IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

KENNETH FITCH,	*	
Platintiff,	*	
v.	*	
YAAKOV WEISSMANN,	*	Case no.: 26-cv-01831-RDB
Defendant.	*	
	*	

* * * * * * * * * * * * * * * *

DEFENDANT'S MOTION TO DISMISS AMENDED COMPLAINT

For the reasons stated in the accompanying memorandum, Defendant Yaakov Weissmann, in his official capacity as Secretary of the Maryland Department of Budget and Management, moves to dismiss the amended complaint in its entirety for failure to state a claim upon which relief can be granted under Federal Rule of Civil Procedure 12(b)(6) and for lack of jurisdiction under Federal Rule of Civil Procedure 12(b)(1). A proposed order is attached.

Respectfully submitted,

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July 24, 2026

CERTIFICATE OF SERVICE

I certify that on this 24th day of July, 2026, the foregoing document was served on all parties or their counsel of record through the CM/ECF system.

__/s/_____
Ryan R. Dietrich (Fed Bar #27945)

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	*	

* * * * * * * * * * * * * * * *

CONSOLIDATED MEMORANDUM IN SUPPORT OF DEFENDANT'S MOTION TO DISMISS AND OPPOSITION TO MOTION FOR PRELIMINARY INJUNCTION

Respectfully submitted,

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INTRODUCTION

In 2011, the Maryland General Assembly enacted a law providing that, in 2019, the State would end its costly prescription drug program for Medicare-eligible retirees and instead allow those retirees to take advantage of the federally-subsidized Medicare Part D program. After a group of Maryland state retirees, including Plaintiff here, filed suit in 2018, a judge of this Court issued a preliminary injunction ordering the State to continue to provide a program for retiree prescription drug benefits. While the injunction was in place, the Maryland General Assembly enacted the law at issue here, which created three reimbursement programs that would assist retirees with prescription drug costs in the event that the injunction was lifted.

The injunction was ultimately dissolved in 2024, and retirees transitioned to Medicare Part D for the 2025 calendar year. To effectuate this transition, and to facilitate the implementation of the reimbursement programs, the Department of Budget and Management (the "Department" or "DBM") contracted with a vendor, Extend Health, LLC, which operates the Via Benefits marketplace. Although Plaintiff advances nine separate causes of action in his lawsuit, they all boil down to one claim: that the law enacted in 2019 does not allow the Department to use a vendor to implement these programs.

Putting aside that this is a question of state law that this Court should decline to hear, Plaintiff's claim is refuted by the statutory language itself, which expressly permits the Department to contract with a vendor to implement the reimbursement programs. Plaintiff's attempt to thwart the Department from engaging in this commonplace and cost-effective arrangement should be rejected.

FACTUAL BACKGROUND[1]

Maryland Creates a Retiree Health Benefits Program.

Plaintiff's complaint stems from the Department's actions in response to statutory changes to Maryland's health benefits program for eligible state retirees. Prior to 2025, this program included a retiree prescription drug program. The program required retirees to make out-of-pocket co-payments for prescription drugs up to a maximum limit, which at the time was $1,500 for the retiree only and $2,000 for the retiree and the retiree's family. Md. Code Ann., State Pers. & Pens § 2-508(d) (LexisNexis 2024).[2] After a retiree reached that out-of-pocket maximum, the State paid the full costs of the retiree's medication.

Congress Establishes Medicare Part D and Closes Coverage Gaps with the Affordable Care Act.

In 2003, Congress established Medicare Part D, a federal prescription-drug benefits program designed primarily for retirees. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066. As enacted, Medicare Part D costs were organized into four sequential phases: (1) a deductible phase, in which enrollees paid the full cost of their drugs; (2) an initial coverage phase (originally set to begin at $250), in which enrollees who exceeded the deductible phase paid 25% of the cost of their drugs; (3) a coverage gap (originally set to begin at $2,250, and colloquially called the "doughnut hole"), in which enrollees no longer received any coverage; and (4) a "catastrophic" coverage

[1] A more detailed account of the State's elimination of its state retiree prescription drug program for Medicare-eligible retirees, and the ensuing litigation and legislation, can be found in the State's memorandum in support of its motion for summary judgment and for dissolution of preliminary injunction in *Fitch v. Maryland*, No. 1:18-cv-02817-PJM (ECF No. 196-1).

[2] Unless otherwise indicated, all statutory references are to the State Personnel and Pensions Article.

phase, in which enrollees who reached a higher cost threshold (originally set at $3,600) only paid 5% of subsequent costs. Congressional Budget Office, *A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit*, at viii (July 2004).

In 2004, to address concerns over Medicare Part D's coverage gap, the Maryland General Assembly directed that the State "shall continue to include a prescription drug benefit plan in the health insurance benefit options" available to retirees. 2004 Md. Laws, ch. 296 (codified at § 2-509.1(a)).

Then, in 2010, Congress enacted the Affordable Care Act ("ACA"). Among other things, the ACA altered Medicare Part D to eliminate the "doughnut hole" coverage gap by 2020. In other words, instead of having no coverage within the "doughnut hole," participants would, as of 2020, pay the same coinsurance for prescription drugs (i.e., 25%) as during the initial coverage phase. The ACA did not affect the "catastrophic" phase, and participants would continue to pay a 5% coinsurance once they reached that threshold.

Maryland Amends its Retiree Benefits Program for Medicare-Eligible Retirees.

In June 2010, the Maryland General Assembly created a commission whose purpose was, in part, to assess the fiscal health of the State's retiree health and prescription-drug plans. *See* Public Employees' and Retirees' Benefit Sustainability Commission, 2010 Interim Report, at iii (January 2011). Following the commission's cost-saving recommendations, the Maryland General Assembly passed legislation in 2011 that ended the retiree prescription-drug program in fiscal year 2020, requiring all Medicare-eligible retirees to obtain their prescription-drug benefits through Medicare Part D. 2011 Md. Laws, ch. 397 (codified at § 2-509.1(b)).

A Lawsuit Prompts the Passage of § 2-509.1(d)-(f).

After the Department notified retirees in mid-2018 of the impending elimination of the retiree prescription drug benefits program,[3] a group of retirees (including Plaintiff) sought injunctive relief against the State's transition to Medicare Part D based on contractual and constitutional theories. *Fitch v. Maryland*, No. 1:18-cv-02817-PJM, (D. Md.), *aff'd*, Nos. 23-2135, 24-2266, 2025 WL 1443938 (4th Cir. May 20, 2025). In response, the State argued that (1) the statutory retiree prescription drug benefits program did not constitute a contract, and (2) that even if it were a contract, the cost-saving effects, as well as the benefits available under Medicare Part D, made the change a "reasonable modification" under Maryland contract law. *See Davis v. Mayor & Alderman of City of Annapolis*, 98 Md. App. 707, 715 (1994) (stating that "the government may unilaterally modify [government programs] so long as the changes do not adversely alter the benefits, or if the benefits are adversely altered, they are replaced with comparable benefits"); *see also Cherry v. City of Baltimore*, 762 F.3d 366, 372 (4th Cir. 2014) ("To qualify as a 'reasonable modification,' a revised plan must provide the employees with 'substantially the program [they] bargained for and any diminution thereof must be balanced by other benefits or justified by countervailing equities for the public's welfare.'" (quoting *City of Frederick v. Quinn*, 35 Md. App. 626 (1977))).

On October 16, 2018, a judge of this Court issued a preliminary injunction after concluding that the statutory retiree prescription drug benefits program constituted a contract

[3] Although the initial legislation contemplated that the retiree prescription drug program would be eliminated for Medicare-eligible retirees as of fiscal year 2020 (i.e., July 1, 2019), in 2018 the legislature moved the date up to January 2019 based on changes to federal law. 2018 Md. Laws, ch. 10.

under Maryland law. *Fitch v. Maryland*, No. 1:18-cv-02817-PJM (D. Md. Oct. 16, 2018) (ECF. No. 31). The Court, however, left open the possibility that the State would be able to show that the change constituted a "reasonable modification." *Id.*

Building on that possibility, the General Assembly promptly enacted the statutory provisions at issue in this case. 2019 Md. Laws, ch. 767; *see also Hearing on S.B. 946 Before the Sen. Budget & Tax. Comm.*, 439th Leg. Sess. (Feb. 27, 2019) (testimony of Sen. Griffith at 05:03:29) (stating that "Senate Bill 946 is our effort to address [unintended consequences in the improvements to Medicare Part D] and to at least limit the out-of-pocket expenditures our retirees would have"). Each of the programs, detailed below, establishes a particular benefit that would go into effect only *if* the preliminary injunction were to be dissolved.

First, § 2-509.1(d) directs the Department to "establish a Maryland State Retiree Prescription Drug Coverage Program [("Drug Coverage Program")] that reimburses a participant for out-of-pocket costs that exceed the limits established . . . in § 2-508(d)(2)(iii) of this subtitle," which are currently $1,500 for a retiree only, and $2,000 for a retiree and the retiree's family. This program "applies only" to a retiree (or dependent) (1) "who is enrolled in a prescription drug benefit plan under Medicare," (2) "if the retiree is retired on or before December 31, 2019," and (3) who is otherwise eligible under Maryland law to enroll in state health benefits. § 2-509.1(d)(1)(ii).

Second, § 2-509.1(e) directs the Department to "establish a Maryland State Retiree Catastrophic Prescription Drug Assistance Program [("Catastrophic Program")] that reimburses a participant for out-of-pocket costs after the participant has entered catastrophic coverage under a prescription drug benefit plan under Medicare." This program "applies only" to a retiree (or dependent) (1) "who is enrolled in a prescription drug benefit plan under

Medicare," (2) "if the retiree: 1. began State service on or before June 30, 2011; [and] 2. retired on or after January 1, 2020," and (3) who is otherwise eligible under Maryland law to enroll in state health benefits. § 2-509.1(e)(1)(ii).

Third, § 2-509.1(f) directs the Department to "establish the Maryland State Retiree Life-Sustaining Prescription Drug Assistance Program [("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). The subsection charges the Department with "develop[ing] a list of the prescription drugs that qualify for reimbursement under" under the Life-Sustaining Program. § 2-509.1(f)(2)(ii).

Three other provisions of § 2-509.1 are critical to understanding the Department's authority and responsibility in creating these programs. First, for each program, the Department is authorized to "provide reimbursements through . . . a health reimbursement account established in accordance with § 105(h) of the Internal Revenue Code." § 2-509.1(d)(3)(i); § 2-509.1(e)(3)(i); § 2-509.1(f)(3)(i).

Second, under §2-509(i), the Department is authorized to "make an emergency procurement for . . . a third-party to administer health reimbursement accounts established under this section." This provision was added as an amendment to the initial bill, and the sponsor of the amendment specified that this provision "allows DBM for staffing . . . or for outsourcing specifically for the health reimbursement account." Floor Debate on S.B. 946, Md. Senate, 439th Leg. Sess. (Mar. 11, 2019) (statement of Sen. Serafini at 01:17:44). The bill's sponsor also confirmed this understanding, stating that the amendment was intended to "allow

some flexibility to DBM with procurement so that they could secure outside assistance in developing their program." *Hearing on S.B. 946 Before the H. Appropriations Comm.*, 439th Leg. Sess. (Mar. 19, 2019) (testimony of Sen. Griffith at 41:59). Finally, the Executive Director of the Department of Legislative Services testified that the bill was drafted to be "very broad for DBM to undertake [the] implementation" and predicted that the Department "will end up contracting with a company to provide health reimbursement arrangements and actually we estimated [that cost] in the bill." *Id.* (testimony of Vicki Gruber at 41:04).

Third, § 2-509(j) requires the Department to report to the Governor and several committees about "the status of procuring any contracts necessary to operate the program" and "the details of the health reimbursement accounts . . . including: (i) the specific out-of-pocket costs eligible for reimbursement; (ii) the required process for receiving reimbursement; (iii) the method of reimbursement; (iv) the timing of reimbursement; and (v) a plan to use debit cards to process reimbursements in a convenient and efficient manner." § 2-509.1(j)(1)(i), (j)(3)(i)-(v).

Congress Amends Medicare Part D Through the Inflation Reduction Act.

After the General Assembly's enactment of § 2-509.1(d)-(f), Congress passed the Inflation Reduction Act ("IRA") in 2022. Inflation Reduction Act of 2022, Pub. L. No. 117-169, 136 Stat. 1818. The IRA contains two key provisions directly relevant to this case. First, the IRA eliminated the cost-sharing burden of Medicare Part D enrollees in the "catastrophic" coverage phase. *See id.* As noted earlier, prior to the IRA, once a retiree's out-of-pocket prescription-drug costs entered the "catastrophic" coverage phase, the retiree was required to pay 5% of the costs of their prescription drugs, with no cap on the total amount they could

spend. The IRA eliminated this cost-sharing entirely, so that retirees would not have to pay anything further once they reached the "catastrophic" coverage phase.

Second, the IRA implemented an out-of-pocket spending cap on Medicare Part D expenses, which was $2,000 in 2025 and $2,100 in 2026. The combined effect of these provisions is that once a Medicare enrollee reaches this level of out-of-pocket spending, they no longer face any additional out-of-pocket expenses.

The Court Dissolves the Preliminary Injunction, and the Department Implements the Programs Under § 2-509.1.

Based on the Fourth Circuit's decision in *AFSCME Md. Council 3 v. Maryland*, 61 F.4th 143 (4th Cir. 2023), which held that Maryland's retiree prescription drug program did not constitute a contract at all, this Court dissolved the preliminary injunction on July 19, 2023.[4] As a result, the state retiree prescription drug program was eliminated for Medicare-eligible retirees, and those state retirees would be transitioned to Medicare Part D as of January 1, 2025.

The Department then moved to implement the programs mandated by § 2-509.1.[5] Consistent with the statutory authorization in § 2-509.1(i), the Department contracted with

[4] This Court later granted summary judgment in favor of the State on all claims, and that decision was affirmed on appeal. *Fitch v. Maryland*, Nos. 23-2135, 24-2266, 2025 WL 1443938 (4th Cir. May 20, 2025).

[5] As noted above, the underlying purpose for creating the programs in § 2-509.1(d)-(f) was to bolster the State's ability to present a "reasonable modification" argument under Maryland contract law. But because the Fourth Circuit in *AFSCME* determined that no contract existed with respect to retiree prescription drug benefits, the need to serve that underlying purpose was no longer present, rendering the reimbursement programs entirely gratuitous in nature. Nonetheless, in light of the statutory mandate, the Department has acted to implement the programs as necessary to fulfill their respective statutory purposes.

Extend Health, LLC, which operates the Via Benefits marketplace. (Declaration of Christina Kuminski ¶¶ 8, 9.)[6] To efficiently track eligibility and to administer the reimbursement programs efficiently, the Department conditioned the availability of those programs on enrollment in a Medicare Part D plan through the Via Benefits marketplace. (Kuminski Decl. ¶ 10.) In other words, to take advantage of the Drug Coverage Program and Life-Sustaining Program, an eligible state retiree must purchase a Medicare Part D plan through the Via Benefits marketplace.

The Drug Coverage Program Meets and Exceeds Statutory Requirements.

With respect to the Drug Coverage Program, the Department established a Health Reimbursement Arrangement ("HRA") program to reimburse retirees for their out-of-pocket expenses above the Maryland state plan maximum ($1,500 for an individual). (Kuminski Decl. ¶ 3.) As explained in the introduction letter that the Department shared publicly in September 2024, the State would make an "annual contribution" to an eligible retiree's HRA that was "designed to be comparable to the maximum you would pay for drugs today under the State-sponsored plan."[7] Retirees are able to access these funds through a debit card that can be used at point of sale. (Kuminski Decl. ¶ 3.) However, rather than apply only to expenditures over the $1,500 out-of-pocket cost threshold for an individual retiree, the HRA funds could be used to cover any out-of-pocket prescription drug costs no matter when they were incurred. (Kuminski Decl. ¶ 3.) In 2026, the fixed deposit amount is $750 for an individual Medicare-eligible retiree, and $2,200 for "two Medicare-eligible family members." (Compl. ¶¶ 45, 46.)

[6] Attached as Exhibit 1.

[7] Available at: https://dbm.maryland.gov/benefits/Documents/Maryland_2024_Retiree_Intro_LetterADA.pdf

This fixed model for the Drug Coverage Program meets and exceeds statutory requirements. As explained above, the Drug Coverage Program is intended to reimburse retirees for the difference between the out-of-pocket maximums under the State plan and under Medicare Part D. For an individual, the out-of-pocket maximum under the Maryland state plan is $1,500, § 2-508(d)(2)), and the maximum out-of-pocket costs under Medicare Part D is now $2,100.[8] (Kuminski Decl. ¶ 3.) Therefore, in 2026, the largest possible difference in out-of-pocket costs for an individual above the maximum established for the Maryland plan would be $600. Nevertheless, in 2026 (like in 2025), the HRA provided up to $750 of reimbursement for each individual retiree. (Compl. ¶¶ 45, 46.) In other words, the deposit to *every* retiree in the HRA exceeds the difference between the State maximum and the Medicare maximum. Furthermore, as explained above, this $750 deposit can cover out-of-pocket costs incurred *before* the retiree reaches the state plan's out-of-pocket maximum.

Table 1 below illustrates the current operating reality of the HRA reimbursement. As shown in Table 1, Retiree A is able to use the $750 HRA deposit to not only reimburse his out-of-pocket expenses above the maximum state out-of-pocket limit, but he is also able to apply the HRA funds to out-of-pocket costs that do not exceed the Maryland state plan maximum, letting Retiree A take full advantage of the $750 deposit and taking Retiree A's net out-of-pocket costs below the Maryland state plan maximum of $1,500. Similarly, Retirees B and C, despite not exceeding the Maryland state plan maximum, can still use their $750 of HRA reimbursement.

[8] Medicare.gov, *How much does Medicare drug coverage cost?*, available at: https://www.medicare.gov/health-drug-plans/part-d/basics/costs

Table 1: Current Operation of the Maryland HRA

HRA Reimbursement (Current)	Retiree A	Retiree B	Retiree C	Retiree D
Prescription-Drug Coverage	Medicare Part D	Medicare Part D	Medicare Part D	MD State Plan
Gross out-of-pocket costs	$2,100	$1,500	$750	$1,500
Current HRA reimbursement	$750	$750	$750	$0
Net out-of-pocket costs	**$1,350**	**$750**	**$0**	**$1,500**

Table 2, however, illustrates Plaintiff's request that the Department "reimburse actual prescription-drug expenses," (Compl. ¶ 45), for all "out-of-pocket costs that exceed the limits established for non-Medicare-eligible retirees in §2-508(d)(2)(iii)." § 2-509.1(d)(1)(i)-(iii)). Under such a plan, Retiree A, who reaches the Medicare maximum of $2,100, is reimbursed for $600, realigning his out-of-pocket costs with the Maryland state plan maximum. However, Retirees B and C are not reimbursed at all because their out-of-pocket spending was less than or equal to the Maryland state plan maximum.

Table 2: Individualized reimbursement tied to expenses above the state max.

Individualized Reimbursement	Retiree A	Retiree B	Retiree C	Retiree D
Prescription-Drug Coverage Plan	Medicare Part D	Medicare Part D	Medicare Part D	MD State Plan
Gross out-of-pocket costs	$2,100	$1,500	$750	$1,500
HRA reimbursement tied to actual expenses above $1,500	$600	$0	$0	$0
Net out-of-pocket costs	**$1,500**	**$1,500**	**$750**	**$1,500**

Together, Tables 1 and 2 illustrate that the current HRA not only reimburses actual prescription-drug expenses incurred above the state plan out-of-pocket maximum, but it also

goes further, allowing retirees to apply reimbursement funds to their out-of-pocket costs below the state plan out-of-pocket limits. In other words, the Drug Coverage Program as implemented by the State is, for *all* covered retirees, more favorable than the model that Plaintiff demands is required under the law.

The Department Declines to Implement the Catastrophic Program.

As explained above, the Catastrophic Program was intended to ensure that a state retiree would not incur any out-of-pocket costs for prescription drugs once they hit the "catastrophic" coverage phase of Medicare Part D. But because of the Inflation Reduction Act, retirees will not have to pay anything further once they reach the "catastrophic" coverage phase. In essence, from the perspective of the retiree, the "catastrophic" coverage phase was eliminated entirely. As a result, the Catastrophic Program has become entirely superfluous. (Kuminski Decl. ¶ 4.) Indeed, because a retiree will no longer incur any costs in the "catastrophic" coverage phase, there are no longer any costs for the Department to reimburse.[9]

STANDARDS OF REVIEW

To survive a motion to dismiss under Federal Rule of Civil Procedure 12(b)(6), "a complaint must contain sufficient factual matter, accepted as true, 'to state a claim to relief that is plausible on its face." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (citation omitted). The factual allegations "must be enough to raise a right to relief above the speculative level."

[9] Even though the Department did not implement the Catastrophic Program, any retiree who would otherwise be eligible for the Catastrophic Program based on his or her retirement date (and who purchases a Medicare Part D plan through the Via Benefits marketplace) is automatically eligible to make reimbursement claims in the Life-Sustaining Program. (Kuminski Decl. ¶ 6.) As of this date, no claims have been submitted for reimbursement under the Life-Sustaining Program by enrollees in the HRA or retirees eligible for the Catastrophic Program. (Kuminski Decl. ¶ 7.)

Kerr v. Marshall Univ. Bd. of Governors, 824 F.3d 62, 71 (4th Cir. 2016) (citation omitted). Although the Court is required to "'take the facts in the light most favorable to the plaintiff,'" the Court "need not accept legal conclusions couched as facts or 'unwarranted inferences, unreasonable conclusions, or arguments.'" *Wag More Dogs, LLC v. Cozart*, 680 F.3d 359, 365 (4th Cir. 2012) (citation omitted).

"A district court should grant a motion to dismiss for lack of subject matter jurisdiction under Rule 12(b)(1) only if the material jurisdictional facts are not in dispute and the moving party is entitled to prevail as a matter of law." *Upstate Forever v. Kinder Morgan Energy Partners, L.P.*, 887 F.3d 637, 645 (4th Cir. 2018).

A preliminary injunction is an "extraordinary remedy never awarded as of right." *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 24 (2008). Preliminary injunctive relief "may only be awarded upon a clear showing that the plaintiff is entitled to such relief." *Dewhurst v. Century Aluminum Co.*, 649 F.3d 287, 290 (4th Cir. 2011) (citation omitted). To obtain a preliminary injunction, a plaintiff must demonstrate "[1] that he is likely to succeed on the merits, [2] that he is likely to suffer irreparable harm in the absence of preliminary relief, [3] that the balance of equities tips in his favor, and [4] that an injunction is in the public interest." *Id.* (citation omitted).

ARGUMENT

I. PLAINTIFF HAS NOT ESTABLISHED A LIKELIHOOD OF SUCCESS ON THE MERITS AND HIS COMPLAINT SHOULD BE DISMISSED.

A. Plaintiff's Equal Protection Claims Should be Dismissed Because the Subclassifications Satisfy Rational Basis Review.

Plaintiff first claims that the Department "created two separate and unauthorized subclassifications within [the] single statutory class [of retirees], resulting in unequal treatment of identically situated retirees" in violation of the Equal Protection Clause of the Fourteenth Amendment. (Compl. ¶ 67.) These two purported subclassifications are: (1) "whether a retiree enrolled [in a Medicare Part D plan] through a private vendor," (Compl. ¶ 68), and (2) "providing HRA funds to some members of the statutory class but not others" based on their date of retirement. (Compl. ¶ 71.)

1. The Department's Use of a Third-Party Vendor to Administer the Reimbursement Programs Satisfies Rational Basis Review.

Plaintiff argues first that the Department's requirement that Medicare-eligible retirees enroll in a Medicare Part D plan through the Via Benefits marketplace creates a subclassification that divides eligible retirees into two groups: first, "retirees who enrolled through the vendor and receive HRA benefits and Life Sustaining Program access," and second, "retirees who did not enroll through the vendor and receive nothing." (Compl. ¶¶ 68-70.) This argument fails to state a claim upon which relief can be granted.

The Equal Protection Clause states that "[n]o State shall . . . deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. amend. XIV, § 1. The Clause "forbids only truly arbitrary distinctions among groups that are similar in 'all respects relevant to attaining the legitimate objectives of legislation.'" *Applegate, LP v. City of Frederick,*

Maryland, 179 F. Supp. 3d 522, 531 (D. Md. 2016) (quoting *Van Der Linde Hous., Inc. v. Rivanna Solid Waste Auth.*, 507 F.3d 290, 293 (4th Cir. 2007)). This is because, as courts have routinely noted, classification is central to the role of legislatures and administrators. *See, e.g.*, *Moss v. Clark,* 886 F.2d 686, 689 (4th Cir. 1989) ("Laws are presumed to be constitutional under the equal protection clause for the simple reason that classification is the very essence of the art of legislation." (citing *City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 440 (1985))). In an equal protection claim, a plaintiff must assert that "he has been treated differently from others with whom he is similarly situated and that the unequal treatment was the result of intentional or purposeful discrimination." *Kolbe v. Hogan*, 849 F.3d 114, 146 (4th Cir. 2017) (en banc) (citation omitted).

After determining that the plaintiff is indeed similarly situated, courts determine the appropriate level of scrutiny with which to review the classification and whether the unequal treatment can be justified under that level of scrutiny. *Id.* Here, Plaintiff appears to concede that his claim is subject to rational basis review (Compl. ¶ 65), which asks whether the classification "bears a rational relation to some legitimate end." *Romer v. Evans*, 517 U.S. 620, 631 (1996).

Under the "deferential standard" of rational basis, "the plaintiff bears the burden 'to negate every conceivable basis which might support'" the challenged classification. *Giarratano v. Johnson*, 521 F.3d 298, 303 (4th Cir. 2008) (citation omitted). Conversely, "the State has no obligation to produce evidence to support the rationality of [a classification], which 'may be based on rational speculation unsupported by any evidence or empirical data.'" *Id.* (quoting *FCC v. Beach Commc'ns, Inc.*, 508 U.S. 307, 315 (1993)); *see also Armour v.*

City of Indianapolis, 566 U.S. 673, 681 (2012) (holding that "any reasonably conceivable state of facts" overcomes rational basis).

In this case, Plaintiff has failed to meet his burden to negate every conceivable basis that might support the classification. For instance, the efficient administration of the HRA program is a clearly legitimate government interest. Using a third-party vendor, especially in a field for which the Department otherwise does not have the necessary staffing and expertise, enables the Department to efficiently track enrollment and eligibility, as well as support the implementation of the HRA. Pursuing government interests such as administrability, efficiency, and reducing burden have been sufficient justifications to satisfy courts that a classification overcomes rational basis review. *See Armour*, 566 U.S. at 683, 686 (holding that a classification that reduces "administrative burden," "administrative costs," and "administrative considerations" satisfied rational basis); *see also Boger v. City of Harrisonburg, Virginia*, No. 5:24-CV-00083, 2025 WL 1696562, at *9 (W.D. Va. June 17, 2025) (holding that "administrative efficiency . . . and limiting the burden" on government officials satisfied rational basis). Plaintiff does not meet his burden to negate the administrative efficiency rationale, or any other conceivable basis, upon which this subclassification could have been supported. Thus, this claim lacks merit.

2. Even if Plaintiff Has Standing, the Statutory Subclassification Based on Retirement Date Satisfies Rational Basis Review.

Plaintiff next argues that the Department "created an additional subclassification by providing HRA funds to some members of the statutory class but not others." (Compl. ¶ 71.) Plaintiff alleges disparate treatment because "[r]etirees who retired on or before December 31, 2019 and are enrolled in the § 2-509.1(d) program receive HRA contributions," while

"[r]etirees who began service on or before June 30, 2011 and retired on or after January 1, 2020, and are enrolled in the § 2-509(e) Catastrophic Program receive no HRA contributions." (Compl. ¶ 72.) Plaintiff's claim fails because he lacks standing and because this classification—which is an inherent feature of the law—survives rational basis review.

a. Plaintiff Lacks Standing Because He is Not Part of the Group that He Alleges Has Been Harmed.

"The party invoking federal jurisdiction bears the burden of establishing" that they have standing. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 561 (1992). To establish standing, a plaintiff must show, among other things, that they have "suffered an injury in fact—an invasion of a legally protected interest which is (a) concrete and particularized and (b) actual or imminent, not conjectural or hypothetical." *Id.* at 560.

Here, Plaintiff fails to meet this burden. As Plaintiff acknowledges in his affidavit, he was retired as of December 31, 2019, and therefore is eligible only for the Drug Coverage Program.[10] The heart of Plaintiff's claim, however, is that, while the Department has provided a benefit to those eligible for the Drug Coverage Program, the Department has improperly denied that same benefit to those eligible for the Catastrophic Program. But because Plaintiff is not a member of that subclass, he cannot have suffered a concrete and particularized harm from the purported classification he describes. Accordingly, Plaintiff lacks standing and his claim should be dismissed under Rule 12(b)(1).

[10] In his complaint, Plaintiff asserts he "meets all statutory criteria for participation in the prescription drug reimbursement programs mandated by § 2-509.1." (Compl. ¶ 17.) But this is an impossibility, given that the Drug Coverage Program and the Catastrophic Program are mutually exclusive based on the individual retiree's retirement date.

b. The Subclassification Satisfies Rational Basis Review.

Furthermore, even if Plaintiff does have standing, this Court should still reject this claim, finding that the alleged classification overcomes rational basis review. In designing two different statutory programs that differed in their reimbursement levels, their eligibility criteria, and the types of out-of-pocket costs to which they could be applied, the General Assembly engaged in necessary and commonplace line-drawing that was reasonably designed to cap state expenditures while still providing a benefit to an effected class.[11] Indeed, by giving a more favorable benefit to those who had already retired by a certain date, the law reasonably expresses a preference for those who would be immediately affected by the elimination of the state retiree prescription drug program, including those who may have retired under the impression that the program would continue indefinitely. "Conserving scarce budgetary resources" is a common rational basis for limiting the size and scope of a statutory class. *Mitchell v. Apfel*, 19 F. Supp. 2d 523, 528 (W.D.N.C. 1998), *aff'd Mitchell v. Commissioner of the Soc. Sec. Admin.*, 182 F.3d 272 (4th Cir. 1999); *see also Schweiker v. Wilson,* 450 U.S. 221, 238 (1981) ("Congress should have discretion in deciding how to expend necessarily limited resources"); *Davis v. Bowen,* 825 F.2d 799, 801 (4th Cir.1987) (holding that the suspension of Social Security benefits for convicted felons was rationally related to the legitimate interest of "conserving scarce social security resources"). As established above, Plaintiff "bears the burden to negate every conceivable basis which might support" the Department's argument. *Giarratano*, 521 F.3d at 303. But Plaintiff does not negate the fiscal

[11] *See Hearing on S.B. 946 Before the Sen. Budget & Tax. Comm.*, 439th Leg. Sess. (Feb. 27, 2019) (testimony of Sen. Griffith at 05:02:46) (explaining that the statutory changes were made in an "effort to address sustainability of what we are able to fund as a state").

rationale, or any other conceivable basis, upon which this classification could have been supported. Thus, this claim lacks merit.

B. Plaintiff's Due Process Claim Fails Because It Improperly Asks this Court to Decide Questions of State Law.

Plaintiff claims that the Department violated the Fourteenth Amendment's Due Process Clause. (Compl. ¶¶ 78, 81.) He claims to have "a protected property interest in the prescription-drug benefits and programs mandated by § 2-509.1" and that the Department deprived him of these property rights "without due process of law." (Compl. ¶¶ 78, 81.)

The Fourteenth Amendment's Due Process Clause provides that no state shall "deprive any person of life, liberty, or property, without due process of law." U.S. Const. amend. XIV, § 1. In a procedural due process claim, a plaintiff must: (1) "demonstrate that he had a constitutionally cognizable life, liberty, or property interest," (2) "show that the deprivation of that interest was caused by 'some form of state action,'"; and (3) "prove 'that the procedures employed were constitutionally inadequate.'" *Sansotta v. Town of Nags Head*, 724 F.3d 533, 540 (4th Cir. 2013) (citation omitted).

Here, Plaintiff's claim fails at the outset because the resolution of any Due Process Clause claim necessarily requires this Court to resolve underlying questions of Maryland law. The Fourth Circuit has explained that, where "state law questions" are "nestled in [a plaintiff's] due process claim," it would be "ill-advised if not impossible" to adjudicate the due process claim in federal court. *Mora v. City of Gaithersburg*, 519 F.3d 216, 229 (4th Cir. 2008).

In *Mora*, the police had confiscated firearms from the plaintiff, who had been subject to a psychiatric evaluation. To facilitate the return of the firearms, the police required Mora to complete a questionnaire that asked him about his mental health and alcohol use. Mora

refused, and filed suit, claiming that the police had no authority under Maryland law to condition the return of his firearms on the completion of the questionnaire. Both the district court and the Fourth Circuit, however, declined to address this question, concluding that to do so would require the Court to answer questions of state law, such as whether Maryland law preempted the police authority to require the completion of the form, and whether Mora was even entitled to possess firearms under Maryland law.

This Court should follow that reasoning and decline to hear Plaintiff's claim. Indeed, the premise of Plaintiff's claim is that the Department's actions—e.g., requiring enrollment through a vendor—are not authorized by the statutory scheme in § 2-509.1. (Compl. ¶¶ 79, 80.) But because the issue of whether the Department is authorized to use a vendor under § 2-509.1 is a "state law question[]" that is "nestled in [Plaintiff's] due process claim," it would be "ill-advised if not impossible" to adjudicate Plaintiff's due process claim here in federal court. *Mora*, 519 F.3d at 229.

Even if this Court were to disregard *Mora* and address Plaintiff's due process claim, this Court should conclude that Plaintiff has nonetheless failed to meet his burden to establish the elements of a procedural due process claim. As a preliminary matter, Plaintiff fails "to offer any legal authority to suggest that Maryland's common law" grants him a protected property interest in benefits under § 2-509.1. *Menk v. MITRE Corp.*, 713 F. Supp. 3d 113, 176-77 (D. Md. 2024) (citation omitted). Further, Plaintiff fails to show "that he was deprived of that interest, and that he was afforded less process than was due." *Higginbotham v. Public Serv. Comm'n of Maryland*, 171 Md. App. 254, 267 (2006).

Mora is again instructive. There, the Fourth Circuit concluded that, because the plaintiff "has had, and continues to have, notice and an opportunity to be heard in Maryland

[state courts], . . . he cannot plausibly claim that Maryland's procedures are unfair when he has not tried to avail himself of them." *Mora*, 519 F.3d at 230. The fact that "[t]he state courts are open to him" was "fatal" to the plaintiff's case. *Id.*

Here, assuming he has standing, Plaintiff is free to seek redress in state courts as to the authority vested in the Department under § 2-509.1. Indeed, the question of whether Plaintiff has been denied a particular benefit created solely by state law is fundamentally a question of state law that should be decided by state courts in the first instance. Because the state courts are open to him to resolve this claim, he cannot claim at this juncture that his Due Process Clause rights have been violated.

C. Plaintiff's State Constitutional Claims Should be Dismissed for Lack of Subject-Matter Jurisdiction and Failure to State a Claim.

Next, Plaintiff claims that his allegations under Counts I and II also violate Article 24 of the Maryland Declaration of Rights. (Compl. ¶ 84.) This Court lacks jurisdiction to hear this claim, which in any event lacks merit.

1. This Court Lacks Subject-Matter Jurisdiction Because State Law Claims Against the State Are Barred by the Eleventh Amendment.

Although the language of the Eleventh Amendment on its face refers only to suits between a State and citizens of another State, the Supreme Court has held that "its greater significance lies in its affirmation that the fundamental principle of sovereign immunity limits the grant of judicial authority in Art. III." *Pennhurst State Sch. & Hosp. v. Halderman*, 465 U.S. 89, 98 (1984). The baseline default is thus that "an unconsenting State is immune from suits brought in federal courts by her own citizens as well as by citizens of another state." *Employees v. Missouri Pub. Health & Welfare Dep't,* 411 U.S. 279, 280 (1973). "Suits against

state officials in their official capacity," as is the case here, are "treated as suits against the State." *Hafer v. Melo*, 502 U.S. 21, 25 (1991).

The general principle of sovereign immunity applies to each claim individually. *Pennhurst*, 465 U.S. at 121 ("A federal court must examine each claim in a case to see if the court's jurisdiction over that claim is barred by the Eleventh Amendment."). In analyzing each claim's jurisdictional basis independently, "neither pendent jurisdiction nor any other basis of jurisdiction may override the Eleventh Amendment." *Id.* Specifically addressing the posture of this case, "a claim that state officials violated *state* law in carrying out their official responsibilities . . . is protected by the Eleventh Amendment," and this protection "applies as well to *state-law* claims brought into federal court under pendent jurisdiction." *Id.* (emphasis added).

Here, Plaintiff's claim is against a state official and emerges under state law, and the State has not given its consent to face this claim in federal court. Therefore, this claim is not independently exempted from the Eleventh Amendment's sovereign immunity bar, and *Pennhurst* prohibits Plaintiff from using supplemental jurisdiction to attach a state claim to his federal constitutional claims. Thus, this Court should dismiss this claim for lack of subject-matter jurisdiction under Rule 12(b)(1).

2. Plaintiff's Claim Fails Because the Text of the Statute Does Not Prohibit Use of a Vendor.

Even if this Court were to overlook Eleventh Amendment immunity and address this claim, this Court should conclude that there is no Article 24 violation. With respect to equal protection, the Supreme Court of Maryland has held that "Article 24 and the Equal Protection Clause of the Fourteenth Amendment are in *pari materia*, and we generally apply them in like

manner and to the same extent," including with regard to the principles under rational basis review. *Ehrlich v. Perez*, 394 Md. 691, 715 (2006). Thus, for the same reasons set forth above, Plaintiff has failed to negate all possible rational bases for the classification that he challenges, and therefore Plaintiff's Article 24 claim, to the extent it relies on equal protection, should fail.

Plaintiff's Article 24 claim based on due process principles also fails on the merits. As noted above, Plaintiff argues that the Department's use of a vendor "imposed unauthorized conditions . . . that deprived retirees" of a protected property right. (Compl. ¶ 80.) However, the text and legislative history of § 2-509.1 refute this claim. First, § 2-509.1(d)-(f) directs the Department to "establish" various reimbursement programs, identifying the broad objective for each program. There is nothing in the text of § 2-509.1(d)-(f) that *precludes* the Department from determining the best procedural methods for achieving those objectives. Indeed, § 2-503(b)(1), which governs state benefits generally, expressly permits the Department to "arrange as the Secretary considers appropriate any benefit option for inclusion in" a retiree benefits program. Although Plaintiff appears to suggest that he is entitled to participate in the programs because he is a retiree "who is enrolled in a prescription drug plan under Medicare," § 2-509.1(d)(1)(i), he overreads this language. By stating that this subsection "applies only" to a particular subset of retirees, the legislature was not establishing a substantive component of the program itself, but rather setting a ceiling on the scope of who might be eligible.

More importantly, the statutory scheme affirmatively contemplates the use of a vendor. Section 2-509(i) grants the Department the authority to "make an emergency procurement for . . . a third-party to administer health reimbursement accounts established under this section." § 2-509.1(i)(2). Confirming this understanding, the legislative history also shows that the General Assembly wrote the statute broadly to give the Department "flexibility" in how it

implemented the program and discussed the use of a vendor at multiple stages. *See supra* pp. 6-7. The text and legislative history of the statute, at a minimum, therefore suggest that the statute was not intended to prohibit the use of a third-party vendor in the way that Plaintiff asserts, a conclusion that undercuts Plaintiff's due process claim entirely.

D. Count IV Should Be Dismissed Because It Is Barred by the Eleventh Amendment, and It Misapplies Article 19 of the Maryland Declaration of Rights.

Plaintiff claims that the Department violated Article 19 of the Maryland Declaration of Rights by "deny[ing] retirees meaningful access to the statutory remedies created by § 2-509.1." (Compl. ¶ 87.) As a preliminary matter, this claim should be dismissed under Rule 12(b)(1) because it presents a state law claim against a state official, and therefore, like Plaintiff's Article 24 claims, it is barred by the Eleventh Amendment and cannot be brought via supplemental jurisdiction under *Pennhurst*.

Looking past Eleventh Amendment immunity, Plaintiff's claim fails. Plaintiff claims that the Department has "den[ied] meaningful access to the statutory remedies created by § 2-509.1." (Compl. ¶ 87.) Plaintiff seemingly asserts that the reimbursement programs and their benefits qualify as "remedies" under Article 19 of the Maryland Declaration of Rights. However, this argument improperly relies on Article 19 and misapplies its purpose where it is inapplicable in this case. In full, Article 19 provides:

> "That every man, for any injury done to him in his person or property, ought to have remedy by the course of the Law of the Land, and ought to have justice and right, freely without sale, fully without any denial, and speedily without delay, according to the Law of the Land."

Md. Decl. Rights, art. 19. In summary, Article 19 protects "two interrelated rights: (1) a right to a remedy for an injury to one's person or property; (2) a right of access to the courts." *Piselli*

v. 75th Street Medical, 371 Md. 188, 205 (2002). When a party alleges that either of those rights has been violated, Article 19 grants a cause of action to ensure that these rights are "not illegally or arbitrarily denied by the government." *State v. Board of Educ.,* 346 Md. 633, 647 (1997). Article 19 allows for remedies of "a right to money or property under . . . common law," *Piselli*, 371 Md. 188 at 205, but "declaratory and injunctive relief" are not "within the purview of Article 19," *Paula v. City of Baltimore*, 253 Md. App. 566, 591 (2022).

Here, Plaintiff does not plead facts that would implicate Article 19 nor does he seek the appropriate remedy under Article 19. First, Plaintiff does not allege that he has been denied access to court or that he has been denied a remedy for injuries. Furthermore, the text of § 2-509.1 does not limit access to courts or the ability to seek a remedy for an injury to legal rights. Plaintiff appears to assert that the "remedies" at issue here are the *benefits* of § 2-509.1 that he alleges have been denied by the Department. But this novel reading, for which Plaintiff provides no support, should be rejected. Article 19 does not prevent the denial of statutory benefits, only the denial of remedies, such as access to court or money damages. Second, the relief that Plaintiff seeks is injunctive and declaratory relief, both of which are not available under Article 19. Thus, this claim, if not dismissed under Rule 12(b)(1), fails on the merits.

E. Count V ("Ultra Vires") and Count VI ("Violation of § 2-509.1") Are Barred by the Eleventh Amendment and Are Undermined by the Text of the Statute.

In Counts V and VI, Plaintiff claims that the Department has engaged in acts that are not authorized by § 2-509.1. For instance, in Count V Plaintiff claims that the Department's "actions exceed[ed] the authority granted by Section 2-509.1 and are ultra vires and void." (Compl. ¶ 92.) In that same count, Plaintiff alleges that § 2-509.1 "does not authorize DBM to eliminate the statutory prescription drug programs, eliminate automatic enrollment, impose

vendor-enrollment requirements, or replace the statutory framework with an HRA system." (Compl. ¶ 91.) Similarly, in Count VI Plaintiff claims that the Department's "actions violate § 2-509.1 and constitute unlawful agency action," (Compl. ¶ 97), because the Department "has never implemented" the three programs established by § 2-509.1, "has eliminated automatic enrollment, and has replaced the statutory scheme with a vendor-based HRA system that does not reimburse actual prescription-drug expenses," (Compl. ¶ 96).

As with several of the claims discussed above, Plaintiff's claim should be dismissed under Rule 12(b)(1) for lack of subject-matter jurisdiction. Each of these claims asserts a state law claim against a state law official, and therefore falls squarely with the prohibition in *Pennhurst* on hearing such claims in federal court, even via supplemental jurisdiction.

On the merits, these claims should be rejected for the same reasons discussed above for rejecting Plaintiff's Article 24 Due Process claim: that the text and legislative history of § 2-509.1 do not preclude, and in fact contemplate, the use of a third-party vendor to administer the statutory programs.

F. Plaintiff's Final Three Counts Should be Dismissed Because They Are Not Viable Causes of Action.

In Count VII, Plaintiff requests a "declaration that DBM's actions violate § 2-509.1, exceed DBM's statutory authority, and violate the federal and state constitutional provisions identified in Counts I-VI." (Compl. ¶ 100.) In Count VIII, Plaintiff asserts that the "*Ex Parte Young* exception to sovereign immunity" entitles him to seek "prospective declaratory and injunctive relief to halt ongoing violations of federal law." (Compl. ¶ 104, 106.) Finally, in Count IX, Plaintiff claims that the Department's "replacement of the statutory scheme with a vendor-based HRA system contradicts the text and structure of § 2-509.1 and is thus unlawful

under [the] judicial governing principles" of *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024) and *PFLAG, Inc. v. Trump*, 766 F. Supp. 3d 535 (D. Md. 2025). (Compl. ¶ 110.)

But none of these claims is an independent or free-standing cause of action. Indeed, it is well established that a claim for declaratory judgment "does not constitute an independent claim." *Manago v. Cane Bay Partners VI, LLLP*, No. 20-CV-0945-LKG, 2022 WL 4017299, at *9 (D. Md. Sept. 2, 2022); *see also Delavigne v. Delavigne*, 530 F.2d 598, 601 (4th Cir. 1976) ("It is axiomatic that the [Declaratory Judgement Act, 28 U.S.C. § 2201] does not supply its own jurisdictional base"). Likewise, *Ex Parte Young* is a legal doctrine, which provides an exemption from sovereign immunity for claims in federal court against a state official for violations of *federal* law, *Ex parte Young*, 209 U.S. 123, 159 (1908), but "by itself does not create [an independent] cause of action." *Michigan Corr. Org. v. Michigan Dep't of Corr.*, 774 F.3d 895, 905 (6th Cir. 2014).

With respect to Count IX, cases like *Loper Bright* and *PFLAG* do not provide an independent cause of action, but instead merely establish the standards for judicial review of agency interpretations of statutes and of agency actions. Moreover, this claim fails for the additional reason that Plaintiff's application of *Loper Bright* to the actions of a *state* agency interpretation of *state* law overextends the holding of that case. Indeed, courts within this Circuit have arrived at the commonsense conclusion that applying federal doctrines discussed in *Loper Bright* to the actions of a state agency is "inapposite" because "[n]either *Chevron*, nor *Loper Bright*, is applicable to . . . a state agency." *Lesane v. Bell*, No. 5:24-CV-564-FL, 2024 WL 5056259, at *4 (E.D.N.C. Dec. 10, 2024).

II. PLAINTIFF IS NOT ENTITLED TO THE EXTRAORDINARY RELIEF OF A PRELIMINARY INJUNCTION.

As noted above, to obtain the "extraordinary remedy" of a preliminary injunction, a plaintiff must demonstrate "[1] that he is likely to succeed on the merits, [2] that he is likely to suffer irreparable harm in the absence of preliminary relief, [3] that the balance of equities tips in his favor, and [4] that an injunction is in the public interest." *Dewhurst*, 649 F.3d at 290 (citation omitted). For the reasons set forth above, Plaintiff has failed to show that he is likely to succeed on the merits of his disparate claims.

Moreover, Plaintiff has failed to show that he can satisfy the three remaining equitable factors. First, Plaintiff has failed to establish any form of irreparable harm. He claims that he will lose access to necessary medications because he was denied access to the Life-Sustaining Program and thus had to incur costs to obtain insulin. (ECF No. 14-1 at 19.) But insulin is not included in one of Medicare Part D's protected classes, and thus is not included under the Life-Sustaining Program. Therefore, Plaintiff would have been denied relief under the Life-Sustaining program even if he had been eligible.[12] (Kuminski Decl. ¶ 5.) Nor can Plaintiff show irreparable harm relating to the "[u]nauthorized [d]isclosure of [p]rotected [h]ealth [i]nformation," given 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. (Kuminski Decl. ¶ 15.) Underscoring this conclusion

[12] As noted above, § 2-509.1(f)(2)(ii) authorizes the Department to "develop a list of the prescription drugs that qualify for reimbursement" under the Life-Sustaining Program. The list, which does not include insulin, can be found at https://dbm.maryland.gov/benefits/Documents/2026%20Drug%20List.pdf

is that Plaintiff has failed to advance any facts suggesting that Extend Health, in operating the Via Benefits marketplace, has or would violate such an agreement. Indeed, the most that Plaintiff can show, as it relates to harm, is the loss of up to $750 in funds available for reimbursement of out-of-pocket costs.[13]

On the other side of the ledger, the Department will incur significant costs if its ability to use a third-party administrator is enjoined. Currently, the Department pays Extend Health approximately $775,000 per year to administer the program through the Via Benefits marketplace.[14] (Kuminski Decl. ¶ 16.) If it were to administer the reimbursement programs on its own, however, the Department estimates that it would be required to hire at least 30 full-time staff, at a cost of more than $3,000,000. (Kuminski Decl. ¶ 18.) And this would not include costs related to training, the acquisition of expertise, and licensing. (Kuminski Decl. ¶¶ 17, 18, 20.) Nor would those costs include the need to hire approximately 100 additional seasonal personnel to assist during the open enrollment timeframe. (Kuminski Decl. ¶ 19.) The potential costs to the Department dwarf any speculative harm advanced by Plaintiff.

[13] This harm is itself speculative, given that the extent to which a state retiree will benefit from the Drug Coverage Program is based on her individual prescription costs. Dor instance, in 2025, more than 80% of eligible retirees did not exhaust their allotment of HRA, while roughly 25% did not use their funds at all. (Kuminski Decl. ¶ 21.) Moreover, under Plaintiff's strict reading of the statutory scheme, the Drug Coverage Program may only provide reimbursement for out-of-pocket costs actually incurred over the $1,500 threshold. Based on the figures from 2025, under Plaintiff's reading of the statute the vast majority of state retirees would have received *no* benefit from the program. And those that would have received a benefit would have received a maximum of only $500 (instead of $750).

[14] The Department pays on a per-account basis; the figure above is based on the administration of approximately 39,000 retiree reimbursement accounts. (Kuminski Decl. ¶ 16.)

Finally, the public interest weighs in favor of denying a preliminary injunction. In 2025, over 50,000 state retirees enrolled in a Medicare Part D plan through the Via Benefits marketplace. (Kuminski Decl. ¶ 12.) Plaintiff, on the other hand, stands alone in his complaint. Moreover, as discussed above, Maryland's reimbursement program, as administered by Extend Health through the Via Benefits marketplace, is *more* favorable than required by the statutory scheme, given that it allows reimbursement of up to $750 (rather than up to $600), and allows access to those funds as soon as a retiree incurs out-of-pocket costs (rather than only being accessible once a retiree reaches the $1,500 threshold). A preliminary injunction would thus not only cost taxpayers millions of dollars to bring the reimbursement programs in-house within the Department (and make Maryland the only State known to act as the administrator of a Medicare HRA program (Kuminski Decl. ¶ 22)), but would deprive benefits from the very class of individuals that Plaintiff claims to represent.

Courts should "pay particular regard for the public consequences in employing the extraordinary remedy of injunction," *Weinberger v. Romero-Barcelo*, 456 U.S. 305, 312 (1982), especially since the decision whether to grant a preliminary injunction is made on an incomplete record, and "the danger of a mistake in this setting is substantial." *Person v. City of Baltimore*, 437 F. Supp. 2d 476, 479 (D. Md. 2006) (internal quotation marks omitted). Those principles ring especially true here.

CONCLUSION

The motion to dismiss should be granted and the motion for preliminary injunction should be denied.

Respectfully submitted,

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July 24, 2026

Exhibit 1

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

KENNETH FITCH,	*	
Platintiff,	*	
v.	*	
YAAKOV WEISSMANN,	*	Case no.: 26-cv-01831-RDB
Defendant.	*	
	*	

* * * * * * * * * * * * * * * * *

DECLARATION OF CHRISTINA KUMINSKI

Christina Kuminski deposes and states as follows:

1. I am more than 18 years of age and competent to testify, upon personal knowledge, to the facts set forth herein.

2. I am the Director of the Employee Benefits Division for the Maryland Department of Budget and Management ("the Department"). As part of my duties, I oversee the implementation of the statutory reimbursement programs set forth in § 2-509.1(d)-(f) of the State Personnel and Pensions Article of the Maryland Code.

3. The Maryland State Retiree Prescription Drug Coverage Program ("Drug Coverage Program") is implemented through a Health Reimbursement Arrangement ("HRA"). The statutory purpose of this program is to "reimburse[] a participant for out-of-pocket costs that exceed the limits established for non-Medicare-eligible retirees" under Maryland law, which is $1,500 for an individual retiree. Under Medicare Part D, however, a participant's individual out-of-pocket costs were capped at $2,000 for an individual retiree in the first year of the program,

calendar year 2025. Although the difference between the $1,500 cap under Maryland law and the $2,000 cap under federal law was $500 in 2025, the HRA provided an annual reimbursement of up to $750 per enrolled retiree for their out-of-pocket Medicare Part D prescription drug costs (meaning that the State was contributing an additional $250 than required to individual retirees). The Part D individual out-of-pocket maximum cap increased to $2,100 in 2026 and will continue to increase in future years based on inflation and the growth of average prescription costs. It is expected that, as this cap increases, the State will increase annual reimbursement levels in order to ensure that retirees will not exceed $1,500 for an individual retiree. One important distinction in the final design is that HRA funds can be used to cover any out-of-pocket prescription drug costs no matter when they are incurred. This mechanism allows many more retirees to seek reimbursement than required under Maryland law since they can be reimbursed for all out-of-pocket prescription drug costs even before they hit the $1,500 limit. Eligible state retirees receive debit cards that can be used at point of sale.

4. The second program, the Maryland State Retiree Catastrophic Prescription Drug Assistant Program ("Catastrophic Program"), is not currently being implemented. The statutory purpose of this program is to "reimburse[] a participant for out-of-pocket costs after the participant has entered catastrophic coverage under a prescription drug benefit plan under Medicare." The Inflation Reduction Act of 2022, however, eliminated the cost-sharing burden of Medicare Part D enrollees in the "catastrophic" coverage phase of Medicare Part D. Because a Medicare Part D enrollee would thus incur no out-of-pocket costs during the "catastrophic" coverage phase, Maryland's Catastrophic Program is superfluous under current law.

5. The third statutory program, the Life-Sustaining Prescription Drug Assistance Program ("Life-Sustaining Program"), reimburses participants for out-of-pocket costs for life-

sustaining prescription drugs that are covered by Maryland's state retiree health benefits program and not under the participant's Medicare Part D plan. Section 2-509.1(f)(2)(ii) charges the Department with "develop[ing] a list of the prescription drugs that qualify for reimbursement under" the Life-Sustaining Program. This list, which does not include insulin, is currently available at: https://dbm.maryland.gov/benefits/Documents/2026%20Drug%20List.pdf.

6. Any state retiree who is enrolled in the HRA is automatically eligible for the Life-Sustaining Program. Moreover, although the Catastrophic Program is not currently administered due to the out-of-pocket caps in the Medicare program eliminating the catastrophic coverage phase, any retiree who would otherwise be eligible for the Catastrophic Program based on his or her retirement date is automatically eligible to make reimbursement claims in the Life-Sustaining Program.

7. As of July 24, 2026, while there have been inquiries about the Program, no claims have been submitted for reimbursement under the Life-Sustaining Program by enrollees in the HRA or retirees eligible for the Catastrophic Program.

8. To implement and operate these large-scale reimbursement programs, including the administration of the HRA under the Drug Coverage Program, the Department contracted with a third-party vendor named Extend Health, LLC, which operates and maintains the Via Benefits marketplace platform. Extend Health is a wholly-owned subsidiary of Willis Towers Watson ("WTW").

9. Section 2-509.1(i) of the State Personnel and Pensions Article authorizes the Department to "make an emergency procurement for . . . staff required to carry out the provisions of this section[,] and . . . a third party to administer health reimbursement accounts established

under this section." The Department's contract with Extend Health was executed as an emergency procurement consistent with state law.

10. This procurement followed the Department's internal decision that it did not possess the capabilities to independently run the statutory reimbursement programs without the assistance of an independent third party. Moreover, to further its goals of effective and efficient operation of the programs, the Department conditioned the availability of the statutory reimbursement programs on enrollment in a Medicare Part D plan through the Via Benefits marketplace platform.

11. The Department maintains a file with the eligibility determinations for each individual retiree based on their retirement date. The Department regularly shares that information with Extend Health.

12. In 2025, 50,526 retirees and their eligible spouses and dependents enrolled in a Medicare Part D plan through Via Benefits.

13. Extend Health serves as the administrator and customer-facing support for the HRA and Life-Sustaining Prescription Drug Program (LSPDP), in addition to facilitating enrollment into individual plans by receiving enrollment intake calls from individual retirees, working with each retiree to determine the right plan for their individual circumstances, and helping retirees enroll in their chosen Medicare Part D plan. Extend Health also runs a support website, handles external-facing communications, provides one-on-one advocacy services and counseling with retirees, and shares information and resources with retirees who are approaching the age of Medicare eligibility. Additionally, Extend Health maintains accounts and administers reimbursements related to the HRA and LSPDP.

14. As a Third-Party Administrator ("TPA"), Extend Health, along with WTW's corporate affiliate Acclaris, Inc., operates the debit card reimbursement system and ensures that the payments are distributed.

15. The Department's contractual relationship with Extend Health includes 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. Extend Health also maintains appropriate confidentiality and privacy safeguards for PHI with insurance carriers available on its platform. Extend Health's privacy practices are described in its Privacy Policy, which individuals are informed of prior to enrollment and is also available on Extend Health's website.

16. For these services, the Department pays Extend Health approximately $775,000 annually to administer the HRA. This figure is based on the number of HRA accounts. There are currently approximately 39,000 active HRA accounts. In 2025, the HRA program reimbursed retirees for approximately $19,000,000 of out-of-pocket Medicare Part D prescription-drug costs.

17. However, if the Department were forced to administer this program internally without the assistance of a third-party vendor, the Department would face higher costs and have a lower level of expertise compared to Extend Health or another third-party vendor.

18. To internally replicate Extend Health's services, I estimate that the Department would need to hire approximately 30 new full-time employees for the administration of the HRA. Based on the expertise needed for these positions, the cost per employee would likely exceed $100,000, including their salary and benefits. This total cost of over $3,000,000 does not include costs related to recruiting, training, and licensing these employees, which would be additional costs incurred by the Department.

19. In addition to full-time staff, I estimate that the absence of a third-party vendor would require the Department to hire approximately 100 seasonal agents to assist with counseling and enrollment during the annual open enrollment period.

20. Furthermore, the Department would face additional hurdles, such as registering itself as a TPA, organizing and implementing the HRA on its own, ensuring that the Department is properly licensed and insured to administer such a program, and contracting with a bank to create its own debit card program. Most importantly, the Department would be responsible for ensuring compliance with Centers for Medicare and Medicaid Services (CMS) and Internal Revenue Service (IRS) rules and regulations. This not only creates an additional burden but also introduces significant risk to the State.

21. In 2025, the HRA consisted of approximately 34,500 accounts. Of those, 8,498 accounts did not utilize any of the allotted HRA funds (i.e., because the retiree did not incur *any* out-of-pocket prescription drug costs). 19,698 accounts did not exhaust their allotment of $750 in HRA funds. Only 6,410 accounts used the HRA's full $750 reimbursement allotment.

22. I know of no other state that administers its own Medicare HRA program without the support of an outside vendor.

I hereby declare, under penalty of perjury, that the foregoing is true and correct to the best of my knowledge, information, and belief

Date: _7.23.2026_____

Christina Kuminski -DBM-

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