IN THE SUPERIOR COURT OF THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

THE RETIRED PUBLIC EMPLOYEES OF ALASKA, INC., Plaintiff, v. LESLIE RIDLE, COMMISSIONER OF THE ALASKA DEPARTMENT OF ADMINISTRATION, Defendant.	Case No. 3AN-16-04537 CI

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RPEA'S REPLY TO DEFENDANT'S CLOSING ARGUMENT

INTRODUCTION

RPEA and the State have very different views of the law, as well as different views of the credible evidence. This reply responds to the State's key points, without repeating arguments set forth in RPEA's opening argument.

THE ALASKA CONSTITUTION PROTECTS COVERAGE, NOT PREMIUMS.

Article XII, section 7 protects more than just the right to purchase a dental insurance plan.

The Alaska Constitution, Article XII, § 7 guarantees that a public employee's "[a]ccrued benefits . . . shall not be diminished or impaired." The Supreme Court has made clear, "The natural and ordinary meaning of 'benefits' in a health insurance context refers to the coverage provided, rather than the cost of the insurance."[1]

[1] *Duncan v. Retired Public Employees of Alaska, Inc.*, 71 P.3d 862, 888-89

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In light of this unambiguous language in *Duncan*, this court should reject the State's claim that the constitution does *not* protect the coverage that employees were promised they would receive if they purchased dental insurance, but only the promise that, when they retire, *some* dental insurance would be available for purchase.[2] To hold that the constitution protects only the promise that retirees can purchase *some* dental insurance would render the promise of dental insurance virtually meaningless. Under that interpretation, the State could cancel the entire dental insurance plan it now offers and instead offer a plan that covers *only* one cleaning per year (and absolutely nothing else), and say it had kept its promise to offer *some* insurance for purchase.

The State seems to recognize the problem. After asserting that the constitution protects only the option to purchase insurance, the State argues that this court could find no diminishment "[a]s long as the State offers retirees a reasonable plan – a plan that is within the mainstream of dental insurance plans."[3] The limitation the State proposes has no basis in the constitution, case law, or language in the State-prepared booklets provided to employees.[4] Because the ordinary meaning of "diminish" is "reduce,"

(Alaska 2003); *see also id.* at 887 ("accrued benefits" should be defined broadly).

[2] Defendant's Closing Argument ("Deft. Arg.") at 2 ("The State contends that the protected benefit is the option to purchase dental coverage, not the coverage itself."), 8-11.

[3] *Id.* at 2; *see also id.* at 11-15.

[4] *Duncan* uses the phrase "the coverage that is offered should generally be 'in keeping with the mainstream' of health insurance packages offered to active public employees in terms of scope and balance." 71 P.3d at 892. But it uses the phrase as a general description of what a retiree health insurance plan should offer, not as a constitutional minimum or as a way to measure whether previously available benefits have been diminished.

diminishment must be measured by the difference between what was and what is offered, not by whether what remains meets some other test.[5]

If the actual coverage offered in the 2013 plan was diminished by adopting the 2014 plan, this court should find that the 2014 changes violate the constitution.

Concern for premiums does not justify diminishing coverage.

In *Duncan*, the Supreme Court rejected the State's argument that the constitution protects only the premium that the State pays for health insurance.[6] The Court acknowledged as valid the concern that rising health care costs could threaten the integrity of the system – but it expressly concluded that the State's policy argument was not "sufficient to change the meaning of the constitutional language."[7]

The State resurrects the argument that the Supreme Court rejected. The State claims a different conclusion is warranted here, because retirees pay the premiums rather than the State.[8] The State offers no legal authority for its position.

Although *Duncan* did not expressly address the significance of premiums when retirees pay them instead of the State, nothing in *Duncan* suggests that the Supreme Court would reach a different conclusion based on who pays the premium. Rather, the

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[5] Furthermore, contrary to the State's assertion, the State did not offer the retirees just a promise that they could purchase *some* DVA plan. The 2013 plan booklet told employees that, as retirees, they could purchase "*this* voluntary Dental–Vision–Audio (DVA) Plan for benefit recipients and their eligible dependents." [Exh. 1000 at 496 (emphasis added)] The plan booklet advises that "benefits may change from time to time." [*Id.*] The constitution controls what changes may be implemented.

[6] *See Duncan*, 71 P.3d at 888-89.

[7] *See id.* at 889.

[8] Deft. Arg. at 4-7. The State returns to this argument at other points in its briefing. Each time, the focus on premiums is legally misplaced.

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Court's clear statement – that concern for assuring the plan's long-term sustainability cannot overcome the constitutional language – applies no matter who pays the premium.

There are other reasons why concern for the premium cannot control here. The State alone sets the premium [Tr. 42, 620-21], and the premium does not depend just on the cost of the dental care purchased. Among other things, the premium takes into account the administrative fees of the TPA, administrative expenses within the State, and funding a reserve account. [Tr. 620, 884] Further, there is actually no "dental insurance" premium. Retirees who desire dental insurance must purchase a DVA package [Tr. 38] – so their premium also is affected by the health care costs and administrative fees associated with visual and audio insurance. The retirees' guarantee against diminished benefits cannot depend on the State's choices in negotiating contracts with TPAs and other expenses the State opts to incur to administer its plans.

There may be one practical difference between State-paid and retiree-paid plans. When retirees pay for the premium, the State may offer them the alternative of paying a lower premium and receiving less coverage, so long as retirees retain the option to continue with a plan with undiminished benefits (even with higher premiums).[9]

As a matter of law, this court should determine that concern for premiums is not a valid basis for resolving this case on some basis other than comparing the coverages in the 2013 and 2014 plans.

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[9] Offering retirees a choice is the obvious answer to the State's belief that retirees are more concerned with premiums than coverage. [Deft. Arg. at 5-8]

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OFFERING A REASONABLE, MAINSTREAM PLAN IS NOT SUFFICIENT.

Comparing the coverages offered by the current retiree dental plan and the current active employee plan is immaterial to whether coverage was diminished.

The State asks this court to conclude that there has been no unconstitutional diminishment of retirees' accrued benefits if the current retiree dental plan is generally similar to the current active employee dental plan. [Deft. Arg. at 12-14]

The State's position is untenable under the Alaska Constitution. The constitution does not protect the benefits offered to active employees. The State could eliminate all health insurance benefits for current employees without violating the constitution. Hence, comparison of retirees' benefits to active employees' benefits will not protect retirees.[10] Only the comparison to the retirees' previous plan is legally relevant.[11]

Comparing the current retiree dental plan and plans offered to public employees in other states is also immaterial to whether coverage was diminished.

The State next contends that the 2014 changes to the retiree dental plan pass muster under the Alaska Constitution so long as the coverages in the 2014 retiree dental plan meet or exceed industry standards for retiree dental plans offered around the country. [Deft. Arg. at 11] Again, the State supplies no legal authority for this view,

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[10] Only a few minutes of trial testimony were devoted to comparing the 2014 retiree dental plan to the 2014 active employee dental plan. The State now points to some similarities, but fails to note two key differences: In the active employee plan, purchase of dental insurance is mandatory for most employees, and the Standard Plan includes some coverage for orthodontia. [Exh. 2013 at p.1 (using the booklet's internal numbering), Part 1.1; p.22, Part 2.2] Unless the court is willing to conduct its own detailed comparison, the court should conclude that the trial record does not provide a basis for determining how comparable the retiree and active plans are.

[11] *See Duncan*, 71 P.3d at 889, 892.

and the court should reject the argument.

Neither the Alaska Constitution nor *Duncan* suggests that the accrued benefits of Alaska retirees may be diminished from past levels so long as retiree dental benefits nationwide have been diminished to the same or greater extent. Historically, Alaska has offered public employees generous benefits in order to encourage talented individuals to move to or to remain in Alaska and to have careers in public service.[12] Such inducement has brought many capable people to live and work in a place where living conditions can be harsh and pay is less than they'd receive in the private sector. The Alaska Constitution guarantees that, after these people devote their careers to Alaska public service, their accrued benefits may not be diminished, no matter what type of benefits retirees in other states are now being offered.

RPEA'S EVIDENCE PROVED DIMINISHMENT IN COVERAGE.

RPEA ESTABLISHED THAT COVERAGE UNDER THE 2013 PLAN WAS BROADER THAN EXPLICITLY STATED IN EXHIBIT 1000.

The evidence at trial (discussed further below) made clear that, under the TPAs that preceded Moda, claims regularly were paid for services not expressly listed as covered in the 2013 plan booklet. The State maintains that the coverage available under the 2013 plan must be determined by looking *only* at the 2013 benefit booklet and

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[12] *See Retired Public Employees of Alaska, Inc. v. Matiashowski*, 2006 WL 4634279 at ¶¶ 32, 34, 36, 38 (Alaska Sup. Ct. Apr. 27, 2006) (decision following remand in *Duncan*) (State proclaimed in 1990 and 1993 that the Public Employees Retirement System was established to attract qualified people into public service and that the plan "is now one of the best plans in the country"); *see also* Tr. 65 (Ms. Miller testified that, when she worked for the State (2004-2009), the Alaska retiree dental plan was "more robust" – i.e., had better coverage – than plans offered in the general marketplace at that time).

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any official benefit clarifications, and not by considering any other documents or testimony. [Deft. Arg. at 16-23] The court should not accept this narrow view.

The State is legally bound by the coverage it actually offered.

In trying to escape responsibility for the coverage actually offered under the 2013 plan, the State ignores the undisputed testimony that it has a fiduciary obligation to supervise the TPA and to ensure that the TPA administers the plan properly in accordance with its terms. [Tr. 40, 44, 818-19, 1259] The State also ignores the undisputed testimony that it did in fact supervise the TPAs carefully. [Tr. 45-46, 51-53, 810-12, 899-900, 910-12, 1033, 1258-59][13] The State unquestionably is responsible for the conduct of the TPA, which serves as its agent in administering the plan.[14] Evidence that the TPA regularly paid claims for services not explicitly listed in the plan booklet is legally equivalent to evidence that the State ratified that this scope of coverage was provided by the 2013 plan.

When the State insists that HealthSmart routinely paid claims in error and the State was unaware of this, this is either incredible or an admission that the State failed to exercise its fiduciary responsibility to retirees who pay premiums for their dental

[13] With respect to its past supervision of the TPA, the State disputes only the testimony concerning whether it ever audited the claims handling by Wells Fargo and HealthSmart. [Deft. Arg. at 21] The State misstates Ms. Farmer's testimony. She testified, without equivocation, that an audit *was* conducted; she was uncertain only when exactly the audit occurred. [Tr. 917] The choice to conduct only one audit was the State's. The court may infer that the results of the audit revealed no significant problem, so the State decided it would not be cost-effective to conduct a repeat audit, even knowing it could demand repayment if the audit disclosed claims paid in error. [Tr. 918, 920]

[14] *See* RPEA's Memorandum in Support of Admitting Exhibits 1001, 1028, and 1030 at 4-9 (Aug. 13, 2018).

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insurance. The State's contract with the TPA entitles it to demand reimbursement for claims paid improperly. [Tr. 918, 920] The State's duty to retirees obligates it to notice if thousands of claims are paid in error, improperly costing retirees who pay premiums hundreds of thousands of extra dollars. With no evidence that the State shirked its supervisory responsibilities, the court should find that the State exercised its duties properly and tacitly, if not explicitly, approved HealthSmart's claim-handling practices.

Moreover, there is no evidence of error. Contrary to the State's argument, Ms. Ricci did not testify that her examination of HealthSmart's claim-handling procedures found errors or inconsistencies in the way HealthSmart administered the plan, as compared to how the State intended the plan to be administered. Ms. Ricci testified only that her review disclosed that HealthSmart was not enforcing frequency limits in the way Ms. Ricci expected (because they were not stated in the plan); this led the State to adopt express frequency limits in the 2014 plan. [Tr. 789-90]

Historically, the State approved coverage of services not specifically listed in the plan booklet or a benefit clarification.

The State notes that witnesses testified that the plan documents "should" control – and RPEA does not disagree that this describes how a well-run plan should be administered. However, that is not how the State has operated. The State's plan booklets have not been clear [Tr. 596, 777, 1037], and the evidence shows that the TPA regularly paid claims that fell outside the narrowest literal language of the plan booklet. [Tr. 734, 740-41, 944][15] This was not improper. As a self-insurer, the State has the

[15] *See also* Tr. 914-15 (Ms. Farmer testified that State employees directed the TPA

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authority to determine the scope of coverage and is not limited by the plan booklet. [Tr. 40-41 ("The State determined what the benefits are.")]

The State suggests that only a formal benefit clarification may extend coverage to include services not specifically listed in the plan booklet – but again, historically, that is not what the State has done.[16] For example, the State covered nitrous oxide as an analgesic *before* the 2006 benefit clarification that Ms. Miller signed. [Tr. 63-64 (referring to Exh. 1002)] As Ms. Miller testified, that benefit clarification was issued because the new TPA wanted clear guidance as to how the State wanted it to process anesthesia and analgesia claims. [Tr. 63-64] The benefit clarification "clarified" that coverage for a service not listed in the booklet would be provided in the future, just as it had been provided before the benefit clarification was issued. [Tr. 64]

Exhibit 1001 reliably establishes the coverage that was provided under the 2013 plan.

The State objects to reliance on Exhibit 1001 as evidence of what the 2013 plan covered. The court should not find the State's objections persuasive. Contrary to the State's account of the testimony, Ms. Farmer was confident that the State was familiar

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to pay all claims for cleanings, regardless of frequency, without scrutiny for dental necessity), 915 (Ms. Farmer recalled medical claims where the State directed the TPA to treat a service as covered even when it was not specifically listed in the plan booklet).

[16] Furthermore, the State is mistaken in asserting that benefit clarifications are intended to notify retirees of how the State interprets the plan. [Deft. Arg. at 19] Until recently, benefit clarifications were not even readily available to members. [Tr. 1264 (benefit clarifications were "internal" documents, not distributed to retirees)] They were directed principally to the TPA. [*Id.*] Even now, benefit clarifications are difficult for a retiree to locate; they are not incorporated into the plan booklet [*e.g.*, Exh. 1000, 1003], and a retiree searching online must be savvy enough to look for a link to "benefit clarifications" separate from the link to the plan booklet. [Tr. 1263; *see also* Tr. 1037-38 (even plan amendments have not been incorporated in the plan booklet)]

with and approved the coverages stated in Exhibit 1001. [Tr. 922-26, 1020-21][17] The fact that neither Ms. Michaud nor Ms. Ricci was familiar with or approved this document means nothing. [Deft. Arg. at 18] Ms. Michaud assumed her position in the Division of Retirement and Benefits (DRB) in April 2014, after the 2014 plan took effect. [Tr. 1032] Ms. Ricci worked for DRB from mid-2012 until the end of in 2013 [Tr. 609-10], but there is no evidence that her job responsibilities included review and approval of documents that were prepared before she began her work.

The accuracy of Exhibit 1001 as a statement of what was regularly covered during HealthSmart's administration of the 2013 plan is confirmed by Exhibit 1015, which is a report that HealthSmart prepared *and* submitted to the State. [Tr. 947, 1264-67] This document shows, for example, that HealthSmart approved thousands of claims for implants (a service listed as covered in Exhibit 1001, page 5, but not mentioned in Exhibit 1000) and paid out hundreds of thousands of dollars in this category each year.

Accepting Exhibit 1001 as a statement of what the 2013 plan covered does not mean the court is giving constitutional protection to "errors" by the TPA. [Deft. Arg. at 20] Given both the State's obligation to supervise the TPA and the extensive evidence that it did in fact supervise the TPA, the facts and law show that the TPA's claim handling was not an error but was endorsed and approved by the State.

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[17] The State makes too much of Ms. Farmer's forthright testimony that in 2018 she did not recall all of the details of the coverage that HealthSmart allowed under direction by the State. [Tr. 984-85] Honest witnesses acknowledge the possibility of error. Still, Ms. Farmer was "confident" that this document was gone over with and approved by the State, and that she was directed to follow it. [Tr. 924-25]

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Even if the court were to rely solely on Exhibit 1000, and not to consider Exhibit 1001, it still could not accept in full the State's description of what was and was not covered under the 2013 plan.

The State's list of services that were not covered under the 2013 plan [Deft. Arg. at 22-23] is too expansive, even if the court relies only on Exhibit 1000 to define the plan's coverage.

First, the view that the 2013 plan covers only services *explicitly* listed in the booklet is too narrow, even according to the State's witness. Ms. Ricci testified that she understood that the 2013 plan language – that the plan does not cover "[s]services or supplies not specifically listed as a covered benefit under the health plan" – refers to "kind of the broad categories of services." [Tr. 777] In other words, every service and supply included within a broad listed category need not be separately listed to be covered.

As discussed below, for the most part the contested items in Exhibit 1001 deal with services that easily fit within Exhibit 1000's lists of covered services. This supports the testimony that Exhibit 1001 was developed to provide guidance to the new TPA on how the listed services should be interpreted. [Tr. 922-25] It also means the court can find that the plan language covers most of the services listed in Exhibit 1001, even if the court prefers not to rely on Exhibit 1001 to determine coverage under the 2013 plan:

- Preparation of diagnostic casts and study models is a part of prosthetic services (such as preparing for a crown, bridge, or dentures) that are specifically covered. [Exh. 1000 at 509]

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- Periodontal splicing is a type of periodontal service, and periodontal services are explicitly covered. [Exh. 1000 at 509]
- Root canal retreatment is a part of endondontics, which is an explicitly covered service. [Exh. 1000 at 508]
- Full-mouth debridement is a type of prophylaxis, which is an explicitly covered service. [Exh. 1000 at 508]
- Tissue conditioning and denture adjustments are both part of the necessary treatment for providing and replacing dentures; dentures and denture replacements are explicitly covered services. [Exh. 1000 at 509]
- Temporary partial and full dentures fit within the explicit coverage for "Dentures, full and partial," where no modifier such as "permanent" is stated. [Exh. 1000 at 509]

Consequently, to the extent the 2014 plan excludes coverage for any of the services listed above, the 2014 plan diminishes the coverage previously available.

Implants (which are listed as covered in Exhibit 1001) cannot be characterized as part of another service explicitly listed as covered in the plan booklet, but there can be no reasonable debate they were covered in some fashion under the 2013 plan. Ms. Michaud testified that the 2013 retiree dental plan covered "implants" by paying for the appliances required for an implant, if the medical plan covered the implant procedure. [Tr. 1042] This is consistent with Exhibit 1001. HealthSmart's report to the State shows $354,902.67 spent on implants in 2012 (for 2740 claims), and $450,094.62 spent on implants in 2013 (for 3581 claims). [Exh. 2015] To ask this court to find (as the State does) that implants were not covered at all under the 2013 plan, because they are not specifically listed as covered, ignores the uncontradicted evidence to the contrary.

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This court should find that RPEA correctly characterized coverage under the 2013 plan,[18] and the State did not.

RPEA ACCURATELY ESTABLISHED THE WAYS THAT COVERAGE WAS DIMINISHED.

The State improperly minimizes the list of diminishments.

Besides attempting to exclude certain clear coverages from the 2013 plan (to avoid having to treat their exclusion from the 2014 plan as diminishments of coverage), the State attempts to minimize the significance of the diminishments it cannot deny. [Deft. Arg. at 23-31] These arguments also should be rejected, because they are inconsistent with the weight of the credible evidence.

Prophylaxis: The 2013 plan covered regular cleanings and periodontal prophylaxis without numerical limitations. [Exh. 1000 at 508, 509] The 2014 plan covers two routine prophylaxis or periodontal maintenance treatments per year for most people, four total treatments for a person with diabetes, and an additional treatment for anyone in the third trimester of pregnancy. [Exh. 1003 at 6405-06, 6410-11] The benefit clarification issued in September 2014 addresses coverage for "cleanings." [Exhibit 1006] It specifies that pregnant women may receive three cleanings per year, and anyone with periodontal disease may receive four cleanings per year; any member whose dentally necessary care requires more than the specified number of cleanings may apply to Moda for additional coverage – and the person will be covered to the extent Moda approves. [Exh. 1006] On its face, the benefit clarification does not expand coverage for periodontal maintenance. [Deft. Arg. at 24]

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[18] RPEA Arg. at 6-11 and Table 1.

The State argues that the allowance of extra cleanings, when approved as dentally necessary, means there is no diminishment of coverage for prophylaxis, since the 2013 plan also did not allow coverage for cleanings that were not dentally necessary. [Deft. Arg. at 24] The court should reject this position. Any time additional hurdles are added, such as requirements for documentation and review, inevitably some claims for dentally necessary care will be denied, or patients will forgo care rather than accept the burden of applying for an exception. [Tr. 247-48, 451-52]

X-rays: The 2014 plan introduced three limitations. Contrary to the State's claim, each is a diminishment of coverage.

(a) The 2013 plan allowed routine full-mouth x-rays each year; the 2014 plan allows full-mouth x-rays only once in five years. [Exh. 1000 at 508; Exh. 1003 at 6405] The credible evidence (including the journal article that both Dr. Rogers and Ms. Smithwick accepted) establishes that professional judgment is required to determine when to order a full-mouth x-ray, and for some patients full-mouth x-rays are dentally necessary more frequently than once in five years. [Tr. 252, 256-57, 457, 459-61, 1136-37] The 2014 plan diminishes coverage for a dentally necessary service.

(b) The 2013 plan allowed bite-wing x-rays (as a type of routine dental x-ray) without a fixed frequency limit. [Exh. 1000 at 508] The 2014 plan covers bite-wing x-rays once per year. [Exh. 1003 at 6406] This is a diminishment. And it can deny dentally necessary care, since some patients should receive bite-wing x-rays every six months. [Tr. 1137]

(c) The 2013 plan contained no limitation on the types of x-rays that could be

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covered for routine or diagnostic purposes. [Exh. 1000 at 508] The 2014 plan excludes x-ray types not explicitly listed, including most significantly cone beam computed tomography. [Exh. 1003 at 6405] These x-rays are dentally necessary for diagnosis and treatment of some patients. [Tr. 461-62] By excluding this type of x-ray, the 2014 plan diminishes coverage.[19]

Fluoride treatment: The 2013 plan covered topical fluoride applications without limitation (other than the general dental necessity requirement). [Exh. 1000 at 508] The 2014 plan covers topical fluoride treatments twice a year for patients under 18; it covers up to two treatments a year for adults only if they fit within a defined category of high-risk patients. [Exh. 1003 at 6405-06] RPEA's experts identified patients who need topical fluoride who do not fit within these categories. [Tr. 263-65, 463-68][20] The 2014 plan diminishes coverage.

To contest diminishment, the State points out that patients who do not qualify for topical fluoride treatments may qualify for prescription-strength fluoride toothpaste that would be paid for by their medical insurance. [Deft. Arg. at 27] The possible

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[19] The State argues that retirees have no constitutional right "to have their insurance policies cover every new piece of technology used or applied in the dental field." [Deft. Arg. at 26 n.43] Later, it argues similarly that no plan is required to cover all dentally necessary services. [*Id.* at 37] Both assertions miss the point legally. Retirees have a constitutional right not to have their benefits diminished. If a former plan covered use of a new technology and the current plan does not, or the former plan covered any service to a greater extent than it is now covered, then coverage has been diminished – and that is unconstitutional.

[20] The State implies that a dentist could submit paperwork to establish a dental necessity exception for these patients [Deft. Arg. at 27 n.45], but the 2014 plan does not have a general "dental necessity" exception for topical fluoride treatment. [Exh. 1003 at 6405-06]

availability of alternative treatment through *another* plan is immaterial to whether coverage under the dental plan has been diminished.[21]

New frequency limits on routine examinations, crowns, bridges, and denture replacements: For these services, the State essentially concedes that the 2014 plan diminishes coverage, but the State asserts the diminishment does not matter because, it says, relatively few people are affected, and *Duncan* requires analysis of the effects of changes on the group as a whole. [Deft. Arg. at 28]

The court should reject the State's position for several reasons.

First, the State is not looking at the big picture; it has isolated a few of the diminishments and contends they are not unconstitutional because they do not affect a lot of people. But the court must consider *all* the diminishments as a group.

Second, the harms of diminished coverage are not just financial. As the experts testified, even if only a few people are affected by new limits on replacement of dentures, for anyone who is denied a new set of dentures because not enough time has elapsed, the result is catastrophic: the person cannot eat solid food. [Tr. 279-80, 503] Although *Duncan* requires this court's analysis to rest on the effects of the changes on the group as a whole, *Duncan* also requires concern for individuals who suffer substantial hardship as a result of a change.[22]

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[21] Further, in order to consider whether shifting coverage from the dental plan to the medical plan has a positive or negative effect on coverage, the court would need to know more about co-pays and annual and lifetime limits in the medical plan. None of that information was introduced.

[22] *See Duncan*, 71 P.3d at 892 ("Where there is an individual showing that a change results in a serious hardship that is not offset by comparable advantages, the affected

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Third, RPEA disputes the numbers relied on by the State to illustrate the apparent impact of the diminishments. The State relies on dollar figures presented by Mr. Ward to show only a modest decrease in the amount of payments for certain services in 2014 as compared to 2013. [Deft. Arg. at 30, citing Exh. 2050] But Mr. Ward's figures for 2013 are inexplicably much lower than the amounts listed in Exhibit 1015, which was HealthSmart's contemporaneous report to the State on amounts it paid in various categories.[23] Apples-to-apples comparisons for all categories are not possible, but the comparisons that are possible reveal substantial discrepancies in the data relied on. Using figures from Exhibit 1015 shows much more dramatic drops in the amount paid by the plan than Mr. Ward reported in Exhibit 2050. For example, Exhibit 1015 reports $830,052.94 was paid for bridges in 2013, whereas Mr. Ward's Exhibit 2050 reports just $244,040. Exhibit 1015 reports $543,291.99 was paid for dentures in 2013; Mr. Ward's Exhibit 2050 reports just $272,642. Given these discrepancies, Exhibit 2050 cannot be relied upon to demonstrate that the changes in various categories have had little impact.

No evidence (rather than speculation) supports the State's suggestion that network discounts, rather than reduced coverage, explain the reduced spending. Moda

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individual should be allowed to retain existing coverage. . . . Further, . . . [c]overage of a particular disease or condition should not be deleted, even though other coverage might be improved, if the deletion would result in serious hardship to those who suffer from the disease or condition in question. . . . [I]f there should be changes that will predictably cause hardship to a significant number of beneficiaries who cannot at the time of the change be specifically identified, we believe that an option of providing an election to beneficiaries to retain existing coverage should be available[.]").

23 *See* Tr. 1264-67 (Ms. Michaud explained what Exhibit 1015 shows).

will not disclose what it pays network providers [Tr. 880, 1046, 1087-88], and Mr. Ward insisted that payments to network providers can be *higher* than payments to non-network dentists. [Tr. 694-95]

The State did not contest other diminishments that RPEA proved.

In its Closing Argument, the State did not discuss a number of the diminishments that RPEA proved. These include the new frequency limits on oral examinations, a new age limit on space maintainers, the deletion of coverage for inlays and indirect pulp caps, new frequency limitations on bridge and denture repair and relining and the shift of these services from Class II to Class III, new frequency limitations on periodontal scaling and root planing, and new limits on anesthesia. These diminishments are established by the straightforward comparison of coverages stated in Exhibit 1000 and Exhibit 1003. [*See* RPEA's Table 1] The court should accept these diminishments as proven because they are uncontested.

Loss of choice is a type of diminishment.

The State disputes RPEA's claim that diminishment of accrued benefits includes the introduction of a financial penalty for seeing a non-network provider. [Deft. Arg. at 32][24] *Duncan* did not address the significance of having a free choice of health care providers, but finding that a loss of unrestricted choices is a kind of diminishment is not inconsistent with *Duncan*. *Duncan* made clear that "coverage" includes not just the

[24] The State implies that adding a penalty for seeing an out-of-network provider is necessary for the plan to reap the advantages of network discounts. [Deft. Arg. at 33] The record does not establish this. Ms. Miller discussed how the plan can enjoy the benefits of a network *without* a penalty for choosing a non-network provider. [Tr. 54-56, 59-60; Exh. 1024 at 3]

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services included as covered under the health insurance plan, but also the extent to which the plan (rather than the retiree) pays for the service. For example, *Duncan* considered increased co-pays a kind of reduction in benefits.[25] Adding a 25% penalty is exactly like increasing the co-pay. Thus, penalizing a member for seeing the provider she prefers, when no such penalty (or "co-pay") previously applied, properly is considered a diminishment of coverage. This is especially true when the retiree has no reasonable way to see a network provider instead of a non-network provider. However, *Duncan* considered any increase in members' costs for services to be a diminishment regardless of whether the member had the ability to avoid the cost.[26]

RPEA'S EVIDENCE PERMITS THE COURT TO COMPARE DIMINISHMENTS AND ENHANCEMENTS OBJECTIVELY AND WITHOUT SPECULATION.

The evidence allows an objective evaluation of whether retirees as a group are harmed or helped by the 2014 changes.

The State contends that RPEA's analysis of the changes is solely a "gut-feeling approach." [Deft. Arg. at 35] That simply isn't true. RPEA systematically and objectively documented the numerous changes in the plan that disadvantage retirees and the few that benefit members of the retiree dental plan. [RPEA Table 1] It provided some data on the numbers of people affected by specific changes. [RPEA Arg. at 12 n.25] It presented an expert who analyzed the changes by class and overall and opined that overall the changes disadvantage the group. [Tr. 378, 390-91, 402]

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25 *See Duncan*, 71 P.3d at 885 n.7.

26 *See id.* (Supreme Court found a "reduction in benefits" when the new plan increased the co-pay for prescription drugs obtained through a pharmacy, even though the retiree could avoid the charge by obtaining the medicine by mail order).

RPEA also argued that, while the expert testimony is helpful, the court can assess whether the detriments outweigh the advantages by considering the nature of the changes and the numbers of people affected by each change. [RPEA Arg. at 12-13, 17] RPEA is asking this court to use the objective evidence that was presented; it is not asking the court to speculate or to hypothesize future impacts.

Furthermore, as RPEA explained in its opening memorandum, *Duncan* strongly indicates that, once RPEA proved significant diminishments, the State must bear the burden of presenting solid evidence that new enhancements in coverage offset the new diminishments. [RPEA Arg. at 36-37] *Duncan* states: "[E]quivalent value must be proved by reliable evidence."[27] Plainly, the *Duncan* Court did not expect RPEA in that case (or in this one) to prove equivalent value, when the complaint was (and is) premised on a claim that the positive and negative changes are *not* equivalent.

The evidence supports this court finding, first, that RPEA proved that the diminishments in coverage are not offset by new enhancements and, second (for the reasons discussed below), that the State did *not* establish that the enhancements offset the diminishments.

The State's actuarial evidence does not prove that, for the group as a whole, any enhancements in coverage equaled or exceeded the diminishments.

The State and Mr. Ward are wrong that his actuarial valuation used the same methodology that was accepted by the superior court in *Matiashowski* (as *Duncan* was renamed following the remand). [Deft. Arg. at 40-41] Judge Rindner's decision does

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27 *See id.* at 892.

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not discuss any expert reports that calculated the percentage of covered benefits paid by the plan rather than the member. Instead, the opinion discusses expert analysis that valued each change per member per month over a member's lifetime.[28] The changes were measured in dollars and cents, not percentages.[29] Some changes increased the plan's value per member per month,[30] and others decreased the value.[31] Overall, the improvements exceeded the diminishments as calculated actuarially for all members over their lifetime participation in the plan.

Mr. Ward used an entirely different approach. After making certain adjustments, he calculated the percentage of covered expenses paid by the plan in 2013 as compared to 2014 and later years. [Tr. 652-53, 659-64; Exh. 2046] In simplest terms, he testified, his "actuarial value is the portion of the pie that's paid by the plan." [Tr. 664] That number really tells nothing about the value of the plan to a member.

An exaggerated hypothetical makes this clear: Suppose Plan A covered a wide variety of dental services, including cleanings, fillings, crowns, and dentures, and it

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28 *See Matiashowski*, 2006 WL 4634279 at ¶¶ 95, 101.

29 *See id.* at ¶ 77.

30 For example, the increase in the lifetime maximum benefit from $1,000,000 to $2,000,000 was calculated to have a value of $0.50 to $0.85 per member per month (PMPM); the change in the way Medicare benefits would be coordinated (so the State pays 100% of the balance left after Medicare instead of just 80%) had a value of $8.20 to $10.08 PMPM; and an improved outpatient mental health benefit had a value of $1.50 PMPM. *See id.* at ¶¶ 66(b), (d), (e), 77(a), (d), (e).

31 For example, increasing the annual deductible from $100 to $150 had a negative value of $2.04 to $2.54 PMPM; increasing the maximum annual out-of-pocket expenditure due to co-pays from $690 to $800 had a negative value of $2.15 to $2.62 PMPM; and increasing the retail drug co-payment for members who elected not to use the mail-order service had a negative value of $3.10 PMPM. *See id.* at ¶¶ 67(a), (b), (c), 77(f), (g), (h).

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covered all of them at 50% of the recognized charge. Under Mr. Ward's methodology, Plan A has an actuarial value of 50%. Suppose Plan B covers one cleaning per year and nothing else, but it covers it at 100% of the recognized charge. Under Mr. Ward's analysis, Plan B has an actuarial value of 100%. Under Mr. Ward's methodology, a shift from Plan A to Plan B is "better" for retirees, but no one with common sense could conclude that Plan B enhances rather than diminishes benefits.

Mr. Ward's methodology may make perfect sense for a different purpose – such as "grading" a plan for purposes of the Affordable Care Act – but because his methodology does not depend on comparing the coverages available under the two plans, it is not an appropriate way to evaluate whether the changed coverage in the new plan is more or less beneficial to retirees than the coverage in the previous plan. His analysis cannot help this court resolve whether the 2014 plan overall enhanced or diminished benefits.

The State asks this court to disregard the percentage calculations that RPEA offered, using data that Moda reported to the State. [Deft. Arg. at 44-45; *see* RPEA Arg. at 38-39] RPEA did not provide these calculations as a way to compare the plans, but to show how Mr. Ward's exclusion of non-network claims (which are 25-34% of the claims in any year) artificially increases the "actuarial value" of the plan in 2014-2016, as computed by Mr. Ward. The State hypothesizes that the data in Moda's report might not be accurate. This is another example of the State disavowing its own supervisory responsibilities and suggesting that it allows the TPA to report unreliable or inaccurate information, knowing the information will be shared with plan members.

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Ms. Michaud testified she would not distribute the Moda reports if she did not consider them reliable. [Tr. 1233] This court should accept the Moda data as reliable enough to demonstrate that Mr. Ward's deletion of non-network claims overstates the percentage of the total paid by the plan and thus invalidates his analysis.

The State also defends Mr. Ward's treatment of inflation. [Deft. Arg. at 46-47] The record shows that the effects of inflation are important and need to be considered appropriately. In Mr. Ward's analysis, the actuarial value of the plan increased each year from 2014 to 2017 – by .4 to .9% each year – largely because of the effects of inflation. [Exh. 2046][32] Yet he took no steps to adjust for how inflation alone would automatically improve the actuarial value of a plan from 2013 to 2014, even if there were no changes in the plan. This also makes his conclusions unreliable.

This court should not accept Mr. Ward's analysis as establishing that the 2014 enhancements in coverage exceeded the diminishments.

The State's emphasis on services paid per member sheds no light on whether the 2014 plan enhanced coverage.

After telling the court that the data reported by Moda in Exhibits 1028 and 1030 may not be reliable, the State offers its own analysis that uses information in these reports on the number of procedures paid-for per member per year and the cost of that coverage. [Deft. Arg. at 49] This analysis proves no useful point. For starters, the

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[32] The State asked: "Why does actuarial value change even when the coverage doesn't? So your numbers for 2014 and 2015 and 2016 are not the same. Why is that?" Mr. Ward answered: "Largely it's due to the plan including fixed-dollar benefit provisions. . . . [T]he deductible is $50 every year, and as costs increase due to inflation from '13 to '14 to '15 to '16, that $50 deductible . . . becomes more valuable." [Tr. 665]

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number of procedures received by members on average says nothing about coverage, as distinct from showing changes in utilization of dental services, reflecting possibly an aging population with greater dental needs or more aggressive efforts to encourage people to obtain dental care.

The claim that members in 2015, as compared to 2013, received marginally more services for only minimally more cost to the State also proves nothing relevant to this case. Multiplying the PMPM payments times 12 to calculate the yearly "spend" per member, then dividing by the average number of services, shows a slight change in cost per service that may not even be statistically significant, particularly given the imprecision in rounding to just two significant digits.[33] Although the State contends this reduction proves that cost-savings are being achieved by the introduction of the network, the data also may mean that retirees are receiving less coverage per procedure on average. Without the ability to compare the amount retirees paid per service in 2013 and 2015 (information that is not available in the current record), the court can draw no meaningful conclusions from the data the State asks this court to use.

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[33] The following table shows the calculations. The State offered the numbers in columns 2 and 3. [Deft. Arg. at 49, taking figures from Exh. 1023 and Exh. 1030] RPEA calculated the numbers in the fourth column by multiplying the column 3 numbers by 12. RPEA calculated the numbers in the fifth column by dividing the column 4 total by the number of services listed in column 2.

Year	Procedures per member	Plan paid PMPM	Plan paid PMPY	Plan paid per procedure
2013	4.4	45.46	545.52	123.98
2015	4.6	45.90	550.80	119.73

CONCLUSION

This court should find that RPEA proved its claim and should enter judgment in RPEA's favor.

Respectfully submitted, this 29th day of October 2018.

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Certificate of Service:

I certify that on October 29 2018,
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