4] B009–10 citing https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

2. The SEBC's Secretive Adoption Of Medicare Advantage

"On February 28, 2022, the SEBC held a public meeting." *Decision* at *1. A091. The action taken at that meeting, without proper notice and compliance with proper rule making, is central to this lawsuit.

A reader of the meeting Agenda (A192, B071) would conclude that the business of the meeting was to be mundane: "According to the agenda for this meeting, the fourth matter to be addressed was '2021 Health Third Party Administrative Services RFP Award Recommendations.'" *Decision* at *1, A091. And "[a]ccording to the February 28, 2022 meeting minutes [B057], it seems as if the members of SEBC were selecting a carrier for Medicare coverage for retirees to start on January 1, 2023." *Id*.

The meeting, however, was anything but mundane. The SEBC, steered by the State Officials, took action far more significant than merely selecting a carrier or administrator for the current and long-standing Medicare supplement benefit, Special Medicfill administered by Highmark ("Medicfill").[5] Instead, and without notice, the SEBC voted to *upend* that long established benefit and *switch* Retirees to

[5] To promote clarity, Plaintiffs underscore the difference between "administrator" and "carrier," although in the litigation the terms have generally been used without distinction. Because Delaware's Medicare Supplement plan is self-insured by the State (to cover the 20% of medical claims not covered by the Medicare trust fund), Highmark acts only as "administrator" for that plan. The Medicare Advantage plan was an outright switch to an insurer or "carrier" funded plan.

Medicare Advantage in a fundamental restructuring of Retirees' healthcare with dramatic adverse impacts. A234. The meeting Agenda had given no notice of this major policy change. A192 & *see Decision* at *1, A091. The SEBC, nonetheless, proceeded to choose Highmark as carrier for a Medicare Advantage plan.[6] A228–29, A234. That choice of carrier was a distinct "key decision point" from choice of plan design, as summarized by Consultant Giovannello for the SEBC. A229.

The abrupt change wrought by the SEBC in retirement benefit to Medicare Advantage was significant. In its Stay Order, the Superior Court identified two very significant changes:

> It is undisputed that *the Medicare Advantage plan is substantially different from retirees current State-funded health insurance* as the Medicare Advantage plan will require prior authorization for significantly more procedures and will require retirees to find in-network doctors to avoid paying out-of-pocket costs for care.

Decision at *2, A094 (italics added). Defendants' factual claim (DOB 6, 10)—that Highmark's Medicare Advantage Plan is "custom designed" to provide "the same benefits coverage" to Retirees as their current Medicfill plan—is wrong and contradicts the Stay Order's finding that the plans were "substantially different." Defendants also made such a claim in their Stay opposition papers. *See, e.g.*, A028.

[6] Highmark's plan is referred to in this litigation as Freedom Blue PPO Medicare Advantage Plan ("HMAP")."

The Superior Court found, and the Defendants had not disputed (A039-45), that the SEBC's switch to Medicare Advantage was a policy change within the meaning of a regulation under the APA:

> According to the APA, a regulation is, in relevant language, "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." Here, SEBC … enacted a policy 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. Therefore, *such policy change is a regulation under the APA*.

Decision at *3, A096–97 (italics added).

The Superior Court further found, however, that the SEBC did not observe the mandates of FOIA or the APA in adopting this regulation. "The procedural safeguards of the APA were ignored in implementation of this regulation." *See Decision* at *4, A098.[7]

Lastly, the Superior Court found that the SEBC's actions threatened irreparable harm for Retirees, because "their government benefit, to which [they] have a reasonable expectation of continuation, is at stake." *Decision* at *4, A099–

[7] The Stay Order also determined that, in adopting Medicare Advantage, the SEBC violated FOIA's open meetings laws. *See Decision* at *4 & n.10, A098–99. Violation of FOIA is the underlying basis for the violation of the APA alleged in Count II and therefore the Court's determination was the basis for the parties' stipulation that Plaintiffs had prevailed on both counts.

100. The SEBC's denial of Retirees' statutorily protected right to give input on the switch to Medicare Advantage also irreparably harmed Retirees. *Id.*

3. State Officials' Improper Efforts To Keep Medicare Advantage

a. Retirees Were Kept Uninformed And Then Misled By State Officials

The State Officials intentionally kept Retirees in the dark for three months after the SEBC's adoption of Medicare Advantage in February 2022. A074–75 ¶¶ 26–28. Not until June 2022 did they provide notice to State Retirees of the impending healthcare switch. A072, A074. That notice came in the form of a letter proclaiming, "we are EXCITED to share positive changes for Medicare-eligible retirees!" and assuring Retirees the switch was in their "best interest."[8] B143 ¶ 2 (Clarkin 1st Aff.), B153–54, B195. The letter misrepresented that the new, excitement-provoking Medicare Advantage plan provided "the same level of medical plan benefits." *See Decision* at *2, A099–100. Defendants do not claim that the State Officials ever corrected the misrepresented portrayal in later communications or that they ever gave a complete picture with all the negative changes. Indeed, subsequent communications continued the misrepresentation: e.g.,

[8] Two directors under the charge of the State Officials signed the letter: Faith Rentz, the Director of the defendant SBO (part of DHR under defendant DeMatteis as noted above) and Pension Administrator Joanna Adams of the Office of Pensions (part of OMB under Defendant Cade). B143 ¶ 2 (Clarkin 1st Aff.), B154.

the new plan covers "the same services as the old plan" (B052); "coverage for Medicare services…remains the same" with "the same access to doctors" (B422); and "*in some cases*," prior approval for care is required (A281, A315, B054). Nor do the State Officials deny they were responsible for what was said.

In short, from the outset, the official information about Medicare Advantage provided to Retirees under the control of the State Officials was uniformly glowing and made no mention of the drastic healthcare ramifications that were actually *not* in Retirees' "best interest." Given this fictitious portrait, only a rare Retiree would suspect that his or her healthcare plan was about to take a fundamental and harmful turn. The imminent and draconian peril to Retirees cannot be overstated. They were given only one choice: take it or leave it—i.e., sign up for Medicare Advantage or forfeit entitlement to State-provided healthcare benefits long promised to Retirees.

b. State Officials' Campaign Of Disinformation

It took an Opinion piece published in the News Journal on August 12, 2022, authored by Representative John Kowalko, to warn Retirees of the truth about the State's change to their healthcare and the resulting harms. B363–64. Kowalko's op-ed, calling out the switch as creating "a fox guarding a hen house," did not escape the attention of the State Officials. B363. They must have seen the Kowalko disclosures as a threat to their evident plan to keep Retirees uneducated about what was truly happening to them.

Faced with the Kowalko disclosures, Defendants DeMatteis and Cade on September 1 published, in their official capacities, an opposition piece to push back, claiming that: everything was "the same" for benefits for services and access to doctors and hospitals (B366); and only "some" services would require prior approval. B367. These official claims have been judicially determined to be misrepresentations. *Decision* at *4, A098. The Superior Court, as noted above, found the plans to be "substantially different." *Decision* at *2, A094. Further, "certainly a reasonable person could not confuse 'some' services with over 1,000 services Highmark requires prior authorizations for." *Decision* at *4, A099. Judge Scott was being conservative in saying "over 1,000 services." The actual number was over 2,000 prior authorizations. B394 ¶ 8 (Peterson 3d Aff.), B416 ¶ 13 (Clarkin 2d Aff.).

DeMatteis and Cade further claimed that the "SEBC went through an extensive public process over the past year on the transition to a Medicare Advantage plan." B367. That claim also was manifestly untrue. The SEBC agenda for the meeting on February 28, 2022 did not provide FOIA notice of the major healthcare overhaul being voted on or warn Retirees of the irreparable harm waiting for them down the road. Nor did subsequent meetings give notice of the significant

differences between current Medicfill and the to-be inflicted Medicare Advantage plan. *See Decision* at *2, 4, A091, 099–100.[9]

Given growing Retiree concerns, on September 12, 2022, two state legislators held a Town Hall meeting at Goldey Beacom College in Wilmington. Defendants DeMatteis and Cade, along with Highmark representatives, were speakers. Hundreds of Retirees attended and expressed deep concerns with the switch to Medicare Advantage. B198 ¶ 16 (Diller Aff.).

In response, rather than follow what the law required, State Officials doubled down. DeMatteis and Cade wrote the Senate Democratic Caucus the next day (September 13, 2022) to foreclose by fear mongering any further interest (i.e., interference) by legislators. B374–75. "[W]riting to confirm and explain the legal, statutory, financial and practical reasons why the transition [to Medicare Advantage] cannot be postponed," DeMatteis and Cade claimed that the State was by then legally powerless to correct course: "Highmark has a legal right to rely on [the March 2, 2023 SEBC] contract award [letter]…." B374.

[9] Nor, from the extensive, meticulous research done by a Retiree, did earlier meetings do so. B413–14 ¶¶ 7–9 (Clarkin 2d Aff.). Indeed, had they, then presumably the February 28, 2022 Minutes (A229, B058) would have read differently. But as noted by the Superior Court, "Page three of the minutes indicates Director Cade believed there would not be material changes to the plan, if the SEBC switched retirees to Medicare Advantage." *See Decision* at *1, A091.

This representation was not true. There was no executed contract; therefore, Highmark could have had no legal rights. Indeed, the governing RFP unequivocally provided that: "Notice in writing to a vendor(s) of the acceptance of its proposal by the SEBC *and* the subsequent full execution of a written contract will constitute a contract and *no vendor will acquire any legal or equitable rights or privileges until the occurrence of both such events.*" A156 § 4.0 (italics added). The inference is inescapable that this false claim—that the State was legally bound to implement Medicare Advantage based on a contract award letter and before a contract had been entered into—was either willful or egregiously reckless.[10]

In another misdirection that can only have been intended to scare off legislators from acting to help Retirees, the DeMatteis/Cade letter claimed that epilogue language in the June 28, 2022 appropriations bill "codifies the change to Medicare Advantage." B375. The obvious implication was that the General Assembly should take no action to help Retirees because it (allegedly) had just voted

[10] The response of defendant DeMatteis below was only to aver that, "[a]fter the Highmark Medicare Advantage contract was signed," it was her "view that the Medicare Advantage contract could not be rescinded without the State incurring substantial damages. A331 ¶ 11. But she was making her representations well before the contract was signed on September 28, 2022, as she knew (A329–31).

to approve and perhaps mandated the switch to Medicare Advantage. No such codification existed.[11]

Secretary DeMatteis then claimed in a meeting with Retiree leaders on September 14 that Highmark had contractual rights that could not be broken and that the State could be sued if it reneged on Medicare Advantage. B203–05 ¶¶ 9–10 (Peterson 2d Aff.). Based on that false rationale, the State Officials refused Retirees' request to delay implementation of Medicare Advantage. *Id*.; B199 ¶ 20 (Diller Aff.).

The State officials thus left 30,000 Retirees without any non-litigation path to avoid the sword of Damocles choice of going on Medicare Advantage or forfeiting their State healthcare benefit. With only weeks to make that choice before the October 3 start of open enrollment, the only path left to Retirees was litigation. B199–200 ¶¶ 21–22 (Diller Aff.).

c. State Officials' Continued Interference With Retirees' Efforts For Redress

The hurdles for undertaking and pursuing a viable lawsuit were enormous. The basic facts required massive work to research. *See, e.g.*, B179–81, B384–87, B413–17. Disinformation by State Officials had created significant further obstacles

[11] *Cf.* B391–92 ¶ 3 (Peterson 3d Aff.). The only legislative action that occurred (i.e., that was buried) in the epilogue was to address the so-called double state share applying to only 266 people. *Id.* B413 ¶ 6 (Clarkin 2d Aff.). Defendants have never argued that the epilogue language overrode the SEBC's APA's obligations here or required the SEBC to switch Retirees to Medicare Advantage.

by misdirecting Plaintiffs down rabbit holes and pulling away hoped-for support from the legislative branch. *Id.*

After an exceptionally intensive effort, Plaintiffs filed this suit on September 25, 2022. *See* B199 ¶ 22 (Diller Aff.). With the open enrollment period of October 3–24 starting in only two weeks, the constraints of time on seeking and obtaining judicial relief were critical. Compounding the time problem, Plaintiffs needed money they did not have to pay for attorneys. B395–96 ¶¶ 9, 12 (Peterson 3d Aff.). Crowd-sourced fundraising appeared to be the only way to make the lawsuit happen, although Plaintiffs had no means to reach the tens of thousands current and future Retirees who would be affected by the healthcare change. *Id.* ¶ 10. As it has turned out, given the limitations of outreach available to the Plaintiffs, the hoped-for ability to fully fund the litigation has not borne out. *Id.* ¶ 11.

The Complaint formally requested a stay of execution of a contract with Highmark and any further implementation of Medicare Advantage. B037. Although Defendants were certainly aware of the Complaint (B439–43), the State Officials proceeded extra-judicially on September 28 to have executed a contract with Highmark for Medicare Advantage[12] without regard for the Superior Court procedural rules and process. *See Decision* at *2, A098.

[12]https://dhr.delaware.gov/benefits/medicare/documents/ma-delaware-contract.pdf?ver=1010#page=11

Meanwhile, DeMatteis and Cade continued their campaign of misinformation to legislators, with predictable effect. *See* B391–94 ¶¶ 2–7 (Peterson 3d Aff.). Relying on that misinformation, some legislators told their constituents that: (1) the lawsuit had no merit; (2) "Highmark would probably sue us to the tune of hundreds of millions of dollars"; (3) the lawsuit was "dangerous" because success would result in "no coverage" for Retirees starting January 1, 2023; and (4) Retirees should not donate to RISE for the lawsuit. *Id.* ¶¶ 4, 6–7.

Retirees were left to counter as best they could this egregious misinformation that impacted fundraising, even while Plaintiffs were pursuing their successful Motion To Stay. *Id.* ¶ 4. The success in the Superior Court came at great expense in attorneys' fees—and there is still a large debt—which is why Plaintiffs sought, and continue to seek, an award of attorneys' fees. B396 ¶ 11 (Peterson 3d Aff.). Plaintiffs' attorneys should be made whole for their uncompensated efforts.

B. Plaintiffs' Successful Challenge To Medicare Advantage

1. Plaintiffs' Superior Court Complaint

Plaintiffs' Complaint includes Counts I and II that sought relief based on the SEBC's violation of the APA by failing to follow the rule-making process of the APA (Count I) and by failing to follow FOIA (Count II) (the "APA claims"). B031–36. (Paragraph 105 of Count III sought a declaratory judgment that Defendants violated the APA. B037.) The remaining paragraphs 102 through 104 of Count III (the

"Communications Claim"), later dismissed by the parties without prejudice, sought a judgment declaring that Secretary DeMatteis failed to execute her duties when communicating with Retirees. B037.

The relief requested included "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." B038.

2. The Superior Court's Order Staying Implementation Of Medicare Advantage

On October 4, 2022, Plaintiffs moved to stay Defendants' implementation of Medicare Advantage for Retirees. After briefing and a hearing, the Court granted the motion on October 19, 2022 and awarded the full relief requested by Plaintiffs' form of proposed order:

> Defendants' implementation of a Medicare Advantage Plan for State retirees and acceptance of enrollment into the Plan, including by way of automatic enrollment in the open enrollment period currently in effect for State retirees[,] is stayed until further Order by this Court.
>
> During the stay, Defendants shall take all necessary and proper steps to ensure that the healthcare insurance and benefits available to State retirees prior to October 3, 2022, or in which they were enrolled prior to that time, remain in full force and effect.

Decision at *5, A101. (Defendants did not contest, if Plaintiffs' motion were granted, that Plaintiffs' proposed form of relief was appropriate.) In granting this relief, the Superior Court recognized the irreparable harm to Retirees from having their

Medicfill benefit, "to which these individuals have a reasonable expectation of continuation," taken away. *See Decision* at *4, A099–100. It also "recognize[d] irreparable harm in Plaintiffs and other retirees being denied a statutorily protected right to review or comment on proposed agency action before its implementation." *Id*. Numerous affiants established the irreparable harm. *See* Affidavits of Brubaker, Clarkin, MacDonald, Maichle, Penoza and Peterson. B136–184.

The benefits for Retirees achieved by the litigation are manifold and substantial. As a direct result of the Stay Order, the SEBC on October 24, 2022 extended Medicfill through 2023, and thereafter through June 30, 2024, rather than proceeding to implement Medicare Advantage. *See* B387 ¶ 12 (LePage Aff.). Thus, Retirees to date have not had their medical care decided by an insurance company's employees or had to seek out "in-network" providers. *See* e.g. B147–49 ¶¶ 13–18 (Clarkin 1st Aff.), B157–59 ¶¶ 5–9 (MacDonald Aff.), B163–66 ¶¶ 4–11 (Maichle Aff.). Moreover, Retirees' treatments will not be delayed and denied by an insurer in the name of "prior authorizations"; and they will not face Medicare Advantage's "cost-sharing," "co-insurance," and other costs not present under their Medicfill benefit. *See e.g.* B137–39 ¶¶ 4–7 (Brubaker Aff.), B146–47 ¶¶ 10–12 (Clarkin 1st Aff.), B179–80 ¶¶ 9–10 (Peterson 1st Aff.), B171–72 ¶¶ 10–11 (Penoza Aff.).

The litigation has also resulted in validation of the Stay Order's recognition of the benefits of public input in rulemaking. The General Assembly in January 2023

in SB29 established the RHBAS advisory subcommittee on Retiree healthcare benefits, led by the Lieutenant Governor and two legislators as co-vice chairs. Over six months, the RHBAS has met numerous times and welcomed extensive public comments.[13] The RHBAS has made important recommendations—including for "grandfathering" into Medicfill anyone retiring before January 1, 2025 and for the SEBC to take Medicare Advantage off the table for the next three years.[14] The next question will be whether the SEBC listens.[15]

3. Subsequent Proceedings To Obtain A Final Order

a. The Parties' Resolution In Superior Court Without Trial And Without Lifting The Stay Order

The Stay Order, which was clearly interlocutory, contemplated further proceedings leading to a final judgment: "A final trial on the merits…will be

[13] *See* RHBAS meeting materials, including minutes, numerous written public comments received, and videos of meetings including oral public comment. https://dhr.delaware.gov/benefits/sebc/subcommittee-materials.shtml

[14] The RHBAS adopted a "grandfathering" recommendation on August 10, 2023 "that current Medicare eligible and pre-Medicare State Retirees and State employees who retire prior to 1/1/2025, shall be entitled to Special Medicfill/Rx benefits…." https://dhr.delaware.gov/benefits/sebc/documents/rhba-subcommittee-2023/0810-minutes.pdf. The motion to take Medicare Advantage off the table (for the next RFP cycle), was adopted on August 24. The minutes are not yet available.

[15] Defendants raise the prospect of serious state finance consequences if Medicare Advantage is not adopted. *See* DOB 6–7. The RHBAS, however, on May 8, 2023 recommended increased State funding, that was codified into law in June 2023 (SB175), which will go a long way to addressing finance concerns. https://dhr.delaware.gov/benefits/sebc/documents/rhba-subcommittee-2023/0508-minutes.pdf (p. 3).

scheduled as soon as possible, where the Court will make a final determination of facts." *Decision* at *5, A102. The Superior Court scheduled that trial for November 28, 2022. *See* B249, B291. The Stay Order by its terms also anticipated a possible "further order" directed to its first injunctive provision against "implementation of a Medicare Advantage plan." *Decision* at *5, A101.

Defendants did not appeal from the Stay Order under Supreme Court Rule 42 which governs appeals from interlocutory orders. Defendants decided instead, as a strategic matter, to reposition the case into an agreed-upon final judgment posture, which would enable them to appeal as of right. *See* B250–55. To facilitate that outcome, Defendants decided to forego a trial and, as a consequence, any right to contest the facts determined in the Stay Order. *See* B254.

To get to a final judgment posture, two predicate matters first needed to be resolved: the Communications Claim and Plaintiffs' Fee Petition. The parties agreed to resolve the Communications Claim by a court-approved Stipulation dismissing that claim without prejudice. *See* B298 n.2. The parties agreed to, and did, brief the Fee Petition. The parties agreed to forego trial, including as to fees. This joint effort was presented to the Superior Court in the form of two separate stipulations, which were both rejected by the Court as insufficient. B256–62, B270–78.

In accordance with the Superior Court's instruction (B278), the parties then presented a Stipulation (with Final Judgment) on December 16, 2022 "reflective of

the resolution of the case." B279–87. That Stipulation provided that the Stay Order "effectively grants Plaintiffs the complete relief sought in [the APA claims]," and "that no trial is necessary for entry of judgment on these issues based upon the Court's holdings in the [Stay Order]." B280. The attached Final Order provided, *inter alia*, that: "The [Stay Order] constitutes the Court's findings of fact and conclusions of law on [the APA claims]"; and "[f]or the reasons outlined in the [Stay Order], final judgment is entered against Defendants and in favor of Plaintiffs on [the APA claims]." B286. Importantly, this Stipulated resolution did not call for the Superior Court to lift the Stay Order's injunctive provision prohibiting the State from implementing a Medicare Advantage plan. The Stipulation did provide that the Stay Order's second injunctive provision, keeping Retirees on Medicfill, "shall remain in place for the 2023 policy year." B286–87. At the time, the State had only extended Medicfill through June 2023.

On February 8, 2023 the Superior Court denied Plaintiffs' pending request for fees, essentially without stated reasons, and stated, "[n]o further order of this Court is needed to close this case." B294. The Superior Court did not, however, approve the parties' submitted December 16, 2022 stipulation or formally enter a final judgment. Thus, for finality purposes, the procedural posture of the case remained in limbo.

b. Defendants' Misguided First Appeal With Subsequent Proceedings Leading To The Final Order And Defendants' Second Appeal

Defendants, however, next appealed to this Court from the Superior Court's February 8, 2023 Order. Noting that the Superior Court had not entered the parties' proposed final judgment, this Court on April 3, 2023 dismissed Defendants' "appeal for failure to comply with Rule 42 when taking an appeal from an interlocutory order." B299.

Defendants then moved in the Superior Court for an order entering final judgment in favor of Plaintiffs on the APA Claims. B306–12. Defendants' proposed form of final judgment (B302–05), while differing in some respects from the earlier agreed-upon form, included the provision that the Stay Order resolved the case in Plaintiffs' favor at the trial court level without need for a trial. B304 ¶ 2. Defendants' proposed form of final judgment did not call for the Stay Order's injunction against implementation of a Medicare Advantage plan to be lifted or modified. B302–05.

After a hearing on Defendants' motion (B313–29), the Superior Court on May 22, 2023, issued its Final Order, a document titled, "The Court's Order on Final Judgment." B330–37. Although entering "final judgment" denying Plaintiffs' request for attorneys' fees, the Final Order did not enter Defendants' proposed final judgment.

Instead, the Court's Final Order recited that Defendants' motion was made "on a record that is undeveloped due to the parties' mutual agreement." B337 ¶ 16. It further determined that, "[s]ince the Court granted Plaintiffs' Motion to Stay, the parties have settled the matter without adjudication from this Court," and "[t]he only issue remaining in this case is of Attorneys' Fees." B336–37 ¶¶ 13, 17. With regard to Plaintiffs' request for attorneys' fees, the Court ruled, again essentially without reasons: "[B]ecause Plaintiffs are not entitled to Attorneys' Fees by Statute or for any other reason, this Court enters judgment against Plaintiffs for Attorneys' Fees." B337 ¶ 17. The document concluded: "IT IS SO ORDERED." B337.

Defendants filed their Notice of Appeal on May 22, 2023 from the Final Order entered that same day. Their Notice of Appeal necessarily referenced the Final Order, as this Court had already held that the Stay Order and the February 8, 2023 order did not permit appeals without a Final Order.

Their Opening Brief, however, argues only that the interlocutory Stay Order was erroneous. It does not argue that the Superior Court erred in its determination in the Final Order that the parties had settled the merits independently of the Court, with the resulting consequence that the Stay Order remained in place. Nor does it claim that the Final Order erred in effectively denying the only motion then before the Court (apart from fees)—Defendants' Motion for Entry of Final Judgment. By arguing only that the Court erred in entering the Stay Order, Defendants would recast

their current appeal following and stemming from the Final Order into something they are not permitted to do—take an interlocutory appeal from the Stay Order, which this Court previously dismissed as violative of Supreme Court Rule 42.

ARGUMENT ON DEFENDANTS' APPEAL

I. DEFENDANTS ARE LEGALLY FORECLOSED FROM CHALLENGING THE STAY ORDER ON THIS APPEAL

A. Question Presented

Should this Court dismiss Defendants' appeal and affirm the Final Order (except as to fees) because: (a) Defendants did not ask the Superior Court at the final judgment stage to lift the Stay Order's injunction against the implementation of Medicare Advantage; and (b) Defendants' Opening Brief did not challenge the Final Order so that their arguments seeking to have the Stay Order overturned amount to an untimely interlocutory appeal not in compliance with Supreme Court Rule 42? These appellate issues of waiver have arisen only on Defendants' appeal and so could not have been raised by Plaintiffs in the Superior Court. The actions of Defendants in the Superior Court at the final judgment stage and in this Court, however, are in the record. In the interests of justice and under Supr. Ct. R. 8, Plaintiffs ask this Court to consider their arguments, which could result in a dismissal of Defendants' appeal.

B. Standard And Scope Of Review

The issues of waiver and their consequence as a result of Appellants' lack of challenge on appeal to the Final Order are questions for this Court under Supr. Ct. R. 8 and Supr. Ct. R. 14(b)(vi)(A)(3). *See Roca v. E.I. du Pont de Nemours and Co*., 842 A.2d 1238, 1242 (2004).

C. Merits Of The Argument

In the Superior Court at the final judgment stage, while Defendants asked to have the Stay Order incorporated into a final judgment, which that Court declined to do, they did not ask for the injunction against Medicare Advantage to be lifted. B302–04. (At most, they asked only for the second injunctive provision—keeping then current Retirees on the existing benefit—to be modified to apply through a set date of 2023. B304 ¶ 4.) Accordingly, they cannot seek that relief now absent a showing that the interests of justice so require. Supr. Ct. R. 8. While Defendants apparently now seek that relief (*see* DOB 24), they do not even attempt to make such a showing. This Court, therefore, should not lift the Stay Order's injunction against implementation of a Medicare Advantage plan.

Moreover, the only Order of the Superior Court that Defendants actually dispute on appeal is the Stay Order. But that Order was interlocutory, and this Court rejected Defendants' initial appeal of that Order as interlocutory and in violation of Supr. Ct. R. 42. B299. As a consequence, Appellants could not appeal that Order unless and until it achieved finality through incorporation into a final judgment. *See Tyson Foods, Inc. v. Aetos Corp.*, 809 A.2d 575, 580 (2002).

But the Superior Court declined on Defendants' Motion For Entry Of Final Judgment to incorporate the Stay Order's holdings on the SEBC's violation of the APA into a final judgment on the merits in the form requested by Defendants

(B303 – 04 ¶¶ 1–2). Instead, on May 22, 2023, the Superior Court issued its own form of Final Order holding that the case, other than as to fees, had been resolved by the parties without further need of adjudication of the Court, a direct consequence of which was that the Stay Order was never lifted and remains in full force and effect. B330–37. Defendants do not argue on this appeal that the Superior Court erred in entering its Final Order.

Defendants also do not argue the Stay Order was merged into and affected the Final Order, such that the Stay Order could be appealed on that basis. *See Camesi v. Univ. of Pittsburgh Med. Ctr.*, 729 F.3d 239, 244–45 (3d Cir. 2013); *In re Westinghouse Securities Litigation*, 90 F.3d 696, 706 (3d Cir. 1996) ("Under the 'merger rule,' prior interlocutory orders merge with the final judgment in a case, and the interlocutory orders (*to the extent that they affect the final judgment*) may be reviewed on appeal from the final order.") (italics added); *see also Two Guys From Harrison-NY v S.F.R. Realty Assoc*., 186 A.D.2d 186, 189 (1992) ("provisional remedy designed to retain the status quo while the action was pending" does not "necessarily affect" the final judgment, and "thus the appeal [of the final judgment] does not bring it up for review). 587 N.Y.S.2d 962. Nor could they make such an argument. The Superior Court's Final Order was affected *not* by the Stay Order, but rather what the parties' own actions to resolve the matter *after* the Stay Order was entered. B336 ¶ 13.

Alternatively viewed, the Defendants waived their right to challenge the Final Order insofar as it left in place the Stay Order, and thereby effectively mooted that issue for purposes of this appeal. As a consequence, the Defendants' attempt to challenge the Stay Order on its merits on this appeal is legally foreclosed. *See Tyson Foods, Inc. v. Aetos Corp.,* 809 A. 2d 575, 580 (Del. 2001)

There is no dispute that the Final Order is cognizable as a "final order" and capable of appeal as such. Unlike the Superior Court's February 8, 2023 Order, where finality and scope were held to be "uncertain" (B299), the Final Order makes its finality and scope certain:

> The Parties did not find trial necessary, therefore no final determination of facts or conclusions of law occurred under these circumstances. *Since this Court granted Plaintiffs' Motion to Stay, the parties have settled the matter without adjudication from this Court.*

B336 ¶ 13 (italics added). The Superior Court entered judgment on the only remaining issue, i.e., Plaintiffs' application for attorneys' fees (which the Court denied). Accordingly, the May 22, 2023 Order is a final order. *See J.I. Kislak Mortgage Corp. of Delaware v. William Matthews, Builder, Inc.,* 303 A.2d 648, 650 (Del. 1973). [16]

[16] After the Superior Court's February 8, 2023 Order and before Defendants' appeal, Plaintiffs on February 15 filed an election to transfer the case to the Court of Chancery for it to address equitable issues on attorneys' fees. Plaintiffs argued that the Superior Court did not have jurisdiction to enter a further order because of the (Cont'd....)

Defendants have, therefore, waived their right to assert now a challenge to the Final Order which left in place the Stay Order. By this Court's rule, "[t]he merits of any argument that is not raised in the body of the opening brief shall be deemed waived and will not be considered by the [Delaware Supreme] Court on appeal." Supr. Ct. R. 14(b)(vi)(A)(3). This Court adheres to this rule. *See Roca*, 842 A.2d at 1242 ("the appealing party's opening brief must *fully* state the grounds for appeal, as well as the arguments and supporting authorities on each issue or claim of reversible error. '[C]asual mention of an issue in a brief is cursory treatment insufficient to preserve the issue for appeal.'"); *Crown Bank v. BCD Assocs., LLC*, 2023 WL 1977573, at *2 (Del. 2023); *TransPerfect Glob., Inc. v. Pincus*, 278 A.3d 630, 651, n.149 (Del. 2022), reargument denied (June 21, 2022), cert. denied, 143 S. Ct. 574 (2023); *Cirillo Fam. Tr. v. Moezinia*, 2019 WL 5107461, at *1, n.7 (Del. 2019).

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election. The Final Order held that the transfer was procedurally defective. B332–34. Plaintiffs are not challenging this conclusion on this appeal.

Plaintiffs do submit, however, as a matter of policy for this Court to consider elsewhere, that the Superior Court's ruling was misguided in following a practice guide by a practitioner setting forth numerous bureaucratic obstacles and delays he had experienced to effectuate a transfer. Those nowhere appear in statute or rules, and suggest a bureaucracy run amok.

II. IF THIS COURT DECIDES TO REACH THE MERITS, IT SHOULD UPHOLD THE STAY ORDER AS CORRECTLY DETERMINING THAT THE SEBC VIOLATED THE APA WHEN ADOPTING MEDICARE ADVANTAGE

A. Question Presented

Did the SEBC, which is subject to the open meeting and open government laws of Title 29, violate the APA when, without proper notice and without observing the APA's requirements for adopting regulations, it unilaterally switched Retirees from their decades-long Medicare Supplement benefit (Medicfill) to Medicare Advantage? This question was preserved at B119–24, B188–90.

B. Standard And Scope Of Review

Issues requiring interpretation of the provisions of the APA, the SEBC's enabling statute and *Free-Flow* are questions of law that are reviewed *de novo*. *City of Wilmington v. Nationwide Ins. Co*., 154 A.3d 1124, 1127 (Del. 2017).

C. Merits of Argument

1. The Policy Change To Medicare Advantage Is A Regulation Within The Meaning Of The APA To Which The SEBC Is Subject

Defendants did not dispute below, nor do they now on appeal, that the SEBC is subject to the APA governing the adoption regulations. *See* 29 *Del. C.* § 10102(1), 10161(b) and Subchapter II. The Defendants' sole position is essentially that their unilateral and furtive switch from Medicfill to Medicare advantage was excused

from rulemaking under the APA because of its authority to select carriers. This argument is meritless.

To be sure, the SEBC did not publicly identify, characterize, promulgate, or publish its sweeping healthcare overhaul as a regulation. But the APA's definition of "regulation" is not limited to matters that an agency itself chooses to treat as a regulation. No agency, including the SEBC, can evade the APA by simply deciding not to label its action as a regulation. Indeed, the authoritative Delaware Administrative Code Drafting and Style Manual for regulations provides that, "*[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." § 2.6 (italics added) available at https://regulations.delaware.gov/agency/docs/draftingmanual.pdf. In other words, what renders an agency action a regulation is the substantive nature of that action, not the linguistic terms employed to label it. *See also Baker v. Delaware Dep't of Nat. Res. & Envtl. Control*, 2015 WL 5971784, at *13 (Del. Super.), *aff'd*, 137 A.3d 122 (Del. 2016) (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 v. Delaware State Bd. of Educ.*, 1994 WL 637000, at *4 (Del. Super.) (action designated by agency as a "calendar change" was a *de facto* regulation).

The Stay Order determined—and the Defendants did not dispute below (A036, A039–45)—that the SEBC's switch to Medicare Advantage was a policy change falling within the statutory definition of a regulation. *Decision* at *3, A096–97. The APA defines "regulation" broadly to encompass "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) (italics added). *See also Retail Liquor Dealers Ass'n of Delaware v. Delaware Alcoholic Beverage Control Comm'n*, 1980 WL 273545, at *1 (Del. Ch.) (state agency's action qualified as a regulation "inasmuch as it was a policy decision"); *DE State Sportsmans' Ass'n. v. Garvin*, 2020 WL 6813997, at *9 (Del. Super. 2020) (agency language restricting rifles and ammunition for deer hunting qualified as a "regulation" because it was both "a statement of 'policy'" and "one of 'requirement'").

Only now on appeal (DOB 20) do Defendants claim that, "[i]f the words [of 29 *Del. C.* § 10102(7) defining "Regulation"] are given their plain meaning, the SEBC's act is not a regulation." But that argument comes too late and is procedurally foreclosed. Supr. Ct. R. 8. The Superior Court's correct determination that the switch to Medicare Advantage was a policy change within the statutory definition of a "regulation" is now procedurally immune from challenge. Moreover, Plaintiffs' Opening Brief in support of a stay gave well-founded reasons why the switch to

Medicare Advantage was a "regulation" within the statutory meaning of statute. B121–24. Defendants did not. contest this position below. A039–45.

2. The SEBC's Adoption Of Medicare Advantage Was Not A Specific Legislative Directive And No Statutory Provision Negated The APA's Rule-Making Obligations That Are Binding On The SEBC

If this Court reaches the merits of the Stay Order, the only question left for it to decide is whether the SEBC was legally excused from compliance with the APA when adopting the policy that switched Retirees' healthcare benefit to Medicare Advantage. For the reasons set forth, the answer is a resounding "no;" and the Defendants' contrary arguments are devoid of merit.

To begin with, Appellants' arguments to this Court, as below (A039–45), conflate conceptually (i) the SEBC's adoption of a policy overhaul (switching from Medicfill to Medicare Advantage) with (ii) the SEBC's selection of a carrier to implement such a plan. This is self-evident from Appellants' *Free-Flow* argument:

> It follows that when the SEBC makes a decision regarding selection of a carrier "deemed to offer the best plan to satisfy the interests of the state," it implements a specific and detailed statutory directive provided by the General Assembly [citing 29 *Del. C.* §§ 5210(2), 9602 (b)(2)]. Thus, under *Free-Flow*, the SEBC need not follow the APA in selecting coverages and carriers—such as selecting Highmark for the Medicare Advantage plan.

DOB 16. This fatally flawed argument ignores that the SEBC's substantively transformational policy change to Medicare Advantage was not qualitatively the

same as choosing a specific insurance carrier to provide a Medicare Advantage plan, whether such a plan was mandated by the General Assembly or adopted as a regulation pursuant to the APA, neither of which was the case here. Indeed, the SEBC itself recognized that these were distinct "*key decision points for the SEBC*." B058 (italics added).

Moreover, and importantly, the SEBC's policy change to Medicare Advantage stands in stark contrast to the agency action at issue in *Free-Flow*, where the assessment of fees by an agency (DNREC) was held not to qualify as a "regulation" because DNREC was merely "implement[ing] a specific and detailed *statutory* directive." 861 A.2d 1233, 1236 (italics added). The statute "instructed DNREC to place each polluting source into one of four specified categories" based on "DNREC's estimation of the number of hours spent performing services." *Id*.

The underlying legislative framework in this case could not be more different. The powers granted the SEBC in 29 *Del. C.* § 9602 (and § 5210) in no way resemble the "specific and detailed statutory directive" present in *Free-Flow.* The SEBC's enabling provisions do not command the SEBC to place Medicare-eligible retirees into a Medicare Advantage plan, let alone one with the specific features of the Highmark plan, which mandates over 2,000 prior authorizations. B394 ¶ 8 (Peterson 3d Aff.), B416 ¶ 13 (Clarkin 2d Aff.). Nor does 29 *Del. C.* § 5203(b)—relied on by Defendants for the first time on appeal (*cf.* DOB 18, n.16 and A023)—direct the

SEBC to select Medicare Advantage as the retirement benefit. That policy change was made by the SEBC alone, without a prior directive from the General Assembly. The Superior Court, therefore, correctly determined that "there is no specific statutory directive for [the] SEBC to force all retirees from their State-subsidized benefits to a Medicare Advantage plan or lose benefits. Therefore, *Free-Flow* does not apply." *Decision* at *3, A097.

Defendants' only remaining APA argument is that applicable canons of statutory construction shield the SEBC from the APA's rulemaking requirements. DOB 19–24. Defendants' argument, however, again necessarily presupposes the validity of their attempted conflation of two conceptually distinct issues. Moreover, it begs the real issue. Plaintiffs never argued, and the Superior Court never found, that the SEBC's *selection of a carrier*, in and of itself and without more, amounted to rulemaking. Rather, the issue is whether the SEBC was required to observe the APA rulemaking procedures *when adopting a regulation that changes the fundamental paradigm for Retirees' healthcare benefit*. When properly focusing on that issue, the answer is plainly "yes" as a matter of statutory construction, and the Court below correctly so held.

Construction of a statute necessarily starts by considering its plain meaning. *PHL Variable Ins. v. Price Dawe 2006 Ins. Trust*, 28 A.3d 1059, 1070 (Del. 2011). If its meaning is plain, then "the plain meaning of the statutory language controls."

Id. Here, the meaning of the SEBC's enabling statute is plain on its face. 29 *Del. C.* § 9602(b)(1) defines the scope of the SEBC's substantive authority and duties as "control and management of all employee benefit coverages including healthcare insurance" and "all other currently existing and future employee benefits coverages." Making clear the applicability of the APA, § 9602(b)(4) grants the SEBC the "[a]uthority to adopt rules and regulations for the general administration of the employee benefit coverages."

The enumerated power to which Defendants point—the selection of carriers in § 9602(b)(2)—is but one of three functioning powers intended to enable the SEBC to involve third parties when discharging its duty of control and management for employee and Retiree benefits. *See also* 29 *Del. C.* § 9602(3) & (5) (authority to contract). None of those provisions operates to negate or excuse the SEBC from observing its underlying statutory obligation to follow the APA. The only reasonable construction and application of the enabling statute is that the SEBC was required to follow the APA when adopting what is clearly a regulation—the switch to Medicare Advantage. None of Defendants' cited cases (DOB 19–24) suggest otherwise, [17] and

[17] The 14 cases Defendants cite to this Court addressing statutory construction (DOB 19–24) are not cited in Defendants' brief in the Court below. *See* A020–22. Nor do they provide any more support for Defendants' argument than the different cases they cited to the Court below. A041.

any other reading would violate the statute's plain meaning and create an unwieldy disharmonious whole. *Lowicki v. State*, 2020 WL 4534903, at *3 (Del. 2020).

Finally, the Defendants' brief is littered with alleged factual assertions that they apparently claim should assist their appeal (DOB 7–12), but many of which (at least) Plaintiffs would not agree with. Such a claim and its underlying assertions should be rejected at least because Defendants voluntarily waived below, in service of their strategic decision as to how they wanted to litigate the case, any right to challenge the factual findings in the Stay Order. *See* B279–87 and Supr. Ct. R. 8; *Turner v. State*, 5 A.3d 612, 615 (Del. 2010).

3. Conclusion

For the foregoing reasons, if this Court decides to address the merits of the Stay Order, it should uphold the Stay Order's determination that the SEBC violated the APA when adopting Medicare Advantage. In any event, given the Defendants' waiver below in not asking to have the injunction against implementation of Medicare Advantage lifted or modified, that injunction should not be lifted as Defendants now request for the first time (DOB 24).

ARGUMENT ON PLAINTIFFS' CROSS APPEAL

I. THE SUPERIOR COURT REVERSIBLY ABUSED ITS DISCRETION IN DENYING PLAINTIFFS' PETITION FOR ATTORNEYS' FEES

A. Question Presented

Did the Superior Court abuse its discretion by declining to consider, let alone grant, an award of attorneys' fees to Plaintiffs, despite their having created in this litigation an indisputably significant common benefit in preventing irreparable harm to Retirees, in the face of State Officials' conduct that purposefully obstructed and burdened Retirees' effort to obtain the protections of the judicial process? This issue was preserved in Plaintiffs' briefing below (B338–443).

B. Standard And Scope Of Review

The Superior Court's formulation of the appropriate legal standard is reviewed *de novo*. *Dover Historical*, 902 A.2d 1084, 1089 (Del. 2006). This Court reviews a denial of attorneys' fees, made under the appropriate legal standard, for abuse of discretion. *See Id.*

C. Merits of Argument

1. By Stopping Defendants' Unilateral Conversion Of Retirees' Healthcare Plan To Medicare Advantage, Plaintiffs Achieved A Substantial Common Benefit That Merits An Award Of Attorneys' fees.

Before commencing their argument in support of their claim to an award of attorneys' fees, Plaintiffs explain why they were compelled to assert that claim in the Court below and in this Court on cross appeal. Plaintiffs did not do that to enrich

themselves or their coffers, as portrayed by Defendants' claim to the Court below that an award of fees would give Plaintiffs a "windfall." B267. The Superior Court judge echoed that notion by suggesting Plaintiffs were being "a little greedy." B315. Plaintiffs are hardly seeking a "windfall" or being "greedy" when seeking to pay the lawyers who achieved the Stay Order the money they are still owed. Rather, they seek to compensate their attorneys, whom they had to retain at the eleventh hour on a non-contingent basis but with risk of nonpayment. B395 ¶¶ 9–10 (Peterson 3d Aff.). Although Plaintiffs were able to raise some funds from individual Retirees, that amount still is woefully short of what was required to compensate outside counsel for their successful efforts. *Id.* ¶ 11.

Plaintiffs submit that an award of their attorneys' fees is more than justified based on the found facts of this case and the common benefit doctrine, which is well-recognized as an equitable basis for awarding fees and an exception to the rule that litigants defray their own attorneys' fees:

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

See Dover Historical, 902 A.2d at 1089.

Underlying this equitable exception is the principle that "persons who obtain the benefit of a lawsuit without contributing to its cost [should not be] unjustly enriched at the successful litigant's expense." *Dover Historical*, 902 A.2d at 1090. Although equitable in nature, the common benefit doctrine is available in a Superior Court proceeding where equitable principles are applied: "The Superior Court does hear cases in which it is occasionally required to apply equitable principles. In such cases the Superior Court has jurisdiction to award attorneys' fees even if no contract or statute requires it." *Id.*

The Superior Court in its February 8, 2023 Order "agree[d] it does hear cases which occasionally require the Court to apply equitable principles and if such occasion is presented then the Court does have jurisdiction to award attorneys' fees even if no contract or statute requires it." B293. But even so, it declined to consider Plaintiffs' fee application on the merits for the stated reason that "Plaintiffs in this case originally sought a declaratory judgment, which is not inherently equitable." B293. The Final Order again denied fees, with no further analysis. B336–37.

The Court's ruling was plain error as the Complaint *did* seek relief in the form of stays of implementation of a Medicare Advantage plan and of execution of the contract with Highmark. B038. These are equivalent to injunctive relief and therefore warrant entertainment of a fee application based on equitable principles. *See Dover Historical*, 902 A.2d at *1090–91 (Appellants' underlying claim—"to

prevent the issuance of [an] architectural review certificate and as a consequence, [certain] proposed [building] construction"—"sought relief equivalent to an injunction" and "was sufficiently equitable in nature to empower the Superior Court to entertain a fee application based on equitable doctrines."). While this Court in *Dover Historical* did not ultimately apply the common benefit doctrine, it was because that litigation was in the nature of "public interest litigation" where a litigant acting "as a private attorney general" achieves for the citizenry-at-large the benefit of causing "a government agency … to do its job properly." 902 A 2d. at *1091. The instant case, by contrast, achieved a critical and concrete benefit for Retirees.

Before addressing the common benefit requirements as met here, Plaintiffs note that, although Defendants had acknowledged by October 28, 2022, that they were on notice that Plaintiffs were seeking fees (B255), and the parties thereafter included briefing of Plaintiffs' fee application in their joint stipulations filed with the Court (B260, B271), Defendants nonetheless took the frivolous position in their fee opposition papers that Plaintiffs had waived their application for attorneys' fees by not pleading such a request in the Complaint. A116–17. To moot that argument, Plaintiffs moved to amend the Complaint to plead attorneys' fees. B444–48. The Superior Court denied that request as "moot" because "[s]eemingly this case ended after [the Stay Order]." B449–50. The Court gave no explanation based on the merits of the motion. To the extent that Defendants press their pleading-waiver argument

on this cross appeal and so as to moot that issue, Plaintiffs ask that this Court reverse the Superior Court's denial of Plaintiffs' motion to amend as an abuse of discretion because it gave no reasons based on the merits of the motion and because Defendants were on full notice that Plaintiffs were seeking fees within a short time after the Stay Order. *See id.*

Given that there is no procedural bar to this Court's consideration of Plaintiffs' fee request, Plaintiffs turn to the merits. All the requirements for finding a fee-awardable common benefit are satisfied here.

First, this action was meritorious when filed, as established by the Stay Order, which has, Plaintiffs submit, become permanent.

Second, the ascertainable group of beneficiaries—Retirees (including their spouses and dependents)—received substantial benefits from the Stay Order. The SEBC was forced to extend the Medicfill plan and it cannot now implement a Medicare Advantage plan because the Stay Order's injunction remains in place. Retirees avoided the considerable irreparable harm found by the Stay Order based on the affidavits submitted by Plaintiffs. As a result, even future Retirees are protected from being forced to choose between involuntarily accepting Medicare Advantage or foregoing their State-funded Medicfill healthcare benefit altogether if they wish to stay on traditional Medicare. And current and future Retirees both

benefit from the ruling that requires the SEBC to observe good government laws (APA and FOIA) in any future effort to restructure Retirees' healthcare.

Finally, the Stay Order established that the State Officials had misrepresented the circumstances and consequences of the SEBC's adoption of Medicare Advantage. Thus, the Stay Order enabled legislators to learn that they had been misled and that the State Officials steering the SEBC had improperly attempted to foist Medicare Advantage on 30,000 current Retirees without their knowledge, let alone consent.

That consequence led to another common benefit for Retirees—the General Assembly's enactment of legislation (SB29) in January 2023 to create the RHBAS subcommittee, discussed above, which has created highly significant protections for Retirees' traditional Medicare benefit into the future, including an official recommendation to keep Medicare Advantage "off the table" in the next bidding cycle. And in an obvious rebuke to the way the SEBC was being run, SB29 expanded the membership of the SEBC from nine to eleven members, with the two new members being citizens, thereby altering the future voting dynamics to reduce the sway of the State Officials.

All these benefits are causally related to the Stay Order. Contrary to the Defendants' argument below, common benefits can be non-monetary. Indeed, fees have been awarded for: corrective disclosures, as "benefit need not be measurable in

economic terms," *Tandycrafts, Inc. v. Initio Partners*, 562 A.2d 1162, 1165 (Del. 1989); a "rectified electoral process, *DeAnn Totta v. CCSB Financial*, 2022 WL 16647972, at *2 (Del. Ch.); and "minimally beneficial" disclosures, *In re Sauer-Danfoss S'holders Litig*., 65 A.3d 1116, 1138 (Del. Ch. 2011).

The very substantial common benefits achieved here from the Stay Order warrant fees. *See, e.g*., *Korn v. New Castle Cty.*, 922 A.2d 409, 413 (Del. 2007).

2. State Officials' Reprehensible Conduct Further Supports Fees

To be clear, the Plaintiffs ground their request for attorneys' fees on the common benefit doctrine. But, in considering the merits of that request, the Court is not required to blind itself to the State Officials' conduct, even pre-litigation, that caused Plaintiffs to incur greater fee liability than would otherwise have occurred. In short, the common benefit that Plaintiffs achieved is all the more deserving of fee recognition because of the State Officials' purposeful interposition of obstacles that made prosecuting this lawsuit extremely expensive, as set forth in the above Statement of Facts and summarized below.

Contrary to what they publicly represented, the State Officials did not act to safeguard the best interest of the vulnerable Retirees whom they are tasked with serving and to whom they owed a fiduciary duty (whether by statute, 29 *Del. C.* § 9603(8), or by virtue of their own conduct). And they did owe such a duty, if for no other reason than their June 1, 2022 letter to Retirees representing that the change

to Medicare Advantage being foisted on them was in their best interest: "A duty to speak can be created by a pre-existing relationship between the parties or a partial disclosure of facts that requires the disclosure of additional facts to prevent a misleading impression." *Mentis v. Delaware Am. Life Ins. Co.*, 1999 WL 744430, at *7 (Del. Super.) (citing *Stephenson v. Capano Dev., Inc.*, 462 A.2d 1069, 1074 (Del. 1983)); *cf. Zirn v. VLI Corp.*, 681 A.2d 1050, 1056 (Del. 1996) (quoting *Arnold v. Soc'y for Sav. Bancorp.*, 650 A.2d 1270, 1280 (Del. 1994)). The conduct of the State Officials was egregious in its subversion of Retirees' best interests.

The State Officials acted in ways that can only have been intended to deter Retirees, the individuals most immediately affected, from taking action. Those defendants delayed for months before announcing the impending healthcare overhaul. Their announcement, when it finally came, glorified Medicare Advantage and misrepresented its features. The State Officials never corrected their misrepresentations. Instead, they doubled down, leaving Retirees without official, accurate information about a matter of the utmost material concern regarding their health and personal well-being—the future of their State-funded healthcare plan.

When some Retirees became educated on their own about Medicare Advantage and began to raise concerns publicly, the State Officials acted in other ways that predictably would interfere with any effort to reverse the adoption of Medicare Advantage. The State Officials waged a political campaign to persuade

legislators that Medicare Advantage was a healthcare benefit qualitatively equal to Medicfill and that its implementation was essential to avoid dire legal and financial consequences. Those Defendants' conduct created a manifestly untruthful political narrative that the switch to Medicare Advantage was already set in stone and could not be undone. *See* B391–94 ¶¶ 3–7 (Peterson 3d Aff.). At least as egregious, the State Officials proceeded extra judicially to execute the Medicare Advantage contract in the face of Plaintiffs' publicly-filed Complaint that requested specific relief to prevent a contract being signed so as to stop Medicare Advantage gaining the force of law.

Plaintiffs submit that the reprehensible conduct by Defendants further supports an award of attorney fees, if only because such conduct would justify fee-shifting in and of itself:

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

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

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

572 A.2d 101, 112 (D.C. 1990); *Cf. Chem. Indus. Council of Del., Inc. v. State Coastal Zone Indus. Control Bd*., 1994 WL 274295, at *15 (Del. Ch. 1994).

This Court is not limited to consideration of conduct in the litigation itself. It may consider the State Officials' impeding of the exercise of Plaintiffs' rights, s*ee Scion Breckenridge v. ASB Allegiance,* 68 A.3d 665, 687 (Del. 2013), as well as their having executed the Medicare Advantage Contract that the Complaint had asked to stop. *See Dover Historical*, 902 A.2d at 1093 (defendant's destruction of historic homes during the litigation meant to protect the homes warranted fee-shifting award).

3. *Sugarland* Factors

The *Sugarland* case, *Sugarland Indus., Inc. v. Thomas*, 420 A.2d 142, 149 (Del. 1980), provides the framework for consideration of how substantial an award of attorneys' fees should be. Of greatest importance is the magnitude of the benefit achieved, which here is a very significant common benefit for Retirees. For example, *see In re Anderson Clayton S'holders Litig*., 1988 WL 97480, at *3 (Del. Ch. Sept. 19, 1998) (Allen, C.) (in corporate disclosure cases where defendants owe a fiduciary duty to shareholders, "[t]his court has traditionally placed greatest weight

upon the benefits achieved by the litigation."). The remaining *Sugarland* factors also support a substantial award of fees. Those factors are: (i) the time and effort by counsel for plaintiffs; (ii) the relative complexities of the litigation; (iii) the standing and ability of petitioning counsel; (iv) the contingent nature of the litigation; (v) the stage at which litigation ended; and (vi) whether the plaintiff can rightly receive all the credit for the benefit conferred or only a portion thereof.

A Herculean effort, within an exceptionally short time frame, was required in this case. Counsel were highly competent. The case was very complex because it required the understanding of the Medicare plan industry and state administrative law; locating and then reviewing a voluminous administrative record, including online materials; and interacting with many Retirees for information, perspective and input—all on a perilously short time frame.

Although counsel were not retained on a contingent fee basis, they undertook a risk (even at reduced rates) that unfortunately has been borne out that Plaintiffs might not be able to raise sufficient funds to compensate them. B395–96 ¶¶ 9–11 (Peterson 3d Aff.). *See Berger v. Pubco Corp.,* C.A. No. 3414-CC (Del. Ch. Sept. 8, 2008) slip op. at 4 (V.C. Chandler) Exhibit 5.

Finally, with respect to the stage at which the litigation was resolved, here the Plaintiffs navigated their claim from commencement through to final judgment. That

factor favors a higher award, because it necessitated greater legal work and greater risk, and at no point was the State willing to back down.

4. Conclusion

For the foregoing reasons, Plaintiffs on their cross appeal ask this Court: to reverse the Final Order insofar as it denies Plaintiffs' application for attorneys' fees; to determine that Plaintiffs are entitled to an award of attorneys' fees; and to remand the case with directions to determine the amount of the award based on the common benefit achieved, despite the obstruction of the State Officials, and other *Sugarland* factors.

CONCLUSION

For the foregoing reasons, Appellants' appeal should be dismissed and, if the merits are reached on that appeal, the Superior Court's Final Order should be affirmed as it relates to the Stay Order. On Plaintiffs' cross appeal, the Superior Court's denial of fees should be reversed with instructions to grant Plaintiffs' Motion to Amend (if necessary) and grant reasonable attorneys' fees to Plaintiffs in accordance with *Sugarland* in recognition of the common benefit achieved and the role of Defendants in increasing the fees that Plaintiffs had to incur.

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