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 Proposed]
FINDINGS AND CONCLUSIONS

FINDINGS OF FACT

I. Parties

1. Plaintiff Retired Public Employees of Alaska, Inc. (""RPEA") is a nonprofit corporation in good standing, organized and operating under the laws of the State of Alaska and is comprised of retired public employees. It has approximately 14,000 members.

2. Defendant Leslie Ridle is the current Commissioner of the Alaska Department of Administration. She is sued in her official capacity. The Department of Administration, through the Division of Retirements and Benefits ("DRB") is responsible for the administration of benefits under the retirement systems for retired public employees.

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II. The Retirement System

3. The Teachers' Retirement System ("TRS") was originally established in 1955. Sect. 1, ch. 145, SLA 1955. The current TRS statute appears in AS 14.25. The Alaska Public Employees' Retirement System ("PERS") was originally established January 1, 1961, and now appears in AS 39.35. Sec. 2, ch. 143, SLA 1960.[1]

4. In 1975, the Alaska Legislature expanded PERS to mandate "major medical insurance coverage" for each person entitled to receive a monthly benefit. Secs. 1, 2, ch. 200, SLA 1975. The Legislature further specified "[c]overage shall become effective on the same date as retirement benefits commence and cease when the retired employee or survivor is no longer eligible to receive a monthly benefit." Secs. 1, 2, ch. 200, SLA 1975. This session law was codified as part of AS 39.35.535.

5. DRB published a health plan booklet in 1975 to provide information on the new benefits guaranteed to PERS members. The booklet promised: "The entire cost of this Medical Program . . . will be paid by [the systems]."[2] The 1980 handbook made a similar promise, stating: "Comprehensive major medical insurance is provided . . . . There is no cost to you for this insurance."[3]

6. The State's history of providing DVA coverage requires more explanation. In 1955, legislation was passed authorizing the Territory of Alaska to

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[1] The issues raised by RPEA's complaint apply equally to TRS as well as PERS. For ease of reference, the Court will refer only to PERS and will collectively refer to the members as retirees.

[2] *Duncan v. Retired Public Employees of Alaska, Inc.*, 71 P.3d 883, 889 n.24 (Alaska 2003).

[3] *Duncan*, 71 P.3d at 889 n. 24 (emphasis in original).

"procure a policy or policies of group insurance covering any class or classes of its employees." Sec. 2, ch. 151, SLA 1955. This legislation granted the Territory the authority to procure certain types of group life insurance; it did not require it. This is reflected in the codified version of the legislation contained in AS 39.30.090(a), which provides that the State "may obtain a policy or policies of group insurance covering state employees." Initially, group life insurance such as DVA coverage was offered only to active employees. Sec. 2, ch. 151, SLA 1955. This changed in 1979, when the Legislature granted retirees the option to purchase DVA coverage. Sec. 1, ch. 55, SLA 1979. The Legislature made clear, however, that any person electing to have coverage "shall pay the cost of the insurance."

7. As with the major medical program, DRB published booklets to explain the DVA coverage. The 1979 employee handbook—the first booklet published for DVA coverage—states 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." [Exh. 2000.] Similar language appeared in the books published from 1979 through 2011. 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.]

8. Membership in PERS is a condition of employment for most state employees. AS 39.35.120(b).

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9. Alaska Statute 39.30.091 allows the State to self-insure any benefit. The State self-insures the DVA plan through the premiums paid by retirees who elect coverage. *See* AS 39.30.090(a)(10); *also* 2 AAC 39.240; 2 AAC 39.280. [Tr. 606–07.]

III. The Retiree Dental Plan

10. A retiree must select DVA coverage at the time they retire. [Tr. 616.] Retirees may not select just dental insurance. [Tr. 616.]

11. Retirees who select DVA insurance must pay a monthly premium to the State for this insurance.

12. Coverage under the DVA plan will end when the retiree does not pay a premium or becomes ineligible to receive a benefit from the retirement system. Once discontinued, retirees are not allowed to re-enroll. [Tr. 615–16.]

13. The State determines the premium level, based on the costs incurred by the covered insurance plans, the cost of administering the plans, and the need to keep a reserve. [Tr. 620.] 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 the retirees' 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.]

14. The State contracts with a private company to administer the benefit plans. This company is called the third party administrator or TPA.

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15. From 2009 through 2013, Wells Fargo and then HealthSmart served as the TPA for the retiree dental plan. (HealthSmart acquired Wells Fargo early in that period).

16. Effective January 1, 2014, Moda became the TPA for the retiree dental plan. Moda is a part of a larger association or network known as Delta Dental. [Tr. 1169.]

17. The TPA is principally responsible for the day-to-day claims-handling process; it is to administer the plan in accordance with its terms.

IV. Premiums are a Concern for the Retirees

18. Freda Miller, a retiree and member of RPEA, served as the State's benefits manager from 2004–2009. She testified 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; and (3) that high premiums may discourage new retirees from joining the plan. [Tr. 69.]

19. Premiums become a bigger concern when managing option benefits such as the retirees' DVA plan. This was reflected in Ms. Miller's testimony. As a retiree, Ms. Miller said that she expects the State to manage the costs so that premiums will stay at a reasonable level. [Tr. 78]. She also acknowledged that she would opt out of the DVA plan if the premiums got too high. [Tr. 79.]

20. Premiums were also discussed by the State's expert, Cathye Smithwick. 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

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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. This may result in a phenomenon known as the actuarial death spiral. [Tr. 1092–1093.]

21. Emily Ricci, DRB's Chief Health Policy Administrator, said that a stable plan requires participation, and participation is impacted not only by the type of coverage offered, but also by the premium rates required to obtain that coverage. [Tr. 607–608.]

22. Michele Michaud, the State's Chief Health Official, testified that DRB receives "numerous complaints every time there is a premium increase." [Tr. 1227.] After the State moved to Moda as its TPA, the State conducted a customer satisfaction survey. Two-thirds of those surveyed said that they were unwilling to pay a higher premium to receive a higher rate of reimbursement for an out-of-network provider. [Tr. 1053.]

23. RPEA's expert in benefit plan evaluation, Todd Allen, agreed that premiums are an important consideration for employees/retirees choosing dental coverage. [Tr. 342–344.]

V. The Dental Coverage

24. The retiree dental plan offered by the State has changed a number of times over the years.

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25. The retiree dental plan in effect in 2013 was largely unchanged since 2003. In accordance with the parties' conventions, this is referred to as the "2013 plan."

26. The retirees' dental coverage is set forth by the summary plan design (handbook or booklet), plan amendments, and benefit clarifications. [Tr. 629–30.]

27. The 2013 plan expressly states that "[t]he 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.] 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.] Based on this express language in the 2013 plan booklet, the Court finds that any service not specifically listed in the booklet or in a formal benefit clarification is not covered.

28. 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.]

29. Ms. Ricci and Ms. Michaud testified that the summary plan design (plan booklet), plan amendments, and benefit 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.]

30. Although admitted into evidence, the Court does not give any weight to Exhibit 1001, an internal HealthSmart document that outlines additional coverages not expressly stated in the 2013 plan or any plan amendments or clarifications.

31. Neither Ms. Ricci nor Ms. Michaud reviewed or approved the coverage description in Exhibit 1001. [Exh. 807; 1035.] 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 the State had reviewed or approved.

32. The Court declines to give Exhibit 1001 any weight based on Ms. Farmer's testimony. She could not independently remember the details of the State's dental coverage when HealthSmart was the State's TPA. [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.]

33. The State's witnesses testified that the State would not sign a document that it did not approve. [Tr. 1036.]

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34. Ms. Farmer also admitted 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.]

35. When DRB believed that the TPA was properly covering a service that was not clearly set forth in the plan document, DRB issued a benefit clarification. [Exhs. 1002, 1003, and 1005.] DRB notifies retirees of any benefit clarification by posting them on its website.

36. Multiple witnesses testified that the HealthSmart's claims data shows that HealthSmart was covering services not specifically listed as covered in the 2013 plan or any benefit clarifications. However, there is no evidence that the State approved of this practice or that it knew of this practice and simply allowed it to continue.

37. 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.]

38. The Court finds it unlikely that the State was made aware of HealthSmart's practice by reviewing appeals or responding to complaints from the retirees. The State's witnesses testified that the retirees did not contact DRB to complain about the TPA covering something that was not specifically listed in the plan booklet. [Tr. 887.]

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39. The State did not become aware of the inconsistencies between HealthSmart's claims approvals and the 2013 plan until the transition to Moda as the State's TPA. [Tr. 789-790; 797–798.] At that time, DRB worked with Moda to make sure its claims administration would be consistent with the State's plan. [Tr. 789–790.]

40. Having declined to rely on Exhibit 1001 or Ms. Farmer's memory about the claims HealthSmart paid as the State's TPA, the Court finds that the 2013 plan did not cover the following: diagnostic casts and study models, brush biopsies, periodontal splinting, gold foil restoration, full-mouth debridement, tissue conditioning, temporary partial and full dentures, root canal retreatment, denture adjustments, or implants.

41. A dental implant is the placement of a screw or rod into the jawbone. [Tr. 514.] This was not covered under the 2013 plan. 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. 514; 1042; 514].

42. The 2013 plan covered "routine dental x-rays" which included bite-wing x-rays. [Exhibit 1000, at 508.] The 2013 plan also covered periodontal scaling and root planning. [Exhibit 1000, at 508.]

43. Because the Court finds that the 2013 plan did not cover services not specifically listed in the plan booklet or benefit clarifications, the Court rejects Exhibit 1007 and Table 1 (submitted by RPEA post-trial to summarize the trial evidence) as accurate statements of the coverages provided under the 2013 plan.

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44. The 2013 plan did not cover services that were not necessary for diagnosis or treatment of dental conditions. [Exh. 1000, at 510; Tr. 71–72.]

45. Effective January 1, 2014, the State adopted and implemented a revised retiree dental insurance plan. This is referred to as the "2014 plan."

46. As with the 2013 plan, the coverages offered through the 2014 plan are set out in the plan booklet and benefit clarifications [Exh. 1000, 1004–1006.]

47. Both plans organize the covered services into classes. The rate of reimbursement varies by class. Services in class I are covered at 100 percent of the recognized charge, and no deductible must be satisfied. For services in class II and class III, a $50 deductible applies. After the deductible is satisfied, services in class II are covered at 80 percent of the recognized charge, and services in class III are covered at 50 percent of the recognized charge.

48. The 2014 amendments did not change the overall organization of the plan into three classes or the reimbursements rate for each class. A few services were moved to a different class.

49. Like the 2013 plan, the 2014 plan only covers services that are dentally necessary. [Exh. 1003, at 6405.]

50. Based on plan booklets and benefit clarifications, the Court finds the following as to the respective coverages between the 2013 plan and the 2014 plan:

Service	2013 Plan	2014 Plan
Routine Oral Exams	Covered when dentally necessary	Covered twice in a benefit year when dentally necessary

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X-rays for diagnosis	Covered when dentally necessary	Covered when dentally necessary. Plan specifies intra-oral x-rays only, but later says that it covers panoramic, periapical, occlusal, and bite-wing x-rays
Routine full-mouth x-rays	Covered when dentally necessary, but not more than once per year	Covered once in 5 years when dentally necessary
Routine bite-wing x-rays	Covered when dentally necessary	Cover once per benefit year when dentally necessary
Diagnostic Casts and Study Models	Not Covered	Not Covered
Topical fluoride	Covered when dentally necessary	Covered twice per benefit year for persons 18 and under; if 19 or older, covers once in 6 months if there is a recent history of periodontal surgery, or high risk of decay due to disease, chemotherapy, or similar treatment
Prophylaxis	Covered when dentally necessary	Covered twice per benefit year. Covered up to 3/year for person in third trimester of pregnancy and up to 4/year for person with diabetes, periodontal disease, or when determined dentally necessary by Moda
Sealants	Covered through age 18 when dentally necessary	Covered once in 5 years when determined dentally necessary. Limited to the unrestored occlusal surface of a permanent molar
Periodontal Maintenance	Covered as a Class II benefit when dentally necessary	Covered as a Class I benefit. Covered 2/benefit year. Covered up to 3/year for pregnancy; up to 4/year for diabetes or periodontal disease or when determined

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		dentally necessary by Moda
Space Maintainers	Covered when dentally necessary as a Class II benefit	Covered when dentally necessary for those under age 14. Limited to once per tooth space, with no coverage for primary anterior teeth or missing permanent teeth Covered as a Class I benefit
Fillings	Covered when dentally necessary	Covered when dentally necessary
Bridges and dentures—repair and relining	Covered when dentally necessary as a Class II benefit	Not covered within 6 months of initial placement;[4] relines covered once per denture per year; adjustments covered 2/denture/year
Palliative emergency care	Covered when dentally necessary	Not covered
Extractions and other oral surgery	Covered when dentally necessary	Covered when dentally necessary. Plan does not cover separate, additional charge for alveoloplasty when done in conjunction with surgical removal of teeth
Brush biopsy	Not covered	Covers 2/year, not including pathology services
Root canal and retreatment	Root canal covered when dentally necessary Root canal retreatment not covered	Root canal covered when dentally necessary Cost of retreatment of same tooth by the same dentists within 24 months of root canal is not eligible for additional charge.

4 RPEA's dental expert testified that, when initially placing a denture, the dentist will perform an initial adjustment and reline within the first six months as part of the procedure. [Tr. 523.]

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		Retreatment is included in the charge for original care.
Pulp capping	Covered when dentally necessary	Direct pulp capping covered when dentally necessary Indirect pulp capping not covered
Apicoectomy	Covered when dentally necessary	Evidence unclear as to whether covered as "other minor surgical procedure." [Exh. 1003, at 6406.]
Periodontal scaling and root planning	Covered when dentally necessary	Covered when dentally necessary; limited to once per quadrant in 24 months
Periodontal splinting	Not covered	Not covered
Gold foil restoration	Not covered	Not covered
Full-mouth debridement	Not covered	Covered one in 3/years; limited to when there was no prophylaxis within 2 years
Local and general anesthesia	Covered when dentally necessary	Covered for surgical procedures or if needed due to a medical condition
Nitrous oxide	Covered	Covered
Crowns and onlays	Covered when dentally necessary; extra cost for porcelain not covered for 2d or 3d molar	Covered when dentally necessary; limited to once/7 years; extra costs for porcelain not covered for upper 2d or 3d molar and lower 1st to 3d molar
Inlays	Covered when dentally necessary; extra cost for porcelain not covered for certain teeth	Not covered[5]
Bridges	Covered when dentally necessary; temporary bridges covered	Covered when dentally necessary; limited to once/7years and only covered if the tooth, tooth

5 RPEA's dental expert testified that amalgam restorations are a reasonable substitute for inlays. [Tr. 285.]

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		site, or teeth involved have not received crown in last 7 years
Dentures (full)	Covered when dentally necessary; limited to once/5 years [Exh. 1000, at 511] Temporary dentures not covered	Covered when dentally necessary; limited to once/7 years and only covered if the tooth, tooth site, or teeth involved have not received crown in last 7 years
Dentures (partial)	Covered when dentally necessary; limited to once/5 years [Exh. 1000, at 511] Temporary partial dentures not covered	Covered when dentally necessary; limited to once/7 years and only covered if the tooth, tooth site, or teeth involved have not received crown in last 7 years Temporary partial dentures covered when placed within 2 months of the extraction of anterior tooth or for missing anterior permanent teeth of covered persons age 16 or under.
Denture adjustment, repair, and relining	Repair/relining of dentures covered when dentally necessary Denture adjustments not covered	Covered when dentally necessary; separate charge not covered within 6 months of initial placement. Subsequent relines covered once per denture in 12 month period and subsequent adjustments limited to 2 adjustments per denture in 12 month period[6]
Denture replacement	Covered when dentally necessary; limited to once/5 years	Covered when dentally necessary; limited to once/7 years
Tissue conditioning	Not covered	Covered 2/denture within 36 months

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6 RPEA's dental expert testified that, when initially placing a denture, the dentist will perform an initial adjustment and reline within the first six months as part of the procedure. [Tr. 523.]

Implants	Covered by medical plan when needed due to accident or disease (including periodontal disease); placement of crown or cast restoration covered by dental plan	Covered by medical plan when needed due to accident or disease (including periodontal disease); covered by dental plan in all other instances[7]
Athletic mouthguard	Not covered	Covered once/12 months if patient is 15 or younger; covers once/24 months if patient is 16 or older

51. The 2014 plan also introduced a network with steerage. A network is a group of providers (dentists) who contract with a TPA 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.]

52. 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 dentists 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

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[7] 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.

Alaska will be reimbursed the lesser of the dentists billed rate or the "prevailing charge" rate. [Exh. 1003, at 6403.]

53. 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 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.][8]

54. A substantial majority of the retirees have access to an in-network provider in the community in which they live. Ms. Nault, an RPEA witness, testified that there are 8 communities in Alaska without a network provider. Even if the Court credits that testimony, only 80–90 members or 0.02 percent of the people enrolled in the retiree dental plan do not have a network provider in the community in which they live. [Tr. 1051.]

55. The Moda network has grown since 2014. 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.] The number of claims being submitted by network dentists has also increased every year since 2014. [*See* Exh. 1008, at. 4.]

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[8] This finding is supported by Dr. Rogers' testimony. 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.]

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56. In 2014 alone, the network saved the dental plan $10 million. [Tr. 664.] This savings benefited all retirees in the form of lower, more stable premiums.

57. By using the network, the retirees are also protected from balance billing. The network providers must accept the agreed upon rate as determined by their contract with Moda. That contract prevents the dentists from billing the members for the difference between the accepted rate and what the dentists would normally charge.

VI. The State's Active Employee Dental Plan

58. Alaska Statute 39.30.090(a) allows the Department of Administration to obtain group insurance policies—including dental—for its active employees. The State offers its active employees a dental plan.

59. 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 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.]

60. Based on plan booklets and benefit clarifications, the Court finds the following as to the dental plans offered to active employees and the retirees as of 2014:

Plan Feature	2014 Retiree Plan	2014 Active Employee Standard Plan
Annual Individual Maximum	$2000 [Exh. 1003, at 006391.]	$1500 [Exh. 2013, at 36.]

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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 [Exh. 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 [Exh. 2013, at 119.]
Inlays	Considered an optional service; alternate benefit of amalgam filling provided. [Exh. 1003, at 6406.]	Same [Exh. 2013, at 119.]
General Anesthesia	Not covered when in conjunction with non-surgical procedures. [Exh. 1003, at 6406.]	Same [Exh. 2013, at 120.]
Pulp Capping	Covered only when there is exposure of the pulp. [Exh. 1003, at 6407.]	Same [Exh. 2013, at 120.]
Periodontal Scaling and Root Planning	Once per quadrant in any 24-month period. [Exh. 1003, at 6407.]	Same [Exh. 2013, at 120.]
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. [Exh. 2013, at 121.]

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Cast restorations	Once/7-year period [Exh. 1003, at 6408.]	Same. [Exh. 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. [Exh. 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. [Exh. 2013, at 122.]
Tissue Conditioning	Twice per denture in a 36-month period. [Exh. 1003, at 6409.]	Same. [Exh. 2013, at 122.]

61. The Court specifically finds that the 2014 plan enhanced the retirees' coverage for periodontal maintenance and implants.

62. 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.] After 2014, the dental plan covered implants for any reason not related to disease or injury. Exhibit 2050 shows a substantial increase in

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the amount the dental plan paid towards implants between 2013 and 2014, which is consistent with the change in coverage.

63. The 2014 plan moved periodontal maintenance from a Class II benefit to a Class I benefit. Periodontal maintenance is also included in the exception for additional cleanings. In the section addressing additional cleanings, the 2014 plan defines cleanings as prophylaxis *or* periodontal maintenance. [Exh. 1003, at 6410.]

64. Based on a comparison of the two plans, the Court finds that 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.

65. The State also offered the testimony of Cathye Smithwick, a dental benefits consultant, who testified as an expert in dental benefit design and analysis. 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 challenge Ms. Smithwick's analysis, and RPEA now accepts her opinion as valid. Even without RPEA's concession, the Court finds her testimony credible and adopts her opinion herein.

VII. Coverage Limitations

66. Dental plans do not cover every service that a dentist believes is dentally necessary. [Tr. 294, 513.]

67. The frequency limits imposed by the 2014 plan will not negatively impact a substantial majority of the retirees.

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68. The 2014 plan allows for additional cleanings that are determined to be dentally necessary by Moda. RPEA did not put on any evidence to suggest that Moda is denying retirees dentally necessary cleanings. Neither Dr. McLean nor Dr. Rogers could testify about Moda's specific practices, and both dentists acknowledge being willing to submit documentation to support a finding of dental necessity. [Tr. 236, 246–47; 517.] 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.]

69. The 2013 plan covered topical fluoride when dentally necessary. [Exh. 1000, at 508 &510.] For patients under the age of 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.]

70. The Court finds that the 2014 plan covers topical fluoride for adult retirees' who need it. The Court accepts Dr. Rogers' opinion that the routine application of topical fluoride is not dentally necessary for all adult patients. [Tr. 463.] The Court also finds that, to the extent a patient suffers from dry mouth, that patient is likely covered by the 2014 plan. Dr. Rogers testified that patients suffering from dry mouth are typically taking some sort of medication, and the underlying reason for that medication would establish dental necessity. [Tr. 520–522.]

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71. The Court also credits the testimony of Ms. Smithwick and Dr. Rogers, who both relied on a 2013 article by the Journal for American Dental Association titled *Topical Fluoride for Caries Prevention*. 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. [Tr. 1144–46.] The retirees have access to prescription level fluoride toothpaste through their major medical plan. [Tr. 1042.]

72. 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.] The evidence did not establish that the standard of care is to obtain a full-mouth x-ray every three years. Dr. Rogers testified that he didn't think that "any x-ray should be done on 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.] That article did not recommend full mouth x-rays on a prescribed time period.

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73. 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; however, the evidence showed that the impact of these coverage limitations to the group as a whole was minimal.

74. 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.]

75. 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 years. [Tr. 522.] In Dr. Rogers's 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.]

76. 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.]

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77. 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.]

78. In 2014, Moda denied 66 claims for a routine examination, 59 claims for a cast restoration (crown),[9] 115 claims for a bridge, and 19 claims for dentures. [Exh. 2024; Tr. 962.]

79. 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. This finding is also supported by comparing 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

VIII. Actuarial Evidence

80. The State is the only party that presented actuarial evidence. This was done through the testimony of Richard Ward.

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

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81. 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, Mr. Ward said that actuaries typically determine the "actuarial value" for each of the plans. [Tr. 647–48.] This number 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 of the plan, if 70 percent are paid by the plan, then the actuarial value is 70 percent on average." [Tr. 648.]

82. 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 v. Mathiashowski*.[10] [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.[11]

83. 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

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[10] 2006 WL 4634279 (Alaska Super April 27, 2006).

[11] *Id.*, at ¶ 76.

actuarial value of the plan was 72.1 percent and it increased steadily to 73.0 percent in 2016. [Exh. 2046.][12] 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 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.]

84. Mr. Ward's analysis did not take into consideration the $10 million the plan saved in 2014 as a result of the network.

85. When calculating the actuarial value for 2014–2017, Mr. Ward did not include out-of-network claims.

86. The Court finds Mr. Ward credible and adopts his opinion as contained in Exhibit 2046. As a result, the Court finds that the actuarial value of the plan in 2014 exceeded the actuarial value of the plan in 2013.

87. 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.] 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

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

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.]

88. The Court also finds this portion of Mr. Ward's analysis credible. As a result, the Court finds that the actuarial value of the enhancements to the 2014 plan—increased coverage for periodontal maintenance and implants—exceeds the actuarial value of the diminishments.

89. Mr. Ward's decision not to include out-of-network claims in calculating the actuarial value from 2014–2017 does not affect the Court's finding. 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.][13] In addition, steerage promotes the utilization of the network and networks lower the costs of the plan. These lower costs are transferred to the retirees in the form of lower, more stable premiums.

90. The Court also finds that Mr. Ward's decision not to characterize the coverage change for x-rays, prophylaxis, periodontal maintenance, full mouth debridement, and general anesthesia as a diminishment does not undermine his opinion. The Court finds that those coverage changes did not diminish the retirees' coverage.

91. The Court does not place any weight on Exhibit 1030 or credit RPEA's calculation of actuarial value based on that exhibit. RPEA offers no testimony to explain

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[13] 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.

the numbers offered in the Moda report. The Court has no ability to determine how Moda calculated those numbers or whether it is a fair comparison to the analysis performed by Mr. Ward.

92. 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.] 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.]

93. The Court also rejects Ms. Farmer's testimony on usage statistics. 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, Ms. Farmer admitted during her testimony that she failed to take into account duplicative claims. [Tr. 1003–04.]

94. Ms. Farmer's 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 tell, of the retirees who were denied coverage for topical fluoride after 2014,

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how many actually submitted documentation to show that their treatment was dentally necessary.

IX. Return to the 2013 Plan

95. A return to the 2013 plan would result in a substantial increase to the retirees' premiums.

96. The 2014 changes resulted in a savings of approximately 10 to 14 percent annually. [Tr. 1226.] The State's witnesses testified that the State needs to increase the premiums by 5.9 percent to cover the claims under the current plan for 2018. [Tr. 1226.] If the State reverts to the old 2013 plan, the State will need to increase the premiums by at least 20 percent. [Tr. 1227.] An individual retiree paid $66 per month for DVA coverage in 2017. [Exh. 2015.] A twenty percent increase would mean that the retirees would have to pay another $13 or $79 per month for dental coverage.

CONCLUSIONS OF LAW

1. RPEA has standing to bring this matter.

2. RPEA bears the overall burden of proof.

3. In a pretrial order granting RPEA's partial motion for summary judgment, the Court held that State's offer of DVA coverage is protected by Article XII, § 7 of the Alaska Constitution.[14]

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[14] 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?").

4. The Court did not address the question of "how the law protects a benefit when the benefit package offered in this circumstance is paid for by the employee."[15]

5. Optional benefits such as the retirees' DVA coverage are not like the major medical coverage at issue in *Duncan v. Retired Public Employees of Alaska, Inc.*[16]

6. To define the accrued benefit, the Court must look at what the State promised the retiree.[17] 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. The natural and ordinary reading of this statute is that the State offered the retirees the option to purchase the same dental coverage offered to its state employees.

7. The promises made to employees in the employee handbook did not expand this coverage. 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.]

8. In comparison, the handbooks for major medical actually promised coverage paid for by the State. As the court said in *Duncan,* the publications

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

16 71 P.3d 883, 888 (Alaska 2003).

17 *Id.* at 888–89.

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"promise[d] coverage, not merely payment of a particular premium."[18] Specifically, "[t]he 1975 booklet promises: 'The entire cost *of this Medical Program* . . . will be paid by [the systems].'"[19] "And the 1980 handbook provides that "[*c*]*omprehensive major medical insurance is provided* . . . . There is no cost to you for this insurance."[20]

9. The Court finds that that the State did not promise retirees certain dental coverage; it promised retirees the option to buy dental coverage.

10. The Court also finds that the option to buy dental coverage is what is protected by Article XII, § 7.

11. The Court valued that option in two different ways. First, the Court compared 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 compared the dental plan offered to retirees with the dental plans offered to similar groups across the United States. Under either method, the Court finds that the State is responsible for offering the retirees a reasonable and affordable dental plan.

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18 *Id.* at 889.

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

20 *Id.* (emphasis in original).

12. Finding the testimony of Cathye Smithwick credible, the Court finds that the 2014 dental plan offered to retirees is at least equivalent to, if not better than, the dental plans offered to similar populations across the country.

13. Having compared the retirees' 2014 retiree dental plan to the 2014 dental plan offered to the State's active employees, the Court finds that 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.

14. Although not needed, the Court also conducted the comparative analysis discussed in *Duncan.* The analysis required in *Duncan* 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."[21] "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."[22]

15. The State offered solid statistical data drawn from actual experience, including accepted actuarial sources, to evaluate the offsetting advantages and disadvantages to the changes to the retirees' dental benefits. The analysis performed by the State fully complies with *Duncan.*

16. The evidence offered by RPEA did not meet the standards required by *Duncan*. RPEA did not present the Court with objective evidence that allowed the Court

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[21] *Id.* at 893.

[22] *Id.* at 894.

to value one change over the other. The Court rejects RPEA's so-called "common sense approach" as a matter of law. The Court also rejects the testimony of RPEA's expert, Todd Allen, as an objective measure to value coverage changes.

17. The 2013 plan expressly provides that the dental plan does not cover services not specifically listed. Evidence that the TPA was covering services not meant to be covered by the plan or benefit clarifications does make that service an accrued benefit under Article XII, § 7. The Court finds that RPEA failed to prove that the State allowed a pattern of poor claims handling to persist.

18. The actuarial analysis performed by the State's expert establishes, as a matter of law, that the actuarial value of the 2014 plan exceeded the actuarial value of the 2013 plan. It also establishes, as a matter of law, that the actuarial value of the enhancements in the 2014 plan exceeded the actuarial value of the diminishments.

19. The Court finds, as a matter of law, that the ability to receive coverage without showing dental necessity is not an accrued benefit protected by Article XII, § 7.

20. The Court finds, as a matter of law, that the ability to choose one's provider is not an accrued benefit protected by Article XII, § 7.

21. Based on the above, the Court finds, as a matter of law, that the changes made to the retirees' dental plan in 2014 did not violate Article XII, Section 7 of the Alaska Constitution.

ORDER

Based upon the above findings and conclusions, it is ordered as follows:

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A. The Court declares that the 2014 changes to the retiree dental plan did not violate Article XII, § 7 of the Alaska Constitution.

B. The Defendant is entitled to judgment dismissing this complaint.

C. The State shall submit an appropriate judgment within 10 days of receipt of these findings.

D. The State is the prevailing party and RPEA had a sufficient economic incentive to bring this action regardless of the constitutional claims involved.

Dated ____________

____
Eric A. Aarseth
Superior Court Judge

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