IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

KENNETH FITCH,	*	
Plaintiff,	*	
	*	
v.	*	Case No.: 26-cv-01831-RDB
YAAKOV WEISSMANN,	*	
Defendant.	*	
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DEFENDANT'S REPLY IN SUPPORT OF MOTION TO DISMISS

Plaintiff's opposition fails to respond to several of the Department's key arguments. As explained below, plaintiff fails to explain why his state-law claims should not be dismissed for lack of jurisdiction, and he does not respond at all to the Department's explanation of why the law at issue, and the manner in which it is being administered, furthers important government interests. Moreover, plaintiff's opposition continues to demonstrate his clear misunderstanding of how the Department's statutory reimbursement programs actually work, and lays bare how those misunderstandings are fatal to the viability of his claims. For reasons stated in the Department's memorandum in support of its motion to dismiss, and for the reasons stated below, this Court should dismiss plaintiff's amended complaint.

1. Aside from his claims under the Equal Protection Clause and (as clarified below) the Due Process Clause of the Fourteenth Amendment (Counts I and II), plaintiff's claims all sound in *state* law. Under clear Supreme Court precedent, these claims are barred

by sovereign immunity. *See Pennhurst State Sch. & Hosp. v. Halderman*, 465 U.S. 89, 121 (1984) ("[A] claim that state officials violated state law in carrying out their official responsibilities . . . is protected by the Eleventh Amendment.").

Plaintiff's response is that he is seeking "only prospective declaratory and injunctive relief to halt ongoing violations of *federal* law by this state official." (ECF 18 at 10 (emphasis added).) But plaintiff does not explain how a violation of the Maryland Declaration of Rights (whether under Article 24 (Count III) or Article 19 (Count IV)) is a violation of *federal* law. Plainly, it is not. Nor does he explain how a violation of the state statute itself (Count VI) is somehow a violation of federal law. Finally, he no cites no viable authority for the notion that a claim that a state agency has acted beyond the authority granted by a state legislature (Count V) is an issue of federal law. Simply saying that something is an issue of federal law does not make it so. The best that plaintiffs can do is to cite federal administrative law cases. (ECF 18 at 13-14 (citing, e.g., *Loper Bright Enter. v. Raimondo*, 144 S. Ct. 2244 (2024).) But, as the Department has already explained, these federal cases have no application to state law. To that, plaintiff has no response.

As to plaintiff's federal Due Process claim, he fails entirely to address this Court's decision in *Mora v. City of Gaithersburg*, 519 F.3d 216 (4th Cir. 2008), and its application to this case. As the Department has explained, plaintiff's Due Process claim, distilled to its essence, is that the Department failed to comply with the requirements of state law. But to resolve that larger question, the exact scope and meaning of the state law must first be determined. Because that is a role for a state court, plaintiff's claim must be brought, if at all, in that forum.

Under plaintiff's broad view, any interpretation or application of state law can be transformed into an issue of federal law. But that is not the way federalism works. Plaintiff's state law claims should therefore be dismissed under Rule 12(b)(1).[1]

2. In his opposition, plaintiff demonstrates a complete misunderstanding of how the statutory programs work. As noted in the Department's memorandum in support of its motion to dismiss, § 2-509.1(d)-(e) of the State Personnel and Pensions Article creates two distinct reimbursement programs: (1) the Drug Coverage Program, which "reimburses a participant for out-of-pocket costs that exceed" $1,500 for an individual retiree, § 2-509.1(d), and (2) the Catastrophic Program, which "reimburses a participant for out-of-pocket costs after the participant has entered catastrophic coverage under a prescription drug benefit plan under Medicare," § 2-509.1(e). The Drug Coverage Program "applies only" to a retiree (or dependent) who "retired on or before December 31, 2019," § 2-509.1(d)(1)(ii), while the Catastrophic Program "applies only" to a retiree (or dependent) who "retired on or after January 1, 2020,"[2] § 2-509.1(e)(1)(ii).

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[1] Plaintiff claims that the Department has waived "certain sovereign immunity arguments" by failing to specify that dismissal should be under Rule 12(b)(1) (as opposed to Rule 12(b)(6)). (ECF 18 at 30.) Plaintiff, however, does not identify the arguments to which he is referring. And plaintiff does not identify any authority suggesting that a State will have waived sovereign immunity simply by referencing the wrong procedural Rule. In fact, plaintiff fails to cite any case that stands for the proposition that a claim that is precluded by the Eleventh Amendment does not, for that very reason, fail to state a claim upon which relief may be granted (and thus should be dismissed under Rule 12(b)(6) as well).

[2] To be eligible under either program, a retiree must have began employment with the State prior to July 1, 2011.

It is unclear, however, whether plaintiff fully understands that § 2-509.1(d) and § 2-509(e) are separate programs that, by design: (1) have mutually exclusive eligibility requirements, and (2) provide entirely different benefits. For example, although plaintiff describes all state employees hired before July 1, 2011 as a "closed statutory class," he asserts that "the Statute"—i.e., § 2-509.1—"does not authorize DBM to treat these retirees differently." (ECF 18 at 5.) Later, he reiterates this position, stating that "Section 2-509.1 . . . does not authorize DBM to provide different levels of financial protection to different members of the statutory class." (ECF 18 at 19.)

But this is plainly incorrect. As noted above, the Drug Coverage Program was designed to "reimburse[] a participant for out-of-pocket costs that exceed" $1,500 for an individual retiree (or dependent). § 2-509.1(d). In other words, this program ensures that an eligible retiree's out-of-pocket costs—no matter when they are incurred—are capped at $1,500. Such a retiree would not need to worry about his out-of-pocket costs once he reached the catastrophic phase of Medicare, because his out-of-pocket costs would have already been capped way before he reached that catastrophic threshold.

The Catastrophic Program, on the other hand, was designed to come into play only once a retiree has "entered catastrophic coverage under a prescription drug benefit plan under Medicare." § 2-509.1(e). Unlike a participant in the Drug Coverage Program, whose costs are capped at $1,500, a participant in the Catastrophic Program would incur non-reimbursable out-of-pockets costs up until those costs reached the catastrophic threshold under Medicare.

On their face, these programs clearly "authorize DBM to provide different levels of financial protection to different members of the statutory class." (ECF 18 at 19.) Indeed, if they did not provide different benefits, there would be no need for separate subsections.

Plaintiff's misunderstanding as to the nature of these programs may explain some of his misstatements in this case. For example, it may explain his assertion in his amended complaint that he "meets all statutory criteria for participation in the prescription drug reimbursement programs mandated by § 2-509.1," (ECF 5 at 17 ¶ 17), despite this being a logical impossibility due to mutually exclusive eligibility requirements. And it may explain why plaintiff believes he has standing to contest the Department's decision not to administer the Catastrophic Program, when he is (1) clearly not eligible for that program, and (2) would not suffer any harm under that program even if he were eligible.

Indeed, it is unclear whether plaintiff fully understands that the Catastrophic Program is completely superfluous under the current state of the law. As the Department has already explained, because the federal government has eliminated cost-sharing in the catastrophic phase of Medicare Part D, a plan participant who reaches the catastrophic phase will no longer incur *any* costs.

Nonetheless, plaintiff demands that the Department administer the Catastrophic Program anyway (notwithstanding, as explained above, that plaintiff is not even eligible for this program in the first place). (*See* ECF 18 at 13 (stating that plaintiff seeks "restoration of the Catastrophic Program going forward").) He thus appears to want this Court to impose upon the Department an obligation to expend scarce resources to create a program that no one will, or even could, use.[3] This demand should be rejected.

[3] Plaintiff appears to suggest that the Department's explanation that the Catastrophic Program is superfluous is a "new argument" "raise[d] . . . for the first time in [its] Motion to Dismiss." (ECF 18 at 30.) Putting aside that the Department's motion to dismiss was its first substantive filing in this case, and thus all of its arguments were "raise[d] . . . for the first time in [its] Motion to Dismiss," the fact that the Catastrophic Program has been

3. Plaintiff also appears to misunderstand the nature of the Department's reimbursement program under the Drug Coverage Program. In its motion to dismiss memorandum, the Department explained how, for each eligible participant in the Drug Coverage Program, the Department deposits $750 into a Health Reimbursement Account, which can then be used by the participant through a debit card to purchase prescription drugs. (ECF 17-1 at 9-12.) Plaintiff, however, claims that "DBM's replacement of statutory reimbursement with a fixed-deposit HRA model deprives retirees of the statutory entitlement to reimbursement of actual costs." (ECF 18 at 25.) He further asserts that "[a] fixed model is not 'reimbursement': it is a subsidy unrelated to statutory entitlement." (ECF 18 at 26.)

The exact nature of plaintiff's complaint is difficult to discern. Under the Drug Coverage program as currently administered by the Department, when a participant purchases prescription drugs with a debit card, they draw down from the $750 that has been deposited in the retiree's Health Reimbursement Account. In other words, this works much the same as a flexible spending account, where a participant is reimbursed only for those eligible expenses actually incurred. It is true that a participant in the Drug Coverage Program will not be reimbursed in a literal sense, since being reimbursed suggests that the retiree has first fronted his own money to purchase the drugs (like with a traditional flexible spending account). *See* Merriam-Webster Dictionary, "Reimburse,"[4] (defining "reimburse" as, among things, "to pay back to someone"). But it is unclear why this somehow makes the program illegal or unconstitutional. Indeed, this type of program was expressly contemplated in the statute itself:

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rendered superfluous is not an "argument," but rather a readily-discernible practical effect of the operation of intervening federal law.

[4] https://www.merriam-webster.com/dictionary/reimburse

"[I]t is the intent of the General Assembly that the Department . . . establish the [Drug Coverage Program] in a manner that allows retirees to access reimbursement at the time of prescription drug purchase, through a mechanism such as debit cards." 2019 Md. Laws, ch. 767, § 4. Given this clear statutory authority, plaintiff fails to explain how a reimbursement program administered by the Department (as opposed to a third party) would be any different from what is being done now.

4. Plaintiff further complains that "retirees with no costs above the State maximum receive $750, while retirees with costs above the maximum receive less than full reimbursement." (ECF 18 at 26.) To the extent that plaintiff complains that "retirees with no costs above the State maximum receive $750," his complaint appears to be that the program, as currently administered, is *more* favorable than it statutorily needs to be. To that, the Department admits guilt. Plaintiff fails to provide any support for the notion that an agency acts unconstitutionally or illegally by providing a benefit that exceeds statutory requirements.

To the extent that plaintiff complains that "retirees with costs above the maximum receive less than full reimbursement," it is unclear whether plaintiffs are in fact lodging a complaint or just describing the program itself. The Drug Coverage program is not designed to provide "full" reimbursement; instead, it is intended to provide reimbursement for all costs once a retiree reaches $1,500 in out-of-pocket costs. And as the Department's chart on page 11 of its memorandum demonstrates, the Drug Coverage Program ensures that no participating retiree—no matter how much they spend in prescription drug costs—will ever spend more than $1,500 in out-of-pocket costs. (ECF 17-1 at 11.)

5. For the first time, plaintiff in his opposition claims that his Equal Protection claim should be evaluated under "heightened scrutiny." (ECF 18 at 17-18.) In support,

plaintiff argues that the purported subclassifications "burden a fundamental interest in life-sustaining medical care" and "correlate[] closely with a disability." (ECF 18 at 18-19.) But this argument, which looks at the impact from the classification and not the basis for the classification itself, would expand Equal Protection jurisprudence beyond recognition. Moreover, plaintiff does not identify what this standard looks like, or the framework under which his claim should be evaluated.

What plaintiff appears to be doing is trying to inject a substantive due process claim into this case, despite no such claim being made in his amended complaint. But federal courts have been extremely reluctant to recognize new fundamental interests, and this Court should reject that attempt here.

6. Plaintiff makes several arguments concerning the Life-Sustaining Program—most notably, its failure to include insulin as a covered drug. (ECF 18 at 14, 20, 23-24.) But this again illustrates a fundamental misunderstanding of the statutory scheme and how it works. Section 2-509.1(f) directs the Department to "establish the [Life-Sustaining Program] that reimburses a participant for out-of-pocket costs for a life-sustaining prescription drug that is 1. covered by [the Maryland state prescription drug benefits available to active employees]; and 2. not covered by the prescription drug benefit plan under Medicare in which the participant is enrolled." § 2-509.1(f)(2)(i). That same subsection expressly charges the Department with "develop[ing] a list of the prescription drugs that qualify for reimbursement under" the Life-Sustaining Program. § 2-509.1(f)(2)(ii).

Plaintiff, however, argues that "insulin is a paradigmatic life-sustaining drug," and is "necessary to prevent death or serious disability in insulin-dependent diabetics." (ECF 18 at 20, 24.) To that end, plaintiff asserts that the Life-Sustaining Program must include insulin,

because "[t]he Statute does not allow DBM to redefine 'life-sustaining' drugs." (ECF 18 at 20.) But the statute does not itself define what it means to be "life-sustaining." Instead, the scope of the statute is defined more broadly by comparing (1) the drugs offered by the Maryland state plan and (2) those offered by a Medicare plan—and then providing reimbursement for drugs covered by the first category but not the second. But even looking beyond that, the statute gave the Department express authority to further define the scope of the program when it mandated that the Department "develop a list of the prescription drugs that qualify for reimbursement under" the Life-Sustaining Program. § 2-509.1(f)(2)(ii). And despite plaintiff's claim that the Department "failed to develop the Life-sustaining drug list," (ECF 18 at 14), the list is available on the Department's public website.[5]

Finally, plaintiff's focus on insulin confirms his misunderstanding of the nature of the Life-Sustaining Program. As explained above, the Life-Sustaining Program contemplates reimbursement for any drug "not covered by the prescription drug benefit plan under Medicare in which the participant is enrolled." § 2-509.1(f)(2)(i). But insulin *is* covered by Medicare Part D. *See Insulin*, Medicare.gov.[6] Indeed, as plaintiff admits, his current plan covers insulin. (ECF 14-1 at 19.) Accordingly, plaintiff would be ineligible for reimbursement under the Life-Sustaining Program.

7. Plaintiff claims that the Department did "not address Plaintiff's allegations that DBM imposed PHI-disclosure requirements without statutory authority [and] delegated PHI-dependent statutory duties to a trademark vendor without a Business Associate Agreement."

[5] https://dbm.maryland.gov/benefits/Documents/2026%20Drug%20List.pdf

[6] https://www.medicare.gov/coverage/insulin

(ECF 18 at 29.) As a preliminary matter, it is not clear that any response was needed, given that plaintiff's "allegation" on this issue was entirely equivocal: "*To the extent* DBM delegated eligibility determinations, enrollment functions, or prescription-drug assistance functions to Extend Health, LLC operating under the 'Via Benefits' brand—without a contract or a compliant Business Associate Agreement—DBM exceeded its lawful authority." (ECF 5 at ¶ 5 (emphasis added).) But the Department *did* address this claim, by noting that "Extend Health is subject to a Business Associate Agreement that contains the appropriate confidentiality and privacy safeguards for protected health information as required by the Health Insurance Portability and Accountability Act ('HIPAA') as well as other federal and state laws." (ECF 17-1 (citing Kuminski Decl. ¶ 15).)

8. Plaintiff also claims that the Department did "not address Plaintiff's allegations that DBM . . . conditioned statutory eligibility on enrollment through VIA Benefits." (ECF 18 at 29.) But, aside from explaining why this Court lacks jurisdiction over this issue, that claim is addressed in the Department's memorandum on pages 22-24. To recap, building on the authority granted to the Department in § 2-503(b)(1) to "arrange as the Secretary considers appropriate any benefit option for inclusion in" a retiree benefits program, there is nothing in the statute that precludes the Department from determining the best procedural methods for achieving the statutory objectives. And the statute actually affirmatively permits the Department to engage "a third-party to administer health reimbursement accounts established under this section." § 2-509.1(i)(2). It is plaintiff who has failed to respond to the Department's arguments.

9. Next, plaintiff claims that the Department did not "address Plaintiff's allegation that 'Via Benefits' is not a legal entity but a trademark owned by WTW, and that the State's

contract is with Extend Health." (ECF 18 at 29.) It is unclear why this matters. It is commonplace for entities to operate through a brand name that is different from the entity that controls it: "Facebook," a social media platform that is owned by Meta Platforms, Inc. (which itself does business as only "Meta"), is but one of many examples.

10. Coming back full circle, the bulk of plaintiff's claims should be dismissed because they are state law claims that, under the Eleventh Amendment, may not be heard in a federal forum without the Department's consent. As to plaintiff's Equal Protection claim, he has failed to rebut any of the proffered reasons for why the Department had a legitimate interest in (1) having an experienced third-party vendor administer the program or (2) providing a more generous benefit to a class of retirees for whom the transition to Medicare Part D may have been more disruptive. Because the Department has acted lawfully—and, with respect to the Drug Coverage program, has acted to provide more favorable benefits than required by the statutory scheme, the Department's motion to dismiss should be granted.

CONCLUSION

The motion to dismiss should be granted.

Respectfully submitted,

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