IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE

THE RETIRED PUBLIC EMPLOYEES OF ALASKA, INC.,	)	
Plaintiff,	)	
v.	)	
LESLIE RIDLE, in her official capacity as Commissioner of the Department of Administration,	)	
Defendant.	)	Case No. 3AN-16-04537 CI

DEFENDANT'S CLOSING ARGUMENT

When granting RPEA's partial motion for summary judgment, the Court addressed *a* key legal question: whether the State's offer of dental-visual-audio ("DVA") coverage to members of the Alaska Public Employee's Retirement System ("PERS") (collectively referred to as "retirees")[1] is protected by Article XII, § 7 of the Alaska Constitution.[2] It did not address *all* of the key legal questions. Remaining is the question of "how the law protects a benefit when the benefit package offered in this circumstance is paid for by the employee."[3] Only after addressing this question can the

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1 The issues raised by RPEA's complaint apply equally to the Teachers' Retirement System ("TRS") as well as PERS. For ease of reference, the State will refer only to PERS and will collectively refer to the members as retirees.

2 Order Denying Defendant's Request for Reconsideration ("Order on Reconsideration"), at 2–3 ("The Parties submitted one question to the Court for consideration of Summary Judgment: is the retired state employees' optional DVA plan subject to the non-diminishment clause of Alaska Constitution Article XII?").

3 Order on Reconsideration, at 2 (declining to address this issue because it "was not at question during the summary judgment motion").

Court determine—based on the facts of this case—whether the 2014 changes to the dental plan amounted to a diminishment of a constitutionally-protected accrued benefit.

The State contends that the protected benefit is the option to purchase dental coverage, not the coverage itself. As long as the State offers retirees a reasonable plan—a plan that is within the mainstream of dental insurance plans—there is no diminishment. RPEA concedes that the retirees' dental plan meets industry standards. Moreover, the State is the only party that presented the Court with the type of objective evidence needed to engage in *Duncan's* comparative analysis. Under either standard, RPEA has failed to meet its burden of proving a diminishment and its claims must be denied.

I. *Duncan* did not address how to value a benefit package paid for entirely by the employee.

In *Duncan*, the Alaska Supreme Court reached several important legal conclusions. First, it rejected the argument that the term "accrued benefits" as used in Article XII, § 7 refers only to the particular types of benefits offered at the time of ratification of the constitution.[4] Instead, "the term includes all retirement benefits that make up the retirement benefit package that becomes part of the contract of employment when the public employee is hired, including health insurance benefits."[5]

Second, the Court addressed how to value the State's offer of major medical coverage. The State argued that the value of the protected benefit was the "highest

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4 *Duncan*, 71 P.3d at 887–88.

5 *Id.* at 888.

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monthly premium paid by the public employer during the employee's employment."[6] In response, RPEA relied not only on the language of Article XII, § 7, but it relied on promises made by the State in the retirees' handbooks.[7] The court agreed with RPEA. It concluded that the "natural and ordinary meaning of 'benefits' in a health insurance context refers to the coverage provided rather than the cost of the insurance."[8] Importantly, the court did not stop there. Just as RPEA suggested, the Court also looked to the promises the State made in the "various employee publications."[9] For major medical, the court found that the publications "promise[d] coverage, not merely payment of a particular premium."[10] Specifically, "[t]he 1975 booklet promises: 'The entire cost *of this Medical Program* . . . will be paid by [the systems].'"[11] "And the 1980 handbook provides that "[*c*]*omprehensive major medical insurance is provided* . . . . There is no cost to you for this insurance."[12]

Given that language, in conjunction with the language found in the diminishment clause, the court found that the "accrued benefit" for major medical coverage was the value of the coverage offered to a retiree, not the highest premium paid by State. Consequently, if the State makes changes to its major medical coverage, it cannot

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6 *Id.*

7 *Id.* (stating that the retirees "contend that the representations made in employee handbooks over the years conflict with the state's current position").

8 *Id.* at 889.

9 *Id.*

10 *Id.*

11 *Id.* at 889 n.24 (emphasis and alteration in original).

12 *Id.* (emphasis in original).

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establish equivalent value by "merely comparing old and new premium costs";[13] it must establish that the new coverage is of an "equivalent value" to the old coverage.[14]

Importantly, when the Supreme Court discusses premiums in *Duncan*, it is referring to premiums paid for by the State. If the costs of providing the promised level of coverage goes up, that cost will be borne by the State, not the retirees.[15] The court did not address the situation in this case, where the cost of the coverage is borne entirely by the retirees.

A. The Court must consider impacts on premiums when evaluating coverage changes made to voluntary plans.

"Voluntary plans" or "optional benefits" refer to benefits fully funded by the retirees. [Tr. 607.] In addition to the DVA plan, the State also offers its retirees an optional long-term care plan. [Tr. 605–607.] These types of benefits present additional policy considerations for the State. In addition to providing coverages that benefit the retirees, the State must manage for the sustainability and attractiveness of the plans overall. [Tr. 606.]

Emily Ricci, the Division of Retirement and Benefit's ("DRB") Chief Health Policy Administrator, discussed these added concerns during her testimony. [Tr. 606–607.] A stable plan requires participation, and participation is impacted not only by the type of coverage offered, but by the premium rates required to obtain that coverage. [Tr. 607–608.] Freda Miller, a retiree and member of RPEA, used to be the State's

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13 *See Id.* at 892.

14 *Id.*

15 *See Id.* at 889 n. 24.

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benefits manager and provided testimony consistent with Ms. Ricci's testimony. [Tr. 29.] She acknowledged that: (1) as the State's benefits manager she was concerned about increases in premiums; (2) that because of an increase in premiums, some retirees will opt out of the plan; (3) that high premiums may discourage new retirees from joining the plan; and (4) whether to join the DVA plan is a one-time choice for the retirees. [Tr. 69.]

Cathye Smithwick, the State's dental coverage expert, further explained the importance of premiums when managing optional benefits. Every participant who decides to join a voluntary plan will run a calculation to determine whether his or her costs would be cheaper to join the plan and pay the premium or to self-insure. [Tr. 1091.] That calculation starts to change as premiums increase. [Tr. 1092.] Once premiums increase, usually the healthy population is the first to decline the option. [Tr. 1092.] This results in a smaller population over which to spread the costs and a more high-risk population of users. [Tr. 1092.] If the administrator of the plan does not address the problem, premiums will continue to increase while participation continues to decrease resulting in a phenomenon known as the actuarial death spiral. [Tr. 1092–1093.]

B. Premiums are a concern for the retirees.

Retirees are undeniably concerned about their dental coverage. This litigation alone proves that. But they are also concerned about the amount of their premiums. Freda Miller testified that she expects the State to manage the costs so that premiums will stay at a reasonable level. [Tr. 78.] She explained that this was one of her concerns

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when she was the State's benefits manager and pointed out that, during that time (2004–2009), most employee and retiree plan premiums were increasing annually by double digits. [Tr. 65, 78–79.] She also acknowledged that she would opt out of the DVA plan if the premiums got too high, stating:

> If the premiums got too high – because it's a benefit that is capped at $2,000. If the premiums rose enough that I thought I could do better on my own, I would absolutely drop that, yes.

[Tr. 79.]

Ms. Miller's testimony regarding the premium increase is consistent with Exhibit 2015, a chart depicting the historical retiree premium rate from 1984–2017. [Tr. 780–781.] In 2000, a retiree electing individual DVA coverage paid $41 a month. That increased to $48 in 2001 and $54 in 2005. [Exh. 2015.] In 2009, the rate increased to $57 per month. [Exh. 2015.] It jumped $13 to $70 per month in 2013, the year before the State revised its DVA plan. [Exh. 2015.] Once the State implemented the 2014 changes, the premiums decreased to $63 per month and stayed at that level through 2016. [Exh. 2015.]

Michele Michaud, DRB's Chief Health Official testified about the savings to the plan because of the 2014 changes. [Tr. 1225–1226.] She stated that the 2014 changes resulted in a savings of approximately 10 to 14 percent annually. [Tr. 1226.] For 2018, under the DVA plan as it exists right now, the State needs to increase the premiums by 5.9 percent. [Tr. 1226.] If the State reverts to the old 2013 plan, the State will need to increase the premiums by at least 20 percent and probably even more. [Tr. 1227.] An individual retiree paid $66 per month for DVA coverage in 2017. [Exh. 2015.] A twenty

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percent increase would mean that the retirees would have to pay another $13 or $79 per month for dental coverage. That is $948 a year, making a benefit plan with an annual maximum of $2,000 even less valuable.

Ms. Michaud also confirmed that the retirees are concerned about premiums, in addition to coverages. [Tr. 1227.] She testified that DRB receives "numerous complaints every time there is a premium increase." [Tr. 1227.] Currently, there are approximately 50,000 members enrolled in the DVA plan.[16] [Tr. 1051.] RPEA has only 14,000 members and it is not clear whether all 14,000 of its members opted for DVA coverage. [Tr. 1051.] Although RPEA is concerned about its membership, the State is concerned about the retiree population as a whole. Based on a customer satisfaction survey conducted by the State, 89 percent of Alaskans, and 84 percent of retirees living outside of Alaska, were at least somewhat satisfied with Moda as the State's third-party administrator. [Tr. 1053.] Two-thirds of those surveyed said that they were unwilling to pay a higher premium so that they could be reimbursed at a higher rate after seeing an out-of-network provider. [Tr. 1053.]

Todd Allen testified as RPEA's expert in benefit plan evaluation. [Tr. 347.] He too agreed that premiums are an important consideration for employees/retirees choosing dental coverage. [Tr. 342–344.] When asked about what he would consider prior to advising a group of employees on the most beneficial plan, Mr. Allen replied that, among other things, he looked at the "financial situation of the organization" and the "income levels of the individuals." [Tr. 342.] He further explained that employees

16 This includes retirees and dependents.

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always want to know about their out-of-pocket expenses, including premiums, co-pays, deductibles, and annual out-of-pocket maximums. [Tr. 343; 533–536.]

The Court should not follow RPEA's directive and conduct a diminishment analysis without considering the impact coverage changes have on the premium rates. Although RPEA's membership may be most concerned with coverage, the retiree population as a whole is not only concerned with coverage, it is concerned with how much this coverage is going to cost. If the Court orders the State to return to the 2013 plan, that is going to come at a cost. Although some retirees will get the coverage they want, other retirees will opt out or choose not to enroll in the plan. Those retirees will need to either self-insure or purchase a different plan on the open market.

II. The accrued benefit is not the coverage, but the option to purchase a reasonable dental plan at a reasonable price.

In its order denying the State's motion for reconsideration, the Court said it had not yet decided "how the law protects a benefit when the benefit package offered in this circumstance is paid for by the employee."[17] The answer to that question depends on how the Court defines the "accrued benefit." In the major medical context, the accrued benefit is the coverage.[18] The retiree is receiving medical coverage paid for by the retirement system. With the DVA plan, the retiree is paying for dental coverage. The only thing the State is offering to the retiree is the option to purchase a plan that the State manages. The "accrued benefit" is the option to purchase coverage, not the

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17 Order on Reconsideration, at 2.

18 *Duncan*, 71 P.3d at 888–89.

coverage itself. By defining the constitutionally protected benefit in this way, the Court will not only protect the actual promise made to retirees during the course of their employment, but it will give the State the flexibility it needs to consider premiums when dealing with voluntary benefits such as DVA and long-term care coverage.[19]

To define the accrued benefit, the Court must look at what the State promised the retiree.[20] Alaska Statute 39.30.090(a) provides that the Department "may obtain" a group insurance policy that *may* include DVA coverage; and subsection (a)(10) provides that a PERS member "may obtain" DVA coverage under this section. In other words, the State offered the retirees the option to purchase the same dental coverage offered to its state employees. This is materially different from the State's promise for major medical coverage. At the time of employment, a PERS member was informed—via AS 39.35.535—that they were "entitled to major medical insurance coverage" in retirement if the retiree met certain conditions. Acceptance of this term was a condition of employment pursuant to AS 39.35.120.

The employee publications also reflect the differences between the two benefits. As the court noted in *Duncan*, the employee handbooks promised the retirees major medical coverage.[21] The 1975 booklet stated that the entire cost of the coverage "will be

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19 As Ms. Ricci testified, the State needs the flexibility to manage these voluntary plans for their long-term stability. [Tr. 606.] This is even more evident in the context of the retirees' long-term care plan, where members pay premiums from the time they elect to participate, but do not receive any benefits from that plan until much later. [Tr. 606.]

20 *Duncan*, 71 P.3d at 888–89.

21 *Id.* at 889 and n. 24.

paid by [the system]."[22] The 1980 booklet promised "comprehensive major medical insurance" at "no cost" to the retiree.[23] The State did not make the same promises when it came to the DVA plan. The 1979 employee handbook—the first booklet published for DVA coverage—stated that a PERS member "may elect coverage under this voluntary group dental-vision-audio plan;" "[t]he cost of the coverage . . . shall be paid by the person electing coverage." [Tr. 770-771; Exh. 2000.] Similar language appeared in the books published from 1979 through 2011. [Tr. 771.] The 2013 handbook stated that the State "is pleased to be able to offer this voluntary [DVA] Plan." [Exh. 1000.] "If coverage is elected, the premiums are paid by deductions from your retirement check." [Exh. 1000.] Like AS 39.30.090(a), the handbooks pertaining to DVA coverage promise the retirees the option to purchase DVA insurance; the handbooks do not promise the retirees coverage.

By defining the "accrued benefit" as the option to purchase DVA coverage, the Court can better consider how changes to coverage affect the retirees' premiums. Under RPEA's theory, the Court can consider only coverage—premiums are irrelevant. But RPEA's position will negatively affect the retirees who are more concerned about premium increases. For those retirees, the ability to obtain unlimited cleanings without any oversight from the third-party administrator, unlimited crowns, or unlimited bridges, may not be worth the increase in premiums. Consequently, they may drop the coverage all together, and, as RPEA's dental experts testified, some patients will choose

22 *Id.* at 889 n.24.

23 *Id.*

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to forego dentally necessary care if it that care is not covered by insurance. [Tr. 238; 433.] Thus, spiraling premiums also diminish the value of the DVA benefit offered to retirees, a fact completely ignored in RPEA's analysis.

Under the State's theory, the constitutionally protected benefit is the option to purchase coverage. That option can be valued two different ways. First, the Court could compare the dental plan offered to retirees to the dental plan offered to the State's active employees. This is supported by the plain language of AS 39.30.090(a)(10), which offers PERS members the option to purchase the same auditory, visual, and dental insurance offered to the State's active employees under the authority of AS 39.30.090(a) & (a)(1). Second, the Court could compare the dental plan offered to retirees with the dental plans offered to similar groups across the United States. Under either theory, the State is responsible for offering the retirees a reasonable and affordable dental plan. It affords the State the flexibility to make changes to the plan to manage costs, but places the responsibility on the State to offer a plan with coverages that appeal to the majority of the retiree population.

The 2014 dental plan offered to retirees is at least equivalent to, if not better than, the dental plan offered to the State's active employees and dental plans offered to similar populations across the country.

Cathye Smithwick, the State's dental benefits consultant, testified as an expert in dental benefit design and analysis. [Tr. 1061.] In her opinion, the 2014 plan offered to retirees meets, and in some areas exceeds, industry standards for dental plans offered in the country. [Tr. 1165.] RPEA did not put on evidence to challenge Ms. Smithwick's

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analysis, and RPEA now accepts her opinion as valid.[24] Rather than challenge her opinion, RPEA argues that it is irrelevant.

The State also presented evidence that the 2014 dental plan meets or exceeds the coverage offered to the State's active employees. [Tr. 1055–1058, 1216–1222; Exh. 2013.] Ms. Michaud testified that the retirees' dental plan is most like the standard plan the State offers to its active employees. [Tr. 1057.] Prior to 2014, the active employees and retirees had similar dental coverage. [Tr. 1057.] Like the retirees, the State offered active employees a dental plan that lacked network steerage and did not specify any specific frequency limits. [Tr. 1057.] In 2014, the State changed not only the retirees' dental plan; it changed the active employee plan as well. [Tr. 1057–58.] Those changes included implementing a network with steerage and adding frequency limits. [Tr. 1058.] The Court can see the similarities between the two plans by comparing Exhibit 2013 with Exhibits 1003 and 1006.[25] Some of the major features discussed during the trial are outlined in the chart below:

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24 RPEA's Closing Argument, at 47-48 ("RPEA accepts [Ms. Smithwick's] testimony at face value . . . .").

25 Any suggestion by RPEA that this argument should be discredited because of the lack of trial time it received should be rejected. *See* RPEA's Closing Argument, at 48 (stating that the State "presented a small amount of testimony about the dental insurance plan currently offered to active State employees"). Although this was a small portion of Ms. Michaud's testimony, a quick review of the plan documents reveals that the plans are nearly identical. Rather than have Ms. Michaud read the plan into the record, the State made sure that enough trial time remained for Ms. Smithwick's testimony. That decision should not undermine the importance of this argument.

Plan Feature	2014 Retiree Plan	2014 Active Employee Standard Plan
Annual Individual Maximum	$2000 [Exh. 1003, at 006391.]	$1500 [Exh. 2013, at 36.]
Routine Exam	Two times/benefit year [Exh. 1006.]	Same [Exh. 2013, at 118.]
Complete Series X-ray or Panoramic Film	Once/five years [Exh. 1003, at 006405.]	Same [Exh. 2013, at 118.]
Supplementary bitewings	Once/benefit year [Exh. 1003, at 006405.]	Same [Exh. 2013, at 118.]
Prophylaxis	Once/6 month with exceptions [Exh. 1006.]	Same [Exh. 2013, at 118–19.]
Periodontal Maintenance	Class I- Once/6 month with exceptions [Exh. 1003, at 006405; Exh. 1006.]	Same [Exh. 2013, at 118–19.]
Sealant	Unrestored, occlusal surfaces of permanent molders. One sealant per tooth during 5-year period [Exh. 1003, at 6405.]	Same [Exc. 2013, at 119.]
Space Maintainers	Once per space. Not covered for primary anterior teeth, missing permanent teeth, or for persons 14 or over. [Exh. 1003, at 6405.]	Same [Exc. 2013, at 119.]
Inlays	Considered an optional service; alternate benefit of amalgam filling provided. [Exh. 1003, at 6406.]	Same [Exc. 2013, at 119.]
General Anesthesia	Not covered when in conjunction with non-surgical procedures. [Exh. 1003, at 6406.]	Same [Exc. 2013, at 120.]
Pulp Capping	Covered only when there is exposure of the pulp. [Exh. 1003, at 6407.]	Same [Exc. 2013, at 120.]
Periodontal Scaling and Root Planning	Once per quadrant in any 24-month period. [Exh. 1003, at 6407.]	Same [Exc. 2013, at 120.]

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Full Mouth Debridement	Once/3-year period and only if there has been no cleaning within 24 months. [Exh. 1003, at 6407.]	Once in 2-year period for children under 19. For adults once/2-year period only if there has been no cleaning within 24 months. [Exc. 2013, at 121.]
Cast restorations	Once/7-year period [Exh. 1003, at 6408.]	Same. [Exc. 2013, at 121.]
Bridges/Dentures	Covered once in a 7-year period and only if the tooth, tooth side, or teeth involved have not received a cast restoration benefit in the last 7 years [Exh. 1003, at 6408.]	Same. [Exc. 2013, at 122.]
Denture adjustments, repairs, and relines	Not covered if done within 6 months of initial placement. Relines covered once per denture in 12-month period. Adjustments are limited to 2 adjustments per denture in a 12-month period. [Exh. 1003, at 6409.]	Same. [Exc. 2013, at 122.]
Tissue Conditioning	Twice per denture in a 36-month period. [Exh. 1003, at 6409.]	Same. [Exc. 2013, at 122.]

RPEA asks the Court to find that the constitution requires the State to continue to offer an "unusually generous plan" even if that "unusually generous plan" becomes unaffordable to some retirees.[26] That cannot be what the Supreme Court had in mind when it decided *Duncan*, and it cannot be what Article XII, § 7 requires. The Court must take into account how the coverage changes affect the premiums, and the State is

[26] *See* RPEA's Closing Argument, at 48 ("If the 2013 retiree dental plan was an unusually generous plan, the 2014 plan must meet that same level of generosity, even if the benefit package has been adjusted.").

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the only party to offer evidence that will allow the Court to do so. The Court should find that the diminishment clause requires the State to offer retirees dental coverage that either meets or exceeds industry standards or meets or exceeds the coverage offered to the State's active employees. If the Court adopts that standard, RPEA concedes that the State should prevail.[27]

III. Even if the Court applies *Duncan's* equivalency analysis, the State should prevail.

RPEA argues that the Court must apply *Duncan's* equivalency analysis. The State disagrees. Nevertheless, the State's evidence demonstrated that, even under that analysis, the 2014 changes to the retirees' dental plan was not a diminishment.

The *Duncan* analysis requires the Court to place a value on the coverage offered. The value is the value to the group, not an individual retiree, and it must be determined by "reliable evidence" based on actual experience.[28] "Offsetting advantages and disadvantages should be established under the group approach by solid, statistical data drawn from actual experience—including accepted actuarial sources—rather than by unsupported hypothetical projections."[29] Importantly, the Alaska Supreme Court also recognized the need to change coverage "'for the purpose of keeping a pension system

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27 RPEA's Closing Argument at 49–50 (stating that RPEA accepts Ms. Smithwick's opinion at face value).

28 *Duncan*, 71 P.3d at 893.

29 *Id.* at 894.

flexible to permit adjustments in accord with changing conditions and at the same time maintain the integrity of the system.'"[30]

This analysis requires the Court to (1) identify the coverage offered in the 2013 and 2014 plans; (2) identify the changes that resulted in a diminishment; and (3) compare the value of the changes.

A. When deciding the coverage offered by the 2013 plan, the Court should limit its review to the plan document and any benefit clarifications issued by DRB.

RPEA bears the burden of proving that retirees experienced a diminishment of their constitutionally guaranteed benefit.[31] To prove the level of coverage offered in 2013, RPEA relies on the 2013 plan booklet [Exh. 1000], a benefit clarification issued by DRB [Exh. 1002], a HealthSmart document [Exh. 1001], and testimony from Ms. Farmer, a former HealthSmart employee.[32] The State maintains that the coverage offered in 2013 was limited to the plan document and any official clarification issued by DRB. RPEA contends that the Court should look outside the plan documents and rely

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30 *Id.* at 889 n. 26 (quoting *Hammond v. Hoffbeck*, 627 P.2d 1052, 1057 (Alaska 1981)); *see also id.* at 892 (stating that this guideline, applied in *Hoffbeck*, also applies to reviewing changes to health insurance coverage).

31 *Retired Public Employees of Alaska, Inc. v. Mathiashowski*, 2006 WL 4634279 (Sup. Ct. April 27, 2006) ("The plaintiffs bear the overall burden of proof as to each of their causes of action."); *see also State, Dep't of Revenue v. Andrade*, 23 P.3d 58, 71 (Alaska 2001) ("A party raising a constitutional challenge to a statute bears the burden of demonstrating the constitutional violation." (internal quotation marks omitted)); *Nicholas v. Penn. State Univ.*, 227 F.3d 133, 13940 (3rd Cir. 2000) (plaintiff pursuing a constitutional due process claim bears the burden of proof).

32 RPEA's Closing Argument, at 5.

on the testimony of Ms. Farmer, a former HealthSmart employee, and an unsigned HealthSmart document.

The most direct piece of evidence the Court has on this issue is the 2013 plan document. Towards the end of the description of the dental coverage is a section titled "Dental Services Not Covered." [Exh. 1000, at 510.] It states, "The Dental Plan does not provide benefits for . . . [s]ervices or supplies not specifically listed as a covered benefit under the health plan." [Exh. 1000, at 510–11.] RPEA argues that this statement is not clear because it says services or supplies not specifically listed as covered under the *health* plan and not the *dental* plan. RPEA's argument lacks merit. Although the Court received the dental plan as an independent document, that is not how it is normally presented to the retirees. The retirees receive a "Retiree Insurance Information Booklet," which includes all of the State's various health care plans (major medical, DVA, and life insurance). [*See* Exh. 2014.] In that context, the statement is clear. If the service or supply was not specifically listed in the health plan (which included the dental plan), it was not covered.

Significantly, the witnesses all agreed that the plan document should prevail. Todd Allen, RPEA's benefits evaluation expert, testified that plan administrators typically keep the description of the coverage all in one place—the plan document. [Tr. 555.] He went on to explain that, in the event of a conflict, the plan document, summary plan description, or the legal document for the plan prevails. [Tr. 556.] This is consistent with the testimony of the State's witnesses.

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Ms. Ricci and Ms. Michaud testified that the summary plan design (plan booklet), plan amendments, and plan clarifications define the coverage offered [Tr. 629–630; 1036.] The plan administrator, the Commissioner of the Department of Administration, or, in some cases, the Commissioner's delegate, approves those plan documents. [Tr. 630.] If there is confusion about what the plan covers, or if the plan is being administered differently than the actual plan booklet, DRB will issue a benefit clarification that is publicly available to all retirees. [Tr. 630; 1036.] That is exactly what the State did with the frequency limits on cleanings implemented by the 2014 plan. According to Ms. Michaud, the 2014 plan always covered additional cleanings determined to be dentally necessary by the State's third-party administrator. [Tr. 1040.] Once the State realized this was not clear within the plan document itself, DRB issued a benefit clarification. [Tr. 1040.] This is not a new practice. Ms. Miller, the benefits manager from 2004–2009, also testified that it was DRB's practice to issue benefit clarifications when the coverage provided was not clear. [Tr. 62–63; *see also* Exh. 1002.]

Rather than rely on a public document, available to all of its members, RPEA attempts to prove coverage by relying on a HealthSmart document (Exhibit 1001). Not only was this document not available to RPEA's 14,000 members or the 50,000 members enrolled in the DVA plan, RPEA failed to prove that this document was even made available to the State.

Ms. Ricci and Ms. Michaud testified that neither of them reviewed or approved the coverage description in Exhibit 1001. [Exh. 807; 1035.] Ms. Michaud clarified that,

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although Exhibit 1001 was produced by the State during discovery, it was a document that the State received from HealthSmart to produce to RPEA for this litigation. [Exh. 1035.] It was not a document that she had reviewed or approved.

Ms. Farmer's testimony did not clarify the issue. She testified that she could not independently remember the details of the State's dental coverage when HealthSmart was the State's third-party administrator. [Tr. 984–985.] Her memory was dependent on Exhibit 1001. [Tr. 985.] She also testified that the State approved the version of the document she relied on when employed by HealthSmart and the State's approval was evident by an electronic signature contained on the document. [Tr. 985.] Because Exhibit 1001 did not have the electronic signature, she could not be sure that Exhibit 1001 was the same document she relied on when employed by HealthSmart. [Tr. 985.] One explanation for the lack of an electronic signature is that the State did not approve of the statement of coverage contained in Exhibit 1001. [Tr. 1036.]

Regarding what was covered, Ms. Farmer testified that she did not remember a time where DRB told HealthSmart to cover something under the dental plan that was not specifically listed. [Tr. 915.] Although she believed there were situations where DRB instructed them to cover something under the medical plan, she did not say whether DRB subsequently issued a benefit clarification to notify all retirees. [Tr. 916–917.]

RPEA also discusses a couple of examples that it claims are clear indications of the State intending something to be covered in spite of the lack of express language in the plan booklet. Those examples are (1) the exception for dentally necessary cleanings,

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and (2) the ability to use nitrous oxide as an analgesic.[33] What RPEA fails to recognize is that the State issued a benefit clarification for both of these examples. [Exhs. 1002, 1003, and 1005.] That benefit clarification included express language by the State that the dental plan included these coverages and it provided notice to all retirees. What RPEA is now asking the Court to do is to find coverages when there was no benefit clarification, and the only evidence of the coverage being included in the plan is an unsigned document kept in the files of the State's third-party administrator.

Not having any evidence that demonstrates the State approved of the coverage description contained in Exhibit 1001, RPEA relies on claims data showing that HealthSmart paid for services not specifically listed in the State's 2013 dental plan.[34] It contends that, "when the State allows a pattern of claim-handling to persist, this court should accept the actual payment practices as reflecting the coverages provided by the plan, even when those coverages are not expressly stated in the plan booklet."[35] There are two problems with this argument.

Most significantly, under RPEA's theory, if the Court finds this coverage was included in the plan, it will extend constitutional protection to errors made by a third party administrator. In other words, the State will not be able to diminish that coverage in the future without providing a comparable benefit. And third party administrator errors operate to change coverage only in one direction—RPEA presumably would not

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33 RPEA's Closing Argument, at 10.

34 *See* RPEA's Closing Argument, at 7–11 and n.19.

35 RPEA's Closing Argument, at 9.

accept that a pattern of denials of claims could operate to constitutionally diminish coverage. RPEA cites no legal authority for the claim that the diminishment clause should be read to constitutionalize bureaucratic errors. In these situations, when the coverage will turn into a constitutionally protected benefit, RPEA must rely on something more than a mistake by the third party administrator.

The other problem with this argument is that the trial record does not support a finding that the State "allow[ed] a pattern of claims handling to persist."[36] First, although DRB has the authority to audit the claims handling, it is not clear whether the State exercised that right. Ms. Farmer testified that she believed that happened, but that she was not 100 percent certain. [Tr. 917.] Second, RPEA argues that the State was made aware of the problems by reviewing appeals and responding to complaints from members. However, as Ms. Michaud testified, retirees typically did not contact DRB to complain about the third-party administrator covering something that it should not have been covering. [Tr. 887.]

According to Ms. Ricci, DRB became aware of the inconsistencies between HealthSmart's claims approvals and the State's dental plan during the transition to Moda as the State's new third party administrator. [Tr. 789-790; 797–798.] Rather than ignoring the problem, as RPEA suggests, DRB addressed the problem when it transitioned to Moda. [Tr. 789-790; 797–798.] DRB worked with Moda to make sure its claims administration would be consistent with the State's plan. [Tr. 789–790.] In doing so, DRB not only amended the plan substantively, but it amended the plan in ways that

36 *See* RPEA's Closing Argument, at 9.

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it believed would make the coverage limitations more understandable to the retirees. [Tr. 775–776; 844–850].

RPEA failed to meet its burden of proving that the State accepted or approved any coverages not specifically listed in the 2013 plan booklet or benefit clarifications. Although there is evidence that HealthSmart paid claims not covered by the 2013 plan, a mistake by the third party administrator should not give rise to a constitutionally protected benefit. The Court should decline to rely on Exhibit 1001 or Ms. Farmer's testimony to establish coverage and look only to the plan booklet (Exhibit 1000) and the related benefit clarification (Exhibit 1002). Doing so would result in a finding that the 2013 plan did not cover the following services:[37]

- Diagnostic casts and study models
- Brush biopsies
- Periodontal splinting
- Gold foil restoration
- Root canal retreatment
- Full-mouth debridement
- Tissue conditioning
- Temporary partial and full dentures

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[37] Although RPEA relies on Exhibit 1001 to establish that routine bite-wing x-rays were covered by the 2013 plan, the State believes that this language was expressly provided for in the actual plan document. [*See* Exhibit 1000, at 508 ("Class I services include . . . [r]outine dental x-rays. . . .").] The State also agrees that periodontal scaling and root planning were covered by the 2013 plan. [*See* Exhibit 1000, at 508 (coverage includes "[p]rophylaxis, including cleaning, scaling, and polishing").]

- Denture adjustments
- Implants[38]

B. Not every change in the 2014 plan resulted in a diminishment.

The parties not only disagree on what the 2013 dental plan covered, but they disagree on whether changes in the 2014 plan amounted to a diminishment. The largest area of disagreement was with the imposition of frequency limits, limitations on topical fluoride, and implementation of a network with steerage.

The 2013 plan covered regular cleanings (prophylaxis) as a Class I service and periodontal maintenance (a more in-depth cleaning needed for patients with periodontal disease) as a Class II service. [Exh. 1000, at 508–09; Tr. 518.][39] Although the 2013 plan did not specify a frequency limit, it did not cover services that were not necessary for diagnosis or treatment of dental conditions. [Exh. 1000, at 510; Tr. 71–72.] The 2014 plan imposed clear frequency limits on these types of cleanings, with exceptions. It automatically covers cleanings (either prophylaxis or periodontal maintenance) up to two times per benefit year; up to 3 times per benefit year for a pregnant patient; and up

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[38] The 2013 dental plan did not cover a dental implant, which is the placement of a screw or rod into the jawbone. [Tr. 514.] However, a dental implant was covered under the major medical plan if needed because of injury or disease, including periodontal disease. [Tr. 1042; Exh. 2014, at 46.] Although it did not cover the implant itself, the 2013 plan would cover the appliance—the crown—that was attached to the implant. [Tr. 1042; *see also* Tr. 514 (Rogers testified that he placed the implant but would send the patient to a different dentist for the placement of the crown).] After 2014, the dental plan covered implants for any reason not related to disease or injury. Exhibit 2050 shows a substantial increase in the amount the dental plan paid towards implants between 2013 and 2014, which is consistent with the change in coverage.

[39] Dr. Rodgers testified that prophylaxis would be ineffective for a patient with periodontal disease. [Tr. 519.]

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to 4 times per benefit year for a patient with diabetes or periodontal disease.[40] [Exh. 1006.] The plan allows for other exceptions when determined dentally necessary by Moda. [Exh. 1006.] In other words, retirees can get as many cleanings (prophylaxis or periodontal maintenance) as they need as long as their dentist can show those cleanings are dentally necessary. In addition, the 2014 plan moved periodontal maintenance from a Class II service to a Class I service. [Exh. 1003, at 6405.] Consequently, the 2014 plan covers 100 percent of the cost of periodontal maintenance where the 2013 plan only covered 80 percent, after the retiree paid a $50 deductible. [Exh. 1000, at 508; Exh. 1003, at 6405.]

Although the 2013 plan required dental necessity, and although the 2014 plan includes an exception for dental necessity when it comes to cleanings, RPEA nevertheless continues to argue that the 2014 plan somehow diminished the retirees' coverage for cleanings. To support this argument, RPEA relies on the testimony of Dr. McLean who believes that insurance administrators do not always grant his request for exceptions. [Tr. 246–247.] But Dr. McLean could not testify about Moda's specific

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40 RPEA relies on Ms. Smithwick's testimony to suggest that the 2014 plan does not cover periodontal maintenance more than two times per year. RPEA's Closing Argument, at 25. Ms. Smithwick was mistaken, and none of the RPEA's witnesses suggested that the exceptions for cleanings did not apply to periodontal maintenance. [*See* Tr. 377–78 (Mr. Allen testifying that the exceptions for cleanings include periodontal maintenance); *see also* Exh. 1007, at 2.] The fact that periodontal maintenance is included in the exception for additional cleanings is evident from the language of the plan itself. In the section addressing additional cleanings, the 2014 plan defines cleanings as prophylaxis *or* periodontal maintenance. [Exh. 1003, at 6410.]

practices,[41] and both Dr. McLean and Dr. Rogers testified that they were willing to submit documentation to support a finding of dental necessity. [Tr. 236, 246–47; 517.] Indeed, the only witness with firsthand knowledge about how Moda implemented this exception was Ms. Miller, and she testified that Moda granted her request for additional cleanings once her dentist submitted documentation showing dental necessity. [Tr. 80-81.] RPEA failed to meet its burden to show that the 2014 changes diminished the retirees' coverage for cleanings. Instead, what the evidence showed was the 2014 plan *enhanced* the retirees' coverage for cleanings. Dr. Rogers testified that covering periodontal maintenance as a Class I benefit was more beneficial to retirees than a plan that covers unlimited prophylaxis cleanings in a benefit year. [Tr. 517–520.]

The 2014 plan also imposed frequency limits on x-rays. The 2013 plan covered x-rays required for diagnosis of a specific condition and "routine dental x-rays," including one full mouth or series per year. [Exh. 1000, at 508.] The 2014 plan covers "[i]ntra-oral x-rays to assist in determining required dental treatment," full mouth or complete series x-rays every five years, and supplementary bitewing x-rays every year. [Exh. 1003, at 6405.] Although RPEA contends that the "standard of care for the dental profession . . . is to obtain a full-mouth x-ray every three years,"[42] its own experts did not agree on this standard. Dr. McLean testified that a routine x-ray every three years was the standard of care when he "graduated from dental school a thousand years ago." [Tr. 252.] But Dr. Rogers testified that he didn't think that "any x-ray should be done on

41 Dr. McLean's testimony amounted to a unsupported hypothetical projection, evidence rejected by the Supreme Court in *Duncan*.

42 RPEA Closing Argument, at 23.

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a prescribed time period." [Tr. 457.] Both Dr. Rogers and Cathye Smithwick, the State's expert, relied on an article published by the American Dental Association and the Federal Drug Administration titled *Dental Radiographic Examination: Recommendations for Patient Selection and Limiting Radiation Exposure*. [Tr. 458; 1134.] According to that article, the ADA and the FDA recommend full mouth x-rays for a *new* patient. [Tr. 1137.] For an adult *recall* patient with clinical caries or an increased risk of caries, the ADA and FDA recommends posterior bitewing x-rays between 6 and 18-month intervals. [Tr. 1137.] For an adult *recall* patient with no clinical carries or increased risk for caries, the recommendation is a set of posterior bitewings every 24 to 35 months. [Tr. 1137–38.] Contrary to Dr. McLean, the ADA and FDA do not recommend full mouth x-rays on a prescribed time period.[43]

The parties also spent a significant amount of time discussing the coverage for topical fluoride. The 2013 plan covered topical fluoride with no limitation other than the dental necessity requirement. [Exh. 1000, at 508 &510.] For patients under the age of

[43] RPEA also argues that the 2014 plan diminished x-ray coverage because it does not cover cone-beam computed tomography and the plan is not clear as to whether it covers extra-oral x-rays. RPEA's Closing Argument, at 23. Ms. Smithwick testified that, although previously used in the medical field, the dentistry field has only recently started to use this cone-beam technology. [Tr. 1132.] It is unreasonable to expect the State to anticipate every new piece of technology that may be used in the dentistry field and decide whether it will be covered. Further, RPEA provides no support for its position that retirees have a constitutionally protected right to have their insurance policies cover every new piece of technology used or applied in the dental field. As to the extra-oral x-rays, RPEA failed to meet its burden that the State changed the coverage in a way that disadvantaged the retirees. Although the plan says it covers "intra-oral x-rays" to assist in diagnosis, it also says that it covers "panoramic" x-rays. All experts agreed that a panoramic x-ray is an extra-oral x-ray. [Tr. 260–61; 1132.] Having no proof that the retirees are being denied coverage for extra-oral x-rays, RPEA failed to meet its burden.

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18, the 2014 plan covers topical fluoride every 6 months. [Exh. 1003, at 6405.] For adults, the plan covers topical fluoride once in any 6-month period if there is a recent history of periodontal surgery or a high risk of decay due to medical disease or chemotherapy or similar type of treatment. [Exh. 1003, at 6405.] But what RPEA fails to recognize or discuss is that the retirees also have access to prescription level fluoride toothpaste through their major medical plan. [Tr. 1042.] In 2013, the Journal for the American Dental Association published an article titled *Topical Fluoride for Caries Prevention*. [Tr. 1143.][44] According to that article, the level of certainty in support of using fluoride is low, but the ADA nevertheless recommends topical fluoride *or* prescription-strength at home toothpaste for people with a high-risk of caries.[45] [Tr. 1144–46.] The only RPEA witness to suggest that fluoride toothpaste was not equivalent to topical fluoride was Dr. McLean. [Tr. 303.] He also acknowledged, however, that his understanding was not based on scientific evidence; it was based on "common sense." [Tr. 303.] So, even if there are a small number of retirees that "need" topical fluoride and do not meet the requirements set forth in the 2014 plan, these

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44 Both Ms. Smithwick and Dr. Rogers testified that this is a publication that they would see as reliable authority in their fields. [Tr. 466–67; 1143.]

45 Dr. Rogers testified that he did not believe that routine application of topical fluoride is dentally necessary for all adult patients. [Tr. 463.] Dr. Rogers also testified that patients suffering from dry mouth are typically taking some sort of medication and that he would be willing to submit the necessary paperwork to establish that fluoride treatment for these patients was dentally necessary. [Tr. 520–522.]

retirees are still entitled to receive prescription-strength fluoride toothpaste under their major medical plan.[46]

The 2014 plan also imposed frequency limits on other services, such as routine exams, crowns, bridges, and the replacement of dentures. For these services, there is no exception for dental necessity, and RPEA's dental experts testified that frequency limits would deny some patients dentally necessary care. Although that may be true, the evidence showed that the impact of these coverage limitations to the group as a whole is minimal.[47]

- Dr. McLean and Dr. Rogers testified that most people need only two routine exams per year. [Tr. 516.] If a patient needed another exam, Dr. Rogers said that he would not consider that a "routine" exam. [Tr. 516.]
- Dr. McLean and Dr. Rogers testified that crowns should last well longer than the 7-year frequency limitation imposed by the 2014 plan. [Tr. 268–69; 522.] Dr. McLean testified that a properly placed crown should last forever [Tr. 268–69], and Dr. Rogers testified that it should last at least 15

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[46] RPEA may argue that, even if prescription fluoride toothpaste is equivalent to topical fluoride, some patients may have a disability that prevents them from applying the toothpaste themselves. [*See* Tr. 244-45]. But other than general speculation, RPEA provides no evidence to support its claim or to indicate how many retirees have such a limitation. With no such evidence, the Court has no way to value the limitation and determine whether it has been offset by comparable advantages—i.e., moving periodontal maintenance to Class I, broader coverage of implants, or stable premiums.

[47] *Duncan* requires the Court to analyze diminishment from a group rather than an individual perspective. 71 P.3d at 886.

years. [Tr. 522.] In Dr. Rogers' view, the 2013 plan's lack of a frequency limit was "exceptionally" unusual. [Tr. 522.] He was not aware of any other dental insurance plan that covered all crowns, and he believed that such a plan is subject to potential abuse. [Tr. 522.] Ms. Smithwick shared Dr. Rogers' concern over potential abuse. She testified that crowns are a service often flagged by the dental industry as an area for potential abuse. [Tr. 1162.] A crown is a more expensive substitute for a filling; in some instances, a dentist may suggest a crown when only a filling is necessary. [Tr. 522, 1162.]

- Dr. McLean and Dr. Rogers testified that a properly placed bridge should last well longer than the 7-year frequency limitation imposed by the 2014 plan. [Tr. 272–73; 497.] According to Dr. Rogers, 90 percent of bridges last longer than 10 years and 75 percent last longer than 20. [Tr. 497.]
- The 2013 plan covered new dentures every 5 years [Exh. 1000, at 511]; the 2014 plan covers new dentures every 7 years. [Exh. 1003, at 6408.] Dr. McLean testified that a new denture should last somewhere between 5–10 years [Tr. 277.] Dr. Rogers said that a partial denture would likely need to be replaced between 5–10 years, but that a complete denture "should last longer." [Tr. 500–01.]

Ms. Farmer discussed the number of claims denied because of certain changes. In 2014, Moda denied 66 claims for a routine examination, 59 claims for a cast restoration

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(crown),[48] 115 claims for a bridge, and 19 claims for dentures. [Exh. 2024; Tr. 962.] Given that there are 50,000 members enrolled in the DVA program, these numbers fail to show a substantial impact on the group as a whole. One way to see the impact to the group as a whole would be to compare the amount paid under the 2013 plan to the amount paid under the 2014 plan. [*See* Exh. 2050.]

Service	2013 Plan Paid	2014 Plan Paid
Oral Examinations	$2,370,162	$2,224,972
Crowns	$5,166,468	$4,959,869
Bridges	$244,040	$217,958
Dentures	$272,642	$246,697

Being that these are the raw figures showing what the two plans paid in 2013 and 2014, these numbers do not account for the network savings—i.e., services that are cheaper for the plan now than in 2013. What they do show is that the 2014 plan paid out nearly the same amount as the 2013 plan for these services. And, as discussed in more detail below, the Moda document relied on by RPEA shows that the retirees are getting more services per member under the 2014 plan than they were under the 2013 plan.[49] All told, the frequency limits only impacted a small number of retirees, but the group as a whole

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48 Dr. McLean clarified that a cast restoration is a crown. [Tr. 267.]

49 The importance of this cannot be understated. In addition to stabilizing premiums, the network benefits retirees by reducing the cost of the services. This allows retirees to get more value out of the $2,000 annual maximum. *See infra* at 48–49.

was positively impacted with stable premiums and a plan less likely to be subject to potential abuse.

The parties also disagree over whether the implementation of a network with steerage amounts to a diminishment. A network is a group of providers (dentists) who contract with a third party administrator to provide care for its members. [Tr. 623.] Steerage refers to a plan design or other feature used to direct plan participants to network dentists. [Tr. 1101–02; 1043.] The 2014 plan introduced steerage by setting a different reimbursement rate ("recognized charged") for in-network and out-of-network providers. [Tr. 1043–44.] An in-network dentist will be reimbursed the lesser of 100 percent of the covered expense, 100 percent of the dentist's accepted filed fee, or 100 percent of the dentist's billed charge. [Exh. 1003, at 6402–03.] An out-of-network dentist in Alaska will be reimbursed the lesser of the dentists billed rate or 75 percent of the 80th percentile of the "prevailing charge." [Exh. 1003, at 6403.] An out-of-network dentists outside of Alaska will be reimbursed the lesser of the dentists billed rate or the "prevailing charge" rate. [Exh. 1003, at 6403.]

Importantly, Ms. Michaud's testimony explained why there is a difference between the recognized charge for out-of-network providers inside and outside of Alaska. Delta Dental—the parent company for Moda—sets a different prevailing charge for every state and that prevailing charge is not public information. [Tr. 1045–46.] Depending on how robust the network is in a given area, Delta Dental may have a more aggressive steerage mechanism. [Tr. 1046.] In other words, if it is a highly competitive area, Delta Dental has the flexibility to steer more members to in-network providers by

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reimbursing out-of-network providers at even a lesser rate. Given her understanding of Delta Dental's contracts, Ms. Michaud believed that, in most cases, 75 percent of the 80th percentile in Alaska will be higher than most of the prevailing charge rates in the lower 48. [Tr. 1046–47.][50]

RPEA argues that the implementation of a network with steerage is a diminishment because it results in a loss of choice.[51] But *Duncan* found that the "accrued benefit" was the *coverage*; the court did not find that the ability to choose one's provider is a constitutionally protected benefit. The retirees will receive the same coverage whether they go to an in-network or out-of-network provider. The only thing that changes is the amount the plan will pay towards the costs of the coverage. [Tr. 1101–03; Exh. 1003, at 6402–03.]

Moreover, RPEA failed to prove that a significant number of retirees do not have access to an in-network provider. There are 50,000 members enrolled in the DVA plan. [Tr. 1051.] If Ms. Nault's testimony is correct and there are 8 communities in Alaska without a network provider, that impacts somewhere between 80–90 members or 0.02 percent of the population.[52] [Tr. 1051.] The State anticipates that this number will

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50 Dr. Rogers' testimony supported Ms. Michaud's. Dr. Rogers has practiced in Washington as well as in Alaska. [Tr. 512–13.] He testified that dentists in Alaska charge more in fees then dentists in any other location he has been. [Tr. 513.] For example, he believes that dentists in Alaska charge at least 15 percent more than dentists in Seattle and Seattle is a relatively expensive market. [Tr. 513.]

51 RPEA's Closing Argument, at 31–32.

52 Ms. Nault did an internet search and believed that the following communities did not have a network provider: Dillingham, Unalaska, Nome, Bethel, Kotzebue, Tok, Wrangell, and Haines. [Tr. 193.] Ms. Michaud later testified that she had confirmed that

decline as long as Moda has the ability to grow the network. As Ms. Smithwick and Ms. Michaud testified, dentists need a financial incentive to join the network. [Tr. 1043; 1104.] The 2014 plan provides that financial incentive; it steers members towards network dentists by offering higher reimbursement rates. [Tr. 1043, 1103.] So far, the numbers demonstrate that the plan is working and the number of network providers in Alaska has grown. [Tr. 1109–10.] In 2013, 49 percent of the practicing dentists in Alaska were in the Delta Dental network. [Tr. 1109; Exh. 2028.] That number has grown to 53 percent in 2017. [Tr. 1109; Exh. 2028.][53] The number of claims being submitted by network dentists has also increased every year since 2014. [*See* Exh. 1008, at. 4.]

Importantly, RPEA's argument also fails to take into consideration that the network saved the plan approximately $10 million dollars in 2014 [Tr. 664], a savings that benefits all retirees in the form of lower, more stable premiums. And, as discussed above, not all retirees want to pay more in premiums to preserve their right to "free choice." Ms. Miller said it depended on the amount of the premium. [Tr. 78.] Of those retirees who were surveyed, two-thirds of them did not want to pay a higher premium so

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Unalaska did have a network provider, and that Haines and Wrangell may have one as well. [Tr. 1050.]

[53] During the trial, Dr. Rogers and Dr. McLean suggested that less experienced dentists are the ones that are more likely to join a network. [Tr. 242-43; 428–29.] Their theory was undermined by their own testimony—both are experienced dentists and both have joined the Moda (Delta Dental) network. [Tr. 297–98; 511.] Moreover, as Ms. Smithwick testified, dentists in Alaska continue to join more networks. [Tr. 1114.] In 2011, on average, a dentist in Alaska was a member of 2.6 networks. [Exh. 2028; Tr. 1114–15] That number increased to 9.5 networks in 2017. [Exh. 2028; Tr. 1114–15.]

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that all dentists are reimbursed at the same rate. [Tr. 1053.] RPEA's desire to keep the plan as is, with no consideration of how the coverage affects premiums is unreasonable. Nor does it consider what is best for all retirees. Not all retirees are willing—or have the ability—to pay more. Should RPEA prevail, the Court would be depriving those retirees of the ability to buy into a dental plan that is in the "mainstream" of dental packages at a price that they can afford.[54]

C. The Court must have an objective way to measure whether the changes implemented in 2014 diminished the retirees' accrued benefit.

To support its claim of a diminishment, RPEA relies on (1) common sense; (2) Mr. Allen's analysis; (3) Dr. Rogers and Dr. McLean's testimony that retirees are being deprived dentally necessary care; (4) statistics on usage; and (5) implementation of a network with steerage.

RPEA concedes that Mr. Allen's analysis is "not far different from [its] common sense approach," and the problem with RPEA's common sense approach is that is not objective. There is no way for the Court or the State to recreate it. The Alaska Supreme Court held in *Duncan* that reasonable modifications to vested benefits are permissible so long as "changes that result in disadvantages to employees [are] accompanied by comparable new advantages."[55] To determine whether the changes offer "equivalent value," the Court must value the benefit to the group, not the individual, and must rely

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54 *See Duncan*, 71 P.3d at 892 (stating "that the coverage that is offered should generally be 'in keeping with the mainstream' of health packages offered to active public employees in terms of scope and balance").

55 *Id.* at 886.

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on "solid, statistical data drawn from actual experience—including accepted actuarial sources."[56] Unsupported hypothetical projections are not sufficient.[57]

This language in *Duncan* is important because it not only guides this Court's analysis, but it guides the State as it considers other changes to the retirees' health coverage. Should the Court adopt RPEA's "common sense" approach (which is effectively a "gut-feeling approach"), the State will have no idea how it can change coverages going forward. The result would be what the court feared in *Duncan*, "a Pyrrhic victory, as [the retirees'] 'frozen' health benefits become more obsolescent with each passing year."[58]

Another concern is whose common sense governs this analysis. RPEA's common sense says that retirees have a constitutionally protected right to see any dentist of their choice. DRB's common sense says that a $13 increase in premiums over 4 years is a lot and that not all retirees can absorb additional costs.

Moreover, how does the State compare a change that advantages a retiree to a change that disadvantages a retiree? As discussed above, the parties disagree on whether the frequency limits for crowns, bridges, and dentures disadvantage the retirees. RPEA argues that although a crown, bridge, and denture should last longer than the prescribed time, not all of them will. But RPEA fails to recognize that diminishment is evaluated based on the group approach. These frequency limits will not disadvantage most

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56 *Id.* at 892.

57 *Id.*

58 *Id.* at 891 (internal quotation marks omitted).

retirees. Nevertheless, even if the Court agrees with RPEA, how does the Court compare this change with a positive change, such as the fact that the 2014 plan now covers dental implants without limitation?[59] Dr. Rogers testified that, when possible, he prefers an implant to a bridge because an implant offers more stability over the long term. [Tr. 515.] Implants are the more expensive procedure [Tr. 514–515], and more retirees will benefit from the ability to get an implant than the small number of retirees who may need a crown, bridge, or a new set of dentures before the prescribed time.

Duncan requires the Court to have an objective way to measure the value of a benefit. RPEA's gut-feeling approach provides no objective measure. As another example, the 2013 plan covered inlays as a Class III benefit, but the 2014 plan does not cover inlays at all. [Exh. 1000, at 509.] RPEA and Mr. Allen's gut says that this is a diminishment, but Dr. McLean testified that an amalgam restoration—covered by the 2014 plan—is a reasonable substitute. [Tr. 285.] He said that inlays are so expensive—nearly four times the cost of an amalgam restoration—that they have only limited use in the general practice of dentistry. [Tr. 305.] Despite this testimony, RPEA still contends

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[59] RPEA wrongly asserts that it is impossible to determine if the 2014 plan enhanced coverage for implants. RPEA Closing Argument, at 16. In support, RPEA points to Ms. Smithwick being unable to think of a situation other than accident or disease for which an implant would be dentally appropriate. [Tr. 1153–54.] The State offered Ms. Smithwick as an expert in dental benefit design and analysis [Tr. 1081.] She was not offered as an expert on how the State administers its dental and medical plans. Ms. Michaud, the State's Chief Medical Officer, testified that the 2014 dental plan now covers implants that were not previously covered under the medical plan. [Tr. 1042.] Her testimony is supported by Mr. Ward's exhibit, which documents what the 2013 plan and 2014 plan paid towards implants. [*See* Exh. 2050.] In 2013, the dental plan only paid $109,818 towards claims related to implants. In 2014, that number jumped by over $600,000 to $781,190. [Exh. 2050.]

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that the removal of inlays from the 2014 plan qualifies as a diminishment and this diminishment should be valued the same as the additional coverage for implants or the change of periodontal maintenance from a Class II benefit to a Class I benefit. That is simply contrary to what the court said should happen in *Duncan*.[60]

RPEA's reliance on the dentists' expert testimony does not solve this problem. The point of Dr. Rogers and Dr. McLean's testimony was that the coverage limitations *might* deprive some retirees of dentally necessary care.[61] But *Duncan* does not require the State to cover everything that is dentally necessary for everyone. Rather the court said that it believes that the "coverage that is offered should generally be 'in keeping with the mainstream' of [] insurance packages offered to active public employees in terms of scope and balance."[62] And the Court must consider what the insurance package offers to the group as a whole, not an individual retiree.[63] Dr. Rogers and Dr. McLean both testified that they have never seen dental insurance that covers everything that may be dentally necessary. [Tr. 294, 513.] If those plans exist, they are certainly not within the "mainstream" of dental insurance policies.

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60 This argument applies to all of the changes that RPEA identified as a diminishment. The State's decision not to discuss all of the alleged diminishments is not meant to serve as concession that these changes were, in fact, diminishments. The State's position is that RPEA failed to show that any of the alleged changes were a diminishment to the group as a whole.

61 Again, this is the type of unsupported hypothetical evidence that the court rejected in *Duncan. Duncan*, 71 P.3d at 892.

62 *Id.*

63 *Id.* at 891–82.

Similarly, RPEA's reliance on usage statistics does nothing to support its common sense approach. First, Ms. Farmer only analyzed the statistics as they relate to coverage for fluoride and coverage for cleanings. As discussed in more detail above, the State strenuously disagrees with RPEA's assertion that the 2014 plan diminished the coverage for cleanings or fluoride treatment. Nevertheless, even assuming these changes did disadvantage the retirees, Ms. Farmer's testimony is not credible. Regarding her analysis of statistics on cleanings, Ms. Farmer was unable to clearly explain what she had done with the excel documents to determine the number of retirees who had received more than two cleanings in 2012 and 2013. [Tr. 990–1003.] Moreover, as she had done during her deposition, Ms. Farmer admitted during her testimony that she failed to take into account duplicative claims. [Tr. 1003–04.] In other words, there were situations on the spreadsheets where it showed four cleanings, but the plan paid for only two of those cleanings. [Tr. 1004.] Ms. Farmer acknowledged that she failed to consider this and therefore her opinion on the number of retirees who had more than two cleanings was not accurate. [Tr. 1004.]

Her testimony about how she came to the number of retirees who received fluoride treatment in 2012 and 2013 was similarly confusing. [Tr. 1008–1014.] In any event, even assuming Ms. Farmer's numbers are accurate, Ms. Farmer did not offer any evidence on the number of retirees who were denied topical fluoride, but received prescription strength fluoride toothpaste instead. Nor does the Court have any way to

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tell, of the retirees who were denied coverage for topical fluoride after 2014, how many actually submitted documentation to show that their treatment was dentally necessary.[64]

Lastly, RPEA argues that the implementation of the network with steerage resulted in a diminishment. For the reasons discussed above, the State contends this was not a diminishment and actually benefited the retirees.

RPEA recognizes that it has the burden of proving that the 2014 changes amounted to a diminishment.[65] That requires giving the Court an objective way to measure whether the alleged disadvantages were more valuable to the retirees as a group than the enhancements. RPEA has not provided the Court with any objective measure and its common sense approach is unworkable in this case or any case in the future. This Court said the diminishment clause protected optional benefits, but recognized that this will be the first time the court will address how to value a benefit that is paid for entirely by the beneficiary. The Court's analysis must work not only in

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64 RPEA's suggestion that it was unable to analyze how many retirees were affected by each change because of a late discovery production by the State is not accurate. *See* RPEA's Closing Argument, at 31 & n.55. The State responded to RPEA's discovery requests in a timely fashion. It produced what it received from Moda, and RPEA worked directly with Moda to get any additional information that it thought was necessary to prove its case. The State requested the raw claims data from Moda to share with its actuary. The State shared that data with RPEA within a week of it being received, and prior to the exchange of the expert reports. The data was shared in a text file that can be opened by any operating system. When RPEA's counsel asked the State's counsel whether the data could be shared in an excel spreadsheet, counsel for the State searched the internet and shared instructions on how to open the text file in excel. RPEA's experts had the data for at least a month prior to their deposition, and RPEA had notified the State that its experts would be prepared to talk about any additional opinions during their depositions. [Tr. 381.]

65 RPEA's Closing Argument, at 36.

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this case, but also the in the future when the State is considering coverage changes to the retirees' optional benefits. RPEA failed to meet its ultimate burden of proving a diminishment by objective, measureable evidence.

D. The State provided credible actuarial evidence that proves the 2014 changes enhanced the retirees' dental plan.

Unlike RPEA, the State offered the Court objective evidence to measure the value of the 2013 plan and the value of the 2014 plan. This was done through the testimony of Richard Ward. Mr. Ward has worked as an actuarial consultant since 1995 and received his credentials as an actuary in 2005. [Tr. 643–44.] He testified that there are multiple ways for actuaries to value health insurance plans. When trying to compare two plans, as the Court is in this case, Mr. Ward said that actuaries typically determine the "actuarial value" for the two plans. [Tr. 647–48.] This value can be used "to measure the relative difference in value between two plans." [Tr. 647.] In simplified terms, the actuarial value is "the portion of total costs that are paid by the plan on average for the entire membership. So for every hundred dollars of expenses that could be paid by either the member or the plan, if 70 percent are paid by the plan, then the actuarial value is 70 percent on average." [Tr. 648.]

Prior to even beginning his analysis, Mr. Ward, through his firm, confirmed that there is not a single standard to apply in this type of situation. [Tr. 657.] Mr. Ward then relied on two main sources to determine his methodology: (1) the process used by the Affordable Care Act; and (2) the expert reports submitted to the superior court in *RPEA*

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v. Mathiashowski.[66] [Tr. 658.] These proceedings occurred after the Supreme Court remanded the matter in *Duncan*. In those proceedings, Judge Rindner found the State's actuaries to be credible.[67] They obtained the raw claims data and determined what benefits had been paid under the new retiree major medical plan and then determined what benefits would have been paid had the plan remained unchanged.[68] Based on that analysis, the State's experts concluded that the 1999-2000 changes to the major medical coverage did not constitute a diminishment.[69] Finding their testimony "credible and persuasive," the court adopted their findings and concluded that the 1999-2000 changes "were in balance a net benefit to retirees."[70]

Relying on the standards set out by the Affordable Care Act and the expert reports in *Mathiaskowski*, Mr. Ward used raw data from Moda to calculate the actuarial value of the plan from 2014–2017. [Tr. 652–53; Exh. 2046.] In 2014, the actuarial value of the plan was 72.1 percent and it increased steadily to 73.0 percent in 2016. [Exh. 2046.][71] Mr. Ward calculated the actuarial value of the 2013 plan two different ways. First, using the Moda data, he made adjustments to determine what the plan would have paid in 2013 under the coverage limitations set by the 2013 plan. [Tr. 653.] That resulted in an actuarial value of 69.7 percent. [Exh. 2046.] Second, he used raw data

66 2006 WL 4634279 (Alaska Super April 27, 2006).

67 *Id.* at ¶ 76.

68 *Id.* at ¶ 95.

69 *Id.* at ¶ 105.

70 *Id.* at ¶¶ 104 & 115.

71 The claims data was not complete for 2017 and therefore the State will not rely on that number. [*See* Exh. 2046]

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from HealthSmart to calculate the actuarial value of the plan in 2013. [Tr. 653.] That resulted in an actuarial value of 66 percent. [Exh. 2046.] Based on these numbers, Mr. Ward concluded that the dental plan benefits were improved in the aggregate from 2013 to 2014. [Tr. 651.]

When calculating the actuarial value of the plan from 2014–2016, Mr. Ward excluded out-of-network claims and claims for services not included in either the 2013 plan or the 2014 plan, such as orthodontia. [Tr. 659–660.] In excluding out-of-network claims, Mr. Ward followed the guidelines set out for valuing health care plans under the Affordable Health Care Act, as well as the superior court's decision in *Mathiaskowski*. [Tr. 659; 749–51.][72] He also explained that steerage promotes the utilization of the network and networks lower the costs of the plan. [Tr. 661.] Therefore, because this plan is 100 percent funded by the retirees, any cost savings that are attributable to the network are passed to the retirees in the form of lower premiums. [Tr. 661.] Nevertheless, Mr. Ward did conduct a "trend analysis" to make sure his assumptions about the out-of-network claims did not skew the results. [Tr. 660.] This analysis confirmed his initial assumption—the addition of the out-of-network claims did not materially alter the actuarial values set forth in Exhibit 2046. [Tr. 660.] Importantly, Mr. Ward's analysis did not take into consideration the $10 million the plan saved in 2014 as a result of the network. [Tr. 663.]

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72 In *Mathiaskowski,* the superior court did not consider changes to the plan that were neither a reduction nor an increase in the benefits provided. *See* 2006 WL 4634279, at ¶ 70.

Mr. Ward also broke his analysis down by calculating the actuarial value for each of the plan changes from 2013 to 2014 that had a non-zero impact. [Tr. 666; Exh. 2050.] As can be seen from that exhibit, all of the coverage changes identified by RPEA as a diminishment had a minimal impact on the actuarial value. [Exh. 2050.] The change to topical fluoride coverage had the biggest negative impact at -0.7 percent. [Exh. 2050.] This can be compared to the positive changes, with the coverage change for periodontal maintenance increasing the actuarial value by 1.5 percent and the addition of implant coverage increasing the actuarial value by 3.0 percent. [Exh. 2050.]

Having declined to offer actuarial evidence of its own, RPEA argues that the Court should reject Mr. Ward's analysis for a number of reasons. First, RPEA questions whether Mr. Ward even conducted an actuarial analysis. Relying on Wikipedia and Investopedia, RPEA argues that actuarial evidence is evidence used "to project reliably how the lifetime benefits of an average retiree will be affected by the new plan."[73] RPEA also contends that to be real actuarial evidence, Mr. Ward was required to show that the years analyzed were "representative of members' needs for dental services over their lifetimes" and "how an average member would fare over a lifetime under one plan compared to the other."[74] RPEA's argument lacks merit. Mr. Ward has been a credentialed actuary for over 10 years and he testified that this method has been used thousands of times to value a plan and that this is a method used by actuaries to compare the relative difference between two plans. [Tr. 647.] He testified that his

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73 RPEA's Closing Argument, at 37 & n. 70.

74 RPEA's Closing Argument, at 38.

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analysis is consistent with the expert analysis adopted by the court in *Mathiaskowski*, and it is the method used to value plans under the Affordable Health Care Act. To discredit Mr. Ward's testimony, RPEA must present something more than counsel's understanding of actuarial evidence as informed by her research on Wikipedia and Investopedia.

Next, without providing an actuarial expert, RPEA calculates its own actuarial value by using numbers from a 2017 presentation provided by Moda to DRB.[75] [Exh. 1030.] There are several problems with this approach. First, RPEA offers no testimony to support its analysis. Second, RPEA offers no testimony to explain the numbers offered in the Moda report. The numbers offered are defined as "allowed per member per month" and "paid per member per month." But neither the State, nor the Court, have any idea how Moda calculated those numbers or what they actually mean. Did Moda use the same data set provided to Mr. Ward? Were any adjustments made? If adjustments were made, why and what were they? Third, and most importantly, none of the State's witnesses testified that they would rely on Moda's report for a purpose as significant as calculating whether a constitutionally protected benefit has been diminished. Mr. Ward testified that a utilization report or a quarterly report is not the best source to use for this type of analysis. [Tr. 703.] Ms. Ricci testified that she uses quarterly reports as a "dashboard" to potentially glean insight into trends and patterns in areas," but that she is careful because it is typically a "rollup of information" and sometimes those inputs can change or may not be completely accurate. [Tr. 813–14.]

75 *See* RPEA's Closing Argument, at 38–39.

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Ms. Michaud testified that quarterly reports may highlight areas where DRB needs to do additional research, but that the agency "would never make a decision based solely on what was in [a] quarterly report." [Tr. 1058.] All told, if RPEA wanted to use Moda's data as its expert analysis, then RPEA should have been prepared to have a witness explain the data and vouch for its accuracy.[76]

RPEA also challenges Mr. Ward's report on an alleged failure to adjust his numbers for inflation.[77] However, as Mr. Ward testified, because his analysis for 2014-2017 depended on the actual claims data, the data already included any inflation. [Tr. 664.] RPEA's real concern is with the fixed-dollar benefit provision. The plan includes a fixed dollar benefit of a $50 deductible. [Tr. 665.] As the cost of dental treatment increases due to inflation, keeping the deductible at $50 becomes more valuable. [Tr. 665.] What this means is that the actuarial value of the plan increased from 2014–2017 even though there was no change in coverage. [Tr. 665.] RPEA argues that Mr. Ward needed to account for this because, under his analysis, the State could chip away at benefits each year as the fixed dollar benefit continues to increase the actuarial value of the plan. But RPEA misses the point. By not adjusting the $50 deductible for inflation, the plan is actually becoming more valuable to the retirees.[78]

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76 The State maintains its objection to the admissibility of Exhibit 1030.

77 RPEA's Closing Argument, at 40.

78 For example, in 2013 the retiree gets a filling for $100. The retiree pays the $50 deductible and the plan pays the remaining $50. In 2017, the retiree gets a filling for $105. The retiree pays the $50 deductible and the plan pays the remaining $55. The value to the retiree has increased because the plan is paying more, but her cost remained the same. [Tr. 665.]

Put another way, the retirees' coverage is enhanced each year the State declines to increase the deductible based on the rate of inflation. [Tr. 665, 714–15.]

RPEA next challenges Mr. Ward's calculation of the actuarial value of the plan in 2013. As discussed above, Mr. Ward calculated the actuarial value in 2013 two different ways. First, using Moda data, he projected back to determine the actuarial value of the plan in 2013. [Tr. 653.] To do so, he adjusted the 2014 data to account for trend and inflation in 2013. [Tr. 655.] He also made adjustments for the benefit changes that occurred in 2014. [Tr. 656.] Mr. Ward explained that his projected 2013 actuarial value was more than the actuarial value produced by HealthSmart's data because it is standard practice to be conservative when projecting. [Tr. 656.] He did not want to understate the 2013 actuarial value and he did not want to overstate the 2014 actuarial value. [Tr. 656.]

RPEA contends that the Court must reject Mr. Ward's projected number because he adjusted for inflation when projecting back to 2013 but did not adjust for inflation when he calculated the actuarial value for 2014–2017. Again, Mr. Ward did not need to make adjustments for inflation for 2014–2017 because he had the actual claims data. When he was projecting back, he was not relying on 2013 data; he was relying on 2014 data. Therefore, he needed to make a specific adjustment for inflation. RPEA also argues that is "impossible" to evaluate Mr. Ward's methodology because he did not sufficiently explain the adjustments he made.[79] This is incorrect. Mr. Ward testified at a level of detail that he believed was necessary to explain his calculations for the Court.

[79] RPEA's Closing Argument, at 41.

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He also explained that he further detailed his specific assumptions in his expert report. [Tr. 655.] RPEA was provided a copy of Mr. Ward's expert report and had every opportunity to (1) depose him[80]; (2) cross-examine him on his assumptions; or (3) retain its own actuary to analyze Mr. Ward's methods.

Mr. Ward used raw claims data from HealthSmart as an alternate way to calculate the actuarial value of the plan in 2013. [Tr. 653.] Using this data, the actuarial value was 66 percent, which was well below the 2014 actuarial value calculated by RPEA using unverified Moda data. [*See* Exh. 2046.][81] RPEA challenges this value as unreliable.[82] It contends that Mr. Ward "dismissed the data set as incomplete and impossible to work with," making it impossible to accept the value as trustworthy. RPEA mischaracterizes Mr. Ward's testimony. Mr. Ward never dismissed HealthSmart's data, and he never said that the data prohibited him from determining a credible actuarial value for 2013. Instead, he testified that the HealthSmart data did not provide sufficient detail to allow him to determine which claims might be associated with particular patients or members. [Tr. 653.] This statement undermined Ms. Farmer—who testified that she relied on the data to determine the number of retirees who received more than two cleanings a year. Mr. Ward did not suggest that the data was not sufficient for his purpose.

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80 RPEA chose not to depose Mr. Ward.

81 *See also* RPEA's Closing Argument, at 39

82 RPEA's Closing Argument, at 41.

RPEA's claim that it did not have sufficient data to offer an alternative actuarial value calculation for 2013 is also misleading. What RPEA means is that HealthSmart's quarterly reports do not provide the same costs allowed and paid per member per month figures as the Moda quarterly reports. However, RPEA had the same raw HealthSmart data as the State. Nothing prohibited RPEA from retaining its own actuary to analyze that data, and nothing prohibited RPEA from subpoenaing a witness from HealthSmart to explain its data.[83]

Not having a witness to offer its own actuarial analysis, RPEA resorts to "unsupported hypothetical projections" to support its claim.[84] Relying on a HealthSmart quarterly report, it notes that the plan paid $44.13 per member per month in fiscal year 2011 and $45.46 per member per month in fiscal year 2012, [Exh. 1023, at 2.] but that the plan only paid $43.86 per member per month in 2014. [Exh. 1030, at 5.] RPEA then reasons that because it is "unlikely" the allowed costs in 2013 were larger than the allowed costs in 2014, the actuarial value in 2013 would be higher than the actuarial value in 2014.[85] This is not the analysis the Supreme Court required in *Duncan*. To prove a diminishment, the court required "solid, statistical data drawn from actual experience," not "unsupported hypothetical projections." Again, RPEA had every opportunity to produce the type of evidence that the Supreme Court requested. It chose

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83 Ms. Farmer was a former HealthSmart employee.

84 *See Duncan*, 71 P.3d at 892 (stating that a diminishment clause analysis requires solid, statistical data . . . rather than unsupported hypothetical projections").

85 RPEA's Closing Argument, at 42.

not to do so, and it cannot overcome that failure now by asking the Court to speculate on how much the plan paid per member per month in 2013.

Moreover, this data actually supports the State's evidence. According to the HealthSmart quarterly report, the utilization rate in fiscal year 2012 and 2013 was 4.4 procedures per member. [Exh. 1023, at 2.] In other words, during fiscal year 2012, the plan paid $44.13 per member per month and the members received 4.4 procedures per member. In fiscal year 2013, the plan paid $45.46 per member per month and the members still received 4.4 procedures per member. According to Moda's quarterly report, the plan paid $45.90 per member per month in 2015 and the members received 4.6 procedures per member. [Exh. 1030, at 5 & 7.][86] Therefore, by comparison, the Moda and HealthSmart plans paid similar amounts per member per month in 2013 and 2015. Under the HealthSmart plan, the members received 4.4 services per member, but under the Moda plan that increased to 4.6 services per member. Rather than support RPEA's claim of a diminishment, these numbers show that the cost savings provisions within the Moda plan are working, and, as a result, the retirees are receiving more services for less.

In addition to calculating the actuarial value of the plan from 2014–2017, Mr. Ward supplemented his analysis by calculating the actuarial value of the changed coverages. [Exh. 2050; Tr. 666–67.] Based on this analysis, he concluded that the actuarial value of the periodontal maintenance and implant coverage exceeded the

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[86] The Exhibit provides a utilization rate of 4,620.3 services per 1,000 members, which amounts to 4.6 services per member.

actuarial value of the alleged diminishments. [Exh. 2050.] RPEA also challenges this opinion, mostly by disagreeing with what Mr. Ward identified as enhancements, diminishments, and changed coverages.[87] Mr. Ward explained to the Court that DRB employees informed his understanding of what the 2013 plan covered. [Tr. 758–59.] The parties have discussed at length their disagreements over the different coverages and the State will not rehash those arguments now. Simply put, the State contends that Mr. Ward's analysis is credible and correct and that it demonstrates the 2014 plan enhanced the retirees' dental coverage.

Even if the Court believes Mr. Ward's analysis is not perfect, it is still the only objective evidence the Court has to measure the value of these plans. *Duncan* requires solid, statistical data drawn from actual experience,[88] and that is what Mr. Ward provided. Putting aside the disagreement over what the 2013 plan actually covered, Mr. Ward's raw numbers show a dramatic increase in the amount the plan paid for periodontal maintenance and implants. [Exh. 2050.] RPEA's own expert, Dr. Rogers, testified about the value of these coverages to the retiree population. [Tr. 515, 519–520.] Mr. Ward's raw numbers also show that the diminishments identified by RPEA do not have the same impact on actuarial value as the coverage change for periodontal maintenance or implants. [Exh. 2050.] This is also consistent with the dentists' testimony. Both dentists testified that the frequency limits would not affect most of the retirees [Tr. 304–307, 457, 463, 516-526], and that they rarely use inlays [Tr. 305],

87 RPEA's Closing Argument, at 42-46.

88 *Duncan*, 71 P.3d at 892.

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sealants [Tr. 521], or general anesthesia [Tr. 305–06; 521.] Even if the Court declines to adopt portions of Mr. Ward's analysis, the raw data remains. It supports a finding that the enhancements to the 2014 plan outweighed any of the alleged disadvantages.

Lastly, RPEA suggests that the Court discredit Mr. Ward's testimony because of his demeanor in the courtroom. The basis for RPEA's assertion is unclear; to discredit Mr. Ward's testimony the Court would have to find that it was somehow improper for Mr. Ward to rely on a federal standard to determine actuarial value. The Court should reject RPEA's request. Mr. Ward is a qualified actuary, and he answered all of counsels' and the Court's questions to the best of his ability. His refusal to agree to RPEA's theory does not make him an "advocate" for the State, and RPEA failed to meaningfully challenge the authority on which Mr. Ward relied.

Moreover, none of the experts were disinterested parties. Although the dentists volunteered their time, both of them acknowledged having relationships with retirees who are interested in this litigation and both of them had a financial incentive to discourage the State's implementation of a network.[89] [Tr. 235; 423–24] And, like Mr. Ward, Ms. Farmer and Mr. Allen were paid for their services. [Tr. 338, 987-988.] Unlike RPEA, the State will not question an expert's veracity simply because they were compensated for their services. However, Mr. Allen testified that he prepared a chart for his expert report that was similar to Exhibit 1007. [Tr. 359–60; 539–40.] In his report and under oath during his deposition, Mr. Allen testified that he could not reach an

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89 By joining the network the dentists must agree to the fee schedule set by Moda. [Tr. 239–40; 430–31.]

opinion on whether certain coverages had been changed or diminished. [Tr. 380.] That changed during the trial. Rather than submitting the chart Mr. Allen prepared, someone else prepared a *new* chart *for* Mr. Allen. [Tr. 539–40.] That chart identified new diminishments and was presented as Exhibits 1007 and 1007a. [Tr. 359–61; 380–83.] It appears that someone from RPEA was doing the work for Mr. Allen, which is much more detrimental to Mr. Allen's credibility than the State compensating Mr. Ward for his work.

CONCLUSION

The State's offer to let retirees' buy into dental coverage was materially different than its offer to provide major medical coverage to retirees. The State promised an option, not actual coverage, and the Court's diminishment clause analysis should reflect that difference. The 2014 dental plan offered to retirees is at least equivalent to, if not better than, the dental plan offered to the State's active employees and dental plans offered to similar populations across the country. The Court should find that RPEA failed to meet its burden of proving that the 2014 changes to the retiree dental plan violated the guarantee in Article XII, Section 7.

Alternatively, the Court should find that RPEA failed to provide reliable evidence to allow the Court to engage in the required comparative analysis for the entire group. RPEA's "common sense" approach is not the solid, statistical data required by the Supreme Court in *Duncan*. The State's actuarial analysis relied on data drawn from actual experience and supports a finding that the enhancements to the 2014 plan outweighed any of the alleged disadvantages.

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The State submits a set of proposed, numbered findings of fact and conclusions of law with this pleading. The proposed findings and conclusions will be also be made available electronically to the Court's judicial assistant, as the Court requested.

Dated: October 15, 2018.

JAHNA LINDEMUTH
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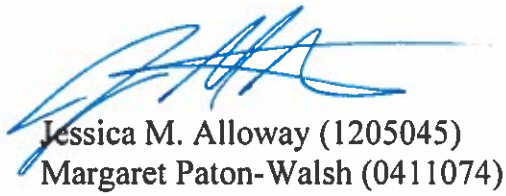
By: 
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