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

THE RETIRED PUBLIC EMPLOYEES of ALASKA, INC.,

Plaintiff,

v.

STATE OF ALASKA, DEPARTMENT OF ADMINISTRATION, DIVISION OF RETIREMENT AND BENEFITS

Defendant.

**Case No. 3AN-18-6722 CI**

# PLAINTIFF OPPOSITION TO STATE MOTION FOR SUMMARY JUDGMENT AND CROSS MOTION FOR SUMMARY JUDGMENT

Plaintiff, The Retired Public Employees of Alaska, Inc. ("RPEA") opposes the State's "Motion of Summary Judgment on All Remaining Claims" and cross-moves for summary judgment.

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# I. INTRODUCTION - MAIN CONTENTIONS OF THE PARTIES AND THRESHOLD ISSUE

The key issues in this case turn principally on the holding of the Alaska Supreme Court in *Duncan v. Retired Public Employees of Alaska, Inc.,* 71 P.3d 882, 888, 889 (Alaska 2003).

In *Duncan*, the Court twice rejected the State's argument that it should be allowed to reduce benefits provided by the AlaskaCare Retiree Health Plan of 2003 ("Plan") to save money because of concerns about rising health care costs. *Duncan*, 71 P.3d at 888, 889 The Court also acknowledged the potential problem posed by a "frozen" package of retirement health insurance benefits becoming "obsolescent" as the science of medicine and health care evolves. *Id*. at 891. For that reason, the Court stated that the Plan could be amended for the purpose of preventing the Plan from becoming obsolete.

It recognized that in certain circumstances, adding new coverages might require one or more existing benefits to be reduced or eliminated to "offset" the costs of providing the new coverages. *Id*. However, the Court made clear that when such reductions were necessary, the benefit reductions were subject to certain conditions, limitations and restrictions. *Id*.

This case arose because the Alaska Division of Retirement and Benefits ("DRB") summarily and unilaterally amended the Plan and made changes in Plan administration that resulted in substantial diminishments and impairments of benefits.

The State does not deny that the DRB amended the Plan and made changes in the Plan administration. Although the State has denied that the changes resulted in diminishments or impairments of Plan benefits,[1] its denials are couched in limiting and qualifying language.[2] The reasons for that are revealed by the State's admissions and by

[1] State's Answer to the RPEA's Amended Complaint, p. 6, para. 23.

[2] For example, the State's Answer to the RPEA's Amended Complaint at p. 7, para. 24 states:

evidence presented with this motion, all of which establish that the changes *did* result in substantial diminishments and impairments of Plan benefits.

The State's defense is based primarily on a unique and self-serving reading of *Duncan*. The State seizes on dicta near the end of that opinion to argue that the DRB can make any changes it wants to the Plan as long as what remains provides coverage that is "generally ... 'in keeping with the mainstream' of health insurance packages offered to active public employees in terms of scope and balance."[3]

If the State's interpretation of *Duncan* were adopted, it would not only render most of that opinion meaningless but would also render meaningless the constitutional command, promise and guarantee of Art. XII, § 7 of the Alaska Constitution.

That is a threshold issue for the Court to decide.

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> Admit that because the 2014 changes were **primarily** administrative and did not **significantly** change coverage, neither Commissioner Fisher nor Commissioner Thayer performed, or had performed for them or for the DRB, a formal analysis to confirm that no diminishment had occurred. [emphasis added]

[3] In its April 2014 "Special Addition" newsletter to Plan members, the DRB wrote:

> In 2003, the Alaska Supreme Court ruled that the retiree health plan could be changed and any coverage diminishments should be offset by coverage enhancements as measured by the impact on the entire retiree population. The Court held that the retiree plan should resemble a "mainstream" public employee health plan. But, in many ways, the retiree health plan no longer resembles a mainstream plan. For example, the plan document is over 10 years old and the plan has recently been administered in ways that have provided coverage for treatments that may not be medically necessary.

## II. STATEMENT OF UNDISPUTED FACTS AND ADMISSIONS

The AlaskaCare Retiree Health Care Plan of 2003, with legal amendments, is the defined benefit retirement health plan that until 2014 was provided to certain retired public employees of Alaska who began working for an Alaska government entity before July 1, 2006 and worked long enough to earned vested retirement benefits under the defined benefits retirement plan provided through the State of Alaska. It is referred to here as "the AlaskaCare Plan" or simply as "the Plan."

The AlaskaCare "Retiree Insurance Information Booklet – May 2003" ("the Booklet") and the legal amendments made since May 2003 are, collectively, the legal plan document.[4] RPEA Exhibit 1 is a complete copy of the Booklet with the original Plan language and the Plan amendments promulgated by the DRB from 2003 up through January 2016. In this case, the RPEA has challenged the legality of Plan Amendment 2014-1 and Plan Amendment 2016-2. The Court has issued summary judgment on the legality of Plan Amendment 2016-2. Only Plan Amendment 2014-1 remains at issue. For purposes of this motion, Plan Amendment 2014-1 is referred to as "the Amendment."

Like any insurance policy, the Booklet establishes and controls what coverages and other benefits the Plan provides.[5] Those vested retirement benefits are deferred compensation for work performed. *Metcalfe v. State*, 484 P.3d 93, 99-100 (Alaska 2021)

Art. XII, § 7 of the Alaska Constitution states that the accrued[6] retirement benefits of the public employees of Alaska arise by contract. It also commands that the benefits shall not be diminished or impaired. Because those vested retirements benefits are considered valuable property rights, they are also protected by the Due Process and the

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[4] EXH 11, p. 1 (see para. 2, of Part I. A.)

[5] EXH 11, p. 6; EXH 2, p. 2 (bottom of the page); EXH 6; EXH 18, p. 1 ("the benefits plan will govern") and p. 2 (same); EXH 19 (same).

[6]

Takings provisions of the constitutions of Alaska and the United States, as well as by the law of contracts.

This case concerns the changes that the DRB has made since 2013 to the substance and the administration of the AlaskaCare Retiree Health of 2003  This motion shows some of the most substantial ways the changes resulted in the diminishment or impairment of Plan benefits and the impact on Plan members.  It also shows that the diminishing changes were not done for the reasons authorized by the Supreme Court and did not comply with the requirements, limitations and conditions for making diminishing Plan changes that were established by the Alaska Supreme Court in the *Duncan* case.  They were also not done in compliance with other constitutional and common law protections provided to retirees who earned vested retirement health benefits under the AlaskaCare Retiree health Plan of 2003.

In order to simplify and shorten this memorandum, the facts with supporting citations that are relevant to each argument are presented with that argument.  However, there are some admitted and otherwise undisputed facts, presented here, that are foundational.

The State admits that the vested retirement benefits of the retired public employees of Alaska are valuable property rights.[7] That establishes that they are protected by constitutional rights of Due Process and the constitutional limitations of the Takings provisions.

Before 2014, the Plan provided members with the "free choice" of hospital and doctor for all medical services.  EXH 1, p. 173

From 2009 to 2014, the third-party administrator of the Plan was Wells Fargo/HealthSmart ("HealthSmart"). *See* EXH 2, p. 18 HealthSmart used the Beech Street Network ("Beech Street") of health care providers and Beech Street was the Plan's network for at least 5 years.  *Id.*

[7] Answer to amended complaint, ¶ 44, p. 9.

The DRB described the Beech Street Network to Plan members as "our network."[8] The DRB encouraged Plan members to find and use health care providers within the Beech Street Network by touting the breadth, depth and excellence of the Beech Street Network and by telling them if they chose a provider in Beech Street, they would avoid the risk of balance billing and "help conserve and wisely use the resources of the retiree health trust." *See e.g.*, EXH 3, pp. 1-2

It is undisputed that on December 31, 2013 the DRB summarily promulgated Plan Amendment 2014-1 ("the Amendment"). *See* EXH 1, pp. 11-51. The 40-page Amendment repealed seven provisions and amended nine sections of the Plan that had been in effect. *Id.* at pp. 11-12. It was made effective the next day, January 1, 2014. *Id.* at p. 51. Plan members were not included on the distribution list. *Id.* at p.11

The DRB did not provide Plan members with a copy of the Amendment before it was promulgated. In an undated newsletter mailed to Plan members probably sometime in November or December of 2013, the DRB advised them that "new plan provisions" would become effective on January 1, 2014. EXH. 2, pp. 9-16. The newsletter stated that the changes that were going to be made would "reflect [the DRB's] values and objectives" as it "work[ed] to keep pace with the ever changing medical market." It stated:

> On January 1, 2014, new plan provisions will become effective in both the active and retiree health plans. It is important that you familiarize yourself with them. These plan provisions reflect our values and objectives as we work to keep pace with the ever-changing medical market while providing high-quality, sustainable health care benefits. The health plan documents for both the employee and retiree health plans are being updated to reflect these plan changes and when complete will be available online at AlaskaCare.gov and in print if requested.

EXH 2, p.11

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[8] *See e.g.*, EXH 3, p. 70

That newsletter also told Plan members that the Aetna Life Insurance Company would be taking over as the third-party administrator ("TPA") of the Plan and that Aetna's network of providers would become the Plan's chosen network. EXH 2 They were also told that it would be to their advantage to utilize health care providers within the Aetna Network. *Id.*

They were also told that there would be a substantial expansion in the number of types of medical procedures, treatments and other benefits that would require "pre-certification." The DRB warned them that unless they chose a provider within the Aetna Network, they would be responsible for getting the required precertifications and that the failure to do so would result in significant financial consequences. EXH 2, p. 15

Other than that, it is undisputed that the DRB gave Plan members no other advance notice of the other changes that it would be making to the Plan on January 2014.

As previously brought to the Court's attention, the State has denied that the changes resulted in diminishments or impairments of Plan benefits,[9] but its denials have been couched in limiting and qualifying language.[10]

The State has admitted that it did not perform, or have performed for it, any formal analysis to determine what diminishments could be expected to occur as a result of the changes made to the Plan. Answer to Amended Complaint at p. 7, para. 24. As shown later in this memorandum, managerial level employees in the DRB and in the Dept. of Administration were aware that the Amendment and other changes would result in diminishments of Plan benefits.

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[9] State's Answer to the RPEA's Amended Complaint, p. 6, para. 23.

[10] For example, Para. 24 of the State's Answer to the RPEA's Amended Complaint states:

> Admit that because the 2014 changes were **primarily** administrative and did not **significantly** change coverage, neither Commissioner Fisher nor Commissioner Thayer performed, or had performed for them or for the DRB, a formal analysis to confirm that no diminishment had occurred. [emphasis added]

It is undisputed that before 2014, when cases arose where there was a good-faith basis for questioning whether a particular medical procedure, treatment or supply was medically necessary, HealthSmart, the Plan TPA before Aetna, relied on a set of standards called the Milliman Care Guidelines ("MCGs") for determining medical necessity. *See, e.g.*, EXH 10, p. 2-6 It is also established that when Aetna took over as the Plan TPA, Aetna's Clinical Policy Bulletins ("CPBs") were substituted for the Plan's standards for determining medical necessity. EXH 1, p. 27. There is no evidence that the DRB made any effort to compare the MCGs to Aetna's CPBs to determine how the change might affect coverage decisions in case where there was a good-faith basis for questioning whether a particular medical procedure, treatment or supply was medically necessary under the standards of medical necessity set forth in the Plan. The fact that as soon as Aetna took over the Plan, claims for various types of medical procedures and treatments that had been covered by the Plan when HealthSmart was the Plan TPA suddenly started being denied—as shown later in this motion—is substantial evidence that Aetna opinions about what is a medically necessary treatment or procedure, and what is "experimental," are stricter than the MCGs.

There is no question that the Amendment substantially expanded precertifications for covered medical procedures, treatments and supplies and substantially increased the penalties for failing to obtain those precertifications. As also shown here, senior DRB and DoA officials have admitted that the main reason for dramatically expanding the precertification requirements and for imposing the substantial new financial penalties (and doubling old ones) for failing to get a required precertification was to "steer" Plan members into using health care providers within Aetna's network. EXH. 13, p. 2; EXH 14. The DRB also recognized that the expanded precertifications raised issues of diminishment of benefits. EXH. 13, pp. 3, 5

The DRB has also admitted that the Amendment reduced the amount of the Plan's co-pay" for covered transplant surgeries from 80% to 60% of the cost if the Plan

member did not have the transplant done at an Aetna Network hospital. EXH. 8, pp. 9, 10 and 14; EXH 11, p. 1.

The Court is aware from prior motion practice concerning some of the State's responses to RPEAs requests for admission that after Aetna became the TPA, the top amount the Plan pays for the fees charged by assistant surgeons who are medically necessary for a surgery but who are not in Aetna's network was reduced from 25% to 16% of the amount the Plan pays the principal surgeon, increasing the share left to be paid by the affected Plan member.

It is also undisputed that from 2003 to 2014, the DRB issued a large volume of "benefit clarifications" ("BCs") concerning what the Plan did and did not cover. EXH 5, p. 7; EXH. 11, p. 3; EXH 15, p. 5. Those BCs were never published by the DRB. According to Mike Barnhill, the former Deputy Commissioner of the Dept. of Administration, those BCs were repealed by the DRB at the same time Plan Amendment 2014-1 ("Amendment") was promulgated. EXH 8, p. 6

It is unclear what happened to those benefit clarifications. Although a few were produced in discovery, it was certainly not a large volume. When asked to provide them before this lawsuit, the DRB first reported they could not be located and was uncertain what happened to them. Eventually, an assistant in the Dept. of Administration located only 26 of them. EXH. 12, The problem the DRB allegedly had finding the BCs is odd. During her deposition, the DRB's Chief Health Policy Administrator, Emily Ricci, testified that she knew that some BCs were in the "G" Drive of the State's computer system, hinting that there were a "significant" number of them. EXH 5, p. 4 (depo p. 77)

# III. APPLICABLE LAW AND LEGAL PRINCIPLES PRINCIPALLY RELIED UPON

## A. Constitutional Law

### 1. Alaska Constitution, Art. XII, Section 7

Art. XII § 7 of the Alaska Constitution is a single, stand-alone section dedicated to one subject—ensuring that the vested retirement benefits of retired public employees of Alaska are not diminished or impaired by future Alaska legislatures or administrations. It provides:

> Membership in employee retirement systems of the State or its political subdivisions shall constitute a contractual relationship. Accrued benefits of these systems shall not be diminished or impaired.

The section is a constitutional command, promise and guarantee. It is a promise and guarantee made to the individuals who, in reliance on the contractual agreement and constitutional guarantee, earned vested[11] retirement benefits they were promised as part of their compensation for their state and local Alaska government public service.

It is also a command to all Alaska officials who take an oath to defend and uphold the Alaska Constitution that they do nothing to diminish or impair the vested retirement benefits earned by Alaska public employees.

The Alaska Supreme Court has consistently rejected efforts by the State to erode or circumvent that constitutional provision. See, e.g., *Hammond v. Hoffbeck*, 627 P.2d 1052 (Alaska 1981); *Sheffield v. Alaska Public Employees' Ass'n, Inc.*, 732 P.2d 1083 (Alaska).

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[11] Although the Alaska Constitution uses the term "accrued," courts commonly use the alternate term "vested" when addressing retirement benefits. See, *Hageland Aviation Services, Inc. v. Harms*, 210 P.3d 444, 449 (Alaska 2009) (noting that for purposes of retirement systems, the terms "vested benefits" and "accrued benefits" have the same meaning), citing *Bidwell v. Scheele*, 355 P.2d 584, 586 n.5 (Alaska 1960). The term "vested benefits" is used throughout this memorandum.

1987); *Duncan v. Retired Public Employees of Alaska, Inc.,* 71 P.3d 882 (Alaska 2003); *Metcalfe v. State*, 484 P.3d 93 (Alaska 2021.

In *Duncan*, the Court stated clearly—twice—that it rejects the argument that concerns about rising medical costs can overcome the plain meaning and intent of Art. XII, §7 of the Alaska Constitution. *Duncan*, 71 P.3d at 888, 889.

### a.) Limited Reasons for Change

In *Duncan*, the Court acknowledged the potential problem of a "frozen" package of health insurance benefits becoming "obsolescent" as the science of medicine and health care evolves. *Id*. at 891. To avoid that, the Court held that the Plan could be amended if necessary to prevent its existing coverages from becoming obsolete. *Id*. at 892 The Court did not restrict its discussion to the effects on Plan "coverages" or "benefits." It used the broader, more comprehensive term of Plan "advantages."

The issue of Plan obsolescence arises if a newly developed and approved medical procedure, treatment or device 1) is shown to be an improvement[12] over other existing medical procedures, treatments or devices, and 2) is not already covered by the Plan.

### b.) Limitations on Types of Plan Changes Allowed

The Court made clear that if that Plan changes are necessary to prevent the Plan from becoming obsolete and the addition of the new Plan advantages requires the diminishment or impairment of any existing Plan advantages, then the offsetting advantages and disadvantages must have equivalent value. *Id*. at 892. The Court explained that equivalent

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[12] "Improvement" in this context can include a new procedure or treatment that is as at least as effective as an existing one, costs less and poses no greater risk of harmful side effects, where the risk is assessed not only in terms of the probability of harm but also the potential magnitude of the harm if harm does occurs. See gen., *Clary Ins. Agency v. Doyle*, 620 P.2d 194, 203 n.14 (Alaska 1980)

value should be determined by "reliable evidence" that includes an equivalency analysis done on a group basis and is founded on

> solid statistical data drawn from actual experience—including accepted actuarial sources—rather than by unsupported hypothetical projections. We also believe that, apart from the individualized approach, the other guidelines concerning equivalency analysis set out in *Hoffbeck* [627 P.2d 1052 (Alaska 1981)] should continue to be generally applicable. Further, we reiterate that equivalent value must be proven by a comparison of benefits provided—merely comparing old and new premium costs does not establish equivalency

*Duncan*, 71 P.3d at 892 (footnotes omitted)

The Court was careful to make clear that even in cases where it was necessary to reduce or eliminate a Plan "advantage" in order to "offset" the cost of the new coverage, it was not giving the DRB *carte blanche* to reduce or eliminate whatever Plan advantage(s) it wanted. The Court explained that not only must the advantages and disadvantages be comparable in terms of kind or type, but the State's equivalency analysis needed to show that they "offset" each other in terms of the actual impacts the changes would have on Plan members as a group. The Court stated:

> [O]ur opinion in this case should not be interpreted as approving major deletions in the types of coverage offered during an employee's term. Coverage 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.

*Duncan*, 71 P.3d at 892

The Court also made a special point of stating that if any Plan member could make "an individual showing that a change results in a serious hardship that is not offset by comparable advantages, the affected individual should be allowed to retain existing coverage." *Id*. The statement is important for more than the fact that it provides a means for Plan members to obtain protection against serious hardship when they can show they are will suffer from the Plan changes.

The key phrase is "retain existing coverage." The fact that the Court stated that those Plan members "should be allowed to retain existing coverage" shows that the Court intended that Plan members be given notice of diminishments *in advance* so they have the opportunity to take steps necessary to retain the existing coverage *before* it is taken away.

Less than a year ago, in *Metcalfe v. State*, 484 P.3d 93 (Alaska 2021), the Alaska Supreme Court again made very clear that it is committed to upholding the Alaska constitutional command, promise, and guarantee that the vested retirement benefits of the retired public employees of Alaska shall not be diminished or impaired. It wrote:

> Interpreting [Art. XII, § 7 of the Alaska Constitution], we have described retirement benefits as a form of deferred compensation, an element of the bargained-for consideration given in exchange for an employee's assumption and performance of the duties of his employment.
>
> […]
>
> Our case law suggests that 'accrued benefits' should be defined broadly. Accrued benefits 'include[] all retirement benefits that make up the retirement benefit package that becomes part of the contract of employment when the public employee is hired' —**not just dollar amounts, but the practical effect of the whole complex of provisions**. Accrued benefits 'arise by statute, from the regulations implementing those statutes, and from the [Division of Retirement and Benefits'] practices.
>
> […]
>
> When determining whether accrued benefits have been diminished or impaired for purposes of article XII, section 7, we disregard the form of the change ... **in favor of its impact**.

*Metcalfe,* 484 P.3d at 97-98 (footnotes and quotation marks omitted, emphasis added).

In his ruling of April 13, 2020 in this case, Judge Aarseth acknowledged that under *Duncan*, the Plan "may be amended *under limited circumstances* to keep [it] from becoming obsolete," and that "the concern of rise of medical costs, and other 'practical considerations,' is not sufficient to allow diminishment." Order at p. 6 (Emphasis added.)

He also acknowledged that *Duncan* required "a strict diminishment analysis" of Plan changes, and that the Court "will consider the *high standard prohibiting diminishment of benefits* and the retirees' reliance and trust in those who facilitate the Plan." *Id*. at pp. 6-7 and 9.

### 2. Constitutional Due Process Rights and Takings Protections

The parties agree that vested retirement benefits are valuable property.[13] As valuable property, they are protected by the Due Process[14] and the Takings[15] provisions of both the Alaska Constitution and the Constitution of the United States.

#### a.) Due Process Protections

Art. I, §7 of the Alaska Constitution provides in relevant part: "No person shall be deprived of life, liberty, or property, without due process of law." Both the Fifth Amendment and the Fourteenth Amendment of the United States Constitution guarantee persons Due Process when the government seeks to deprive a person of life, liberty, or property. "Due process of law requires that before property rights can be taken directly or infringed upon by governmental action, there must be notice and opportunity to be heard."[16]

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[13]. *See* Amended complaint, ¶ 44, p. 13; Answer to amended complaint, ¶ 44, p. 9.

[14] Art. I, § 7 of the Alaska Constitution and Amendments V and XIV of the Constitution of the United States Constitution prohibit the State from depriving a person of property without Due Process of the law, including the right to be given reasonable notice and an opportunity to be heard before any deprivation occurs.

[15] Art. I, § 18 of the Alaska Constitution ("Private property shall not be taken or damaged for public use without just compensation.") The relevant part of the Fifth Amendment to the Constitution of the United States provides: "[N]or shall private property be taken for public use, without just compensation."

[16] *Herscher v. State, Dept. of Commerce*, 568 P.2d 996, 1002 (Alaska 1977) (emphasis added); *Frontier Saloon, Inc. v. Alcoholic Beverage Control Bd.*, 524 P.2d 657, 659 (Alaska 1974) (same, citing *inter alia, Fuentes v. Shevin*, 407 U.S. 67 (1972) and *Mullane v. Central Hanover Trust Co.*, 339 U.S. 306, 313, (1950).

One of the fundamental requirements of Due Process is reasonable notice and opportunity to be heard at a meaningful time and in a meaningful manner.[17]

> The United States Supreme Court has said that to comply with due process requirements, notice 'must be given sufficiently in advance of scheduled court proceedings so that reasonable opportunity to prepare will be afforded.' The Court has emphasized that the hearing must occur **before** the property interest is taken away. [emphasis added]

*State, Dept. of Natural Resources v. Greenpeace, Inc.*, 96 P.3d 1056, 1064 (Alaska 2004) (footnote/citations omitted; emphasis added)

Due process and the fundamental fairness it embodies[18] require that all persons whose property rights the State proposes to take or infringe upon be given notice that informs them of the proposed action, the specific property rights that the State is attempting to take or infringe and the reasons for the action.[19]

### b.) Prohibition of Government Taking of Property

The 5th Amendment to the U.S. Constitution commands that private property shall not be taken for public use without just compensation. Art. I, § 18 of the Alaska Constitution states that "[p]rivate property shall not be taken or damaged for public use without just

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[17] *Goldberg v. Kelly*, 397 U.S. 254, 267 (1970)

[18] See, *P.M. v. State, Dep't of Health & Soc. Servs., Div. of Fam. & Youth Servs.*, 42 P.3d 1127, 1133 (Alaska 2002) ("Fundamental fairness is the main requirement of the due process clause.")

[19] See *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306, 314–15 (1950); see gen., *Wetherhorn v. Alaska Psychiatric Institute*, 156 P.3d 371, 380 (Alaska 2007) ("[D]ue process requires that the notice of a hearing must be appropriate to the occasion and reasonably calculated to inform the person to whom it is directed of the nature of the proceedings. Due process also requires that a respondent be notified in such a manner that respondent has a reasonable opportunity to prepare.") (footnote/internal quotes omitted)

compensation." Like its federal counterpart, the Takings provision applies to personal property as well as real property.[20]

However, the Takings provision of the Alaska Constitution provides greater protections than the Takings Clause of the U.S. Constitution. The Alaska Supreme Court interprets the Alaska Takings Clause liberally in favor of the property owner, whom it protects "more broadly" than the federal Takings Clause.[21]

In sum, the vested retirement benefits earned by the retired public employees of Alaska are valuable property and therefore are protected by the Takings provisions of the Constitution of Alaska and the Constitution of the United States. Any diminishment or impairment of those benefits by the DRB requires the State to provide Plan members with just compensation, including interest.[22] The failure to provide Plan members with such compensation violates the Takings provisions of the Alaska and U.S. constitutions.

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[20] *Brewer v. State*, 341 P.3d 1107, 1111 (Alaska 2014) ("This protection [of the Alaska Takings provision] applies to personal as well as real property and allows compensation for temporary as well as permanent takings.") (footnotes omitted)). *Horne v. Department of Agriculture*, 576 U.S. 350, 358 (2015) ("Nothing in the text or history of the Takings Clause, or our precedents, suggests that the rule is any different when it comes to appropriation of personal property.")

[21] *Brewer*, 341 P.3d at 1111 (Alaska 2014) ("We liberally interpret Alaska's Takings Clause in favor of property owners, whom it protects more broadly than the federal Takings Clause.") (footnotes and internal quotations omitted)

[22] The duty to pay Plan members interest is both constitutionally and statutorily required. AS 39.35.520(d) states in relevant part:

> The plan shall pay interest on amounts owed to a [Plan] member or beneficiary. […] The interest paid under this subsection is at the rate established by regulation for indebtedness contributions owed. Interest accrues from the date on which the correct payment was due.

Requiring a Plan member to pay medical costs that should have been paid by the Plan deprives the Plan member of the use of those funds. Because that deprivation is done by the government, the payment of interest is part of the just compensation required by the Takings provisions of the constitutions of Alaska and the United States. *State v. Doyle*, 735 P.2d 733, 736 (Alaska 1987) ("We have also stated: 'The term just compensation implies full indemnification to the owner for

## B. Common Law Protections for Vested Retirement Health Benefits

### 1. Common Law of Contracts

The vested retirement benefits earned by the public employees of Alaska arise from contract. Art. XII, § 7, Alaska Constitution. Alaska's common law of contracts provides that every contract made in this State contains "an implied covenant of good faith and fair dealing that neither party will do anything which will injure the right of the other to receive the benefits of the agreement." *Guin v. Ha*, 591 P.2d 1281, 1291 (Alaska 1979). "When one party acquires vested rights under a contract, the other party may not amend the terms of the contract so as to unilaterally deprive the first of its rights." *Zuelsdorf v. University of Alaska*, 794 P.2d 932, 935 (Alaska 1990)

### 2. Fiduciary Duties the DRB Owes to Plan Members

Judge Aarseth ruled that in addition to the duty of good faith and fair dealing, the DRB owes Plan members the fiduciary duties of undivided loyalty and the disavowal of self-interest. Order of April 13, 2020. "The duty of a fiduciary embraces the obligation to render a full and fair disclosure to the beneficiary of all facts which materially affect their rights and interests." *Greater Area Inc. v. Bookman*, 657 P.2d 828, 830 (Alaska 1982); *Carter v. Hoblit*, 755 P.2d 1084, 1086 (Alaska 1988)

Since at least 2013, the DRB itself has been assuring Plan members in the newsletters it sends to them that it also owes them the fiduciary duty to provide them with information about their benefits and any changes to the Plan, stating:

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the property taken. In other words, the property owner should be placed as fully as possible in the same position as he was in prior to the taking of his property.' ") (emphasis in original). And see *Otay Mesa Prop., L.P. v. United States,* 779 F.3d 1315, 1327 (Fed.Cir.2015) ("The Supreme Court has long held that 'just compensation' includes interest compounded from the date of a taking when payment for the taking does not coincide with the taking itself." (citing, *Phelps v. United States,* 274 U.S. 341, 344 (1927); *Seaboard Air Line Ry. Co. v. United States,* 261 U.S. 299, 306 (1923))

> The Division has a fiduciary duty to provide both its active and retired members with information regarding their health and retirement benefits, including but not limited to benefit education, plan enrollment, and any changes in the plans. [...] It is necessary to keep our members up to date on current information and educational opportunities concerning their health and retirement benefits.

See, *.e.g.*, EXH 2, pp. 8, 16, and 47

Whether based on a fiduciary duty or simply on the assurances the DRB has given to Plan members that it would provide them with information about Plan benefits and Plan changes, the information the DRB is obligated to provide to Plan members must be correct, complete and not misleading. *Carter* 755 P.2d at 1086; *Bookman*, 657 P.2d at 830

## C. Burden of Proof

If a fiduciary engages in conduct that benefits itself under circumstances that raise a substantial question whether the conduct was at the expense of the beneficiaries whose interests the fiduciary is required to serve with undivided loyalty and the disavowal of self-interest, then the fiduciary bears the burden of proving by clear and convincing evidence that beneficiaries' interests were not harmed by the fiduciary's conduct.[23]

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[23] *Williams v. Baker*, 446 P.3d 336, 340 (Alaska 2019); see *Knaebel v. Heiner*, 663 P.2d 551, 553 (Alaska 1983); *Miller v. Sears*, 636 P.2d 1183, 1190 (Alaska 1981), Also,

> Where one in a special relationship—either fiduciary or confidential—deals with the person whose interests he is under a duty to represent, there is great opportunity for him to abuse the confidence reposed in him. Courts have therefore said that where he deals with the persons he represents, the burden is upon him to justify the transaction if it is later attacked, and that unless he sustains the burden of showing that it is fairly made, he may be made to disgorge any gains he received in the transaction.

D. Dobbs, *Remedies*, § 10.4 et seq. (1973) (footnote omitted)

However, there is another, separate reason why the DRB bears the burden of proof. It is well-established in the law that where a party controls the key evidence on an issue, that party bears the burden of proof on that issue.[24] In this case, that party is the State/DRB and its agent, Aetna.

The *Duncan* opinion establishes that when changes are made to the Plan that result in any diminishment or impairment of a Plan benefit, the burden is on the State to prove that comparable new Plan benefits or "advantages" were added that were of "equivalent value." *Duncan* also states that equivalent value "must be proven by a comparison of benefits provided—merely comparing old and new premium costs does not establish equivalency." *Duncan*, 71 P.3d at 892.

Of course, it would be irrational to require the RPEA to prove that the DRB added new benefits of a comparable type to offset the benefits reduced ("disadvantages") and that the benefits added (Plan "advantages") had an equivalent value. For that simple reason, the State bears the burden of proof on those issues.

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[24] See *Sloan v. Jefferson*, 758 P.2d 81, 83 (Alaska 1988), citing with approval *Dixon v. Anadarko Prod. Co.,* 505 P.2d 1394, 1396 (Okla.1972). And see gen., *Hydaburg Co-op Ass'n of Hydaburg v. Hydaburg Fisheries*, 826 P.2d 751, 757 (Alaska 1992) ("It is also consistent with the general policy of placing the burden on the party that controls the proof."). Relying on a U.S. Supreme Court opinion, a federal district court in the District of Columbia wrote:

> As the Supreme Court has explained, it is 'entirely sensible to burden the party more likely to have information relevant to the facts about [the matter at issue] with the obligation to demonstrate [those] facts.... Such was the rule at common law.' *Concrete Pipe & Prods. v. Constr. Laborers Pension Trust*, 508 U.S. 602, 626, 113 S.Ct. 2264, 124 L.Ed.2d 539 (1993)

*Elec. Priv. Info. Ctr. v. Dept. of Justice*, 416 F. Supp. 2d 30, 40 (D.D.C. 2006)

See also, *United States v. N.Y., New Haven & Hartford R.R. Co.,* 355 U.S. 253, 256 n. 5, (1957) ('The ordinary rule, based on considerations of fairness, does not place the burden upon a litigant of establishing facts peculiarly within the knowledge of his adversary.').

## D. Legal Standards for Summary Judgment

Summary judgment is warranted where "there is no genuine issue as to any material fact" and "the moving party is entitled to judgment as a matter of law."[25] "[A] material fact is one upon which resolution of an issue turns."[26] "The moving party bears the initial burden to show an absence of a material fact and that it is entitled to judgment as a matter of law."[27]

Once the burden shifts, the non-moving party must "set forth specific facts showing that he could produce evidence reasonably tending to dispute or contradict the movant's evidence."[28] The facts and all factual inferences must be viewed in the light most favorable to the non-moving party.[29] But the non-moving party cannot create a genuine issue of material fact by offering evidence "too conclusory, too speculative, or too incredible to be believed."[30] "[S]ummary judgment is appropriate only when no reasonable person could discern a genuine factual dispute on a material issue."[31]

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[25] *Alaska R. Civ. P. 56(c)*

[26] *Christensen v. Alaska Sales & Service, Inc.,* 335 P.3d 514, 519 (Alaska 2014)

[27] *Kelly v. Municipality of Anchorage*, 210 P.3d 801, 803 (Alaska 2012)

[28] *Christensen*, 335 P.3d at 517.

[29] *Kelly*, 270 P.3d at 803.

[30] *Christensen*, 335 P.3d at 516.

[31] *Id.*

# IV. ARGUMENT

## A. Facts and Arguments Relevant to Diminishment and Impairments of Plan Benefits as a Result of the Amendment

### 1. Ceasing To Provide Network Benefits to Plan Members Whose Providers Are in the "Beech Street" Network

According to the DRB, **during the first month** after the Amendment and Aetna took over as the Plan TPA, (January 2014), the DRB, Aetna and Moda (the dental TPA) call centers received **50,000 calls from Plan members**. EXH. 2, p. 18 The following month, the DRB mailed a newsletter to Plan members to address "several issues that arose during the transition." *Id*. at p. 17. Presumably those "several issues" were among the main concerns expressed by the Plan members who made those 50,000 calls, as well as other Plan members who communicated their concerns to the DRB by mail and email during that month. One of the "several" issues addressed in the DRB's February 2014 newsletter concerned the consequences of changing the Plan's preferred network of healthcare providers from the Beech Street Network to the Aetna Network. EXH 2, p. 19

The relationship between a patient and doctor is a fiduciary one. It embodies confidence, reliance and a trust that develops over time.[32] Continuity of care is an important part of that relationship and improves the quality of the health care provided.[33]

> [S]everal district and circuit courts have found that disruption of the physician-patient relationship can cause irreparable harm that justifies issuing preliminary injunctive relief, particularly when the patient belongs to a vulnerable class or may have a deep trust relationship with the physician because of the serious nature of the patient's illness or medical needs. *Schisler*

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[32] *See gen*., *Pedersen v. Zielski*, 822 P.2d 903, 909 (Alaska 1991). *See also*, EXH 27*

[33] *Gilmore v. Decker*, 2020 WL 1443198, at p. 7 (S.D. Ind. Mar. 25, 2020) ("Proper medical treatment requires consideration of a person's medical history and continuity of care among medical providers [...]. The lack of continuity of care also undermines meaningful review of the medical records by upper-level providers.").

> *v. Heckler,* 574 F.Supp. 1538, 1552–53 (W.D.N.Y.1983); *see also Roudachevski v. All–Amer. Care Ctrs., Inc.,* 648 F.3d 701, 706–07 (8th Cir.2011). Other district courts have also found that dropping certain physicians from insurance plans, or altering elderly patients' access to specialists by terminating provider plans with those physicians, may cause irreparable harm and offend the public interest. *See, e.g., Barron v. Vision Serv. Plan,* 575 F.Supp.2d 825, 835–36 (N.D .Ohio 2008).

*Fairfield Cty. Med. Ass'n v. United Healthcare of New England*, 985 F. Supp. 2d 262, 271 (D. Conn. 2013), *aff'd as modified sub nom. Fairfield Cty. Med. Ass'n v. United Healthcare of New England, Inc.*, 557 F. App'x 53 (2d Cir. 2014)

From 2009 to 2014, the DRB subscribed to the Beech Street Network of healthcare providers for purposes of administering the Plan. EXH 2, pp. 18, 70; EXH 15, p. 15 Beech Street, like other health care provider networks, is composed of health care providers who have agreed to accept discounted fees in return for prompt payment and some expectation that their membership in the network may lead to an increased patient volume.[34] The Beech Street Network is a “rental network” used by health insurers and health plans that do not have their own proprietary provider network.[35] EXH 3, p. 5

Since at least 2009, the DRB, through HealthSmart, encouraged AlaskaCare Plan members to find and use healthcare providers who were part of the Beech Street network. It did so by assuring Plan members that providers in the Beech Street network accepted the amount paid by the Plan as payment-in-full, meaning that Plan members would not be “balance billed” by that provider; that is, billed for the difference between what the provider normally charged for the service and the amount the Plan paid. EXH 3, pp. 2-4

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[34] See, *e.g*. EXH. 3, p. 6.

[35] See, *Aetna Life Ins. Co. v. Huntingdon Valley Surgery Ctr.*, 703 F. App'x 126, 129 (3d Cir. 2017); see also, *W. St. Paul Fed'n of Tchrs. v. Indep. Sch. Dist. No. 197, W. St. Paul*, 713 N.W.2d 366, 373 (Minn. Ct. App. 2006)

When Aetna became the Plan TPA in 2014, Plan members were told that if they wanted to avoid the risk of balance billing in the future, they would need to find and use health care providers in the Aetna network. EXH 2 That created a serious dilemma for all the Plan members who, in reliance upon the past assurances and the encouragement of the DRB, had selected and established long-term, trusted doctor-patient relationships with health care providers within the Beech Street Network. They could either continue to receive care and treatment from their established and trusted providers and be subjected to balance-billing, or they could try to find a health care provider within the Aetna network and (assuming they were able to do so[36]), then give up the long-standing doctor-patient relationship they had established with their Beech Street Network provider(s).

The DRB admitted in its February 2014 newsletter that the DRB recognized that Aetna's Alaska network was "not fully developed at this time." EXH 2, p. 19. It told retirees:

> Our goal is to, over time, as network options become more accessible, reduce the precertification list, and shift the responsibility for complying with this list to the provider.

EXH 2, p. 19.

It is worth repeating that prior to this time, for at least the previous 5 years, the DRB had been encouraging Plan members to seek out and develop doctor-patient relationships with health care providers within the Beech Street Network. Now, over a month after Aetna became the Plan TPA, the DRB was telling them they should seek providers in the Aetna network which, by the DRB's own admission, was "not fully developed" and with work

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[36] There is, of course, no assurance that in all parts of Alaska and elsewhere in the U.S. there even is an Aetna network provider practicing in the specialty the Plan member needs who is located reasonably close by and taking new patients. Therefore, as a practical matter, some affected Plan members might not even have a choice of an Aetna network provider. And if their regular health-care provider was in the Beech Street Network, the DRB's choice to drop that network in favor of Aetna's was likely to have significant financial consequences by suddenly subjecting the Plan member to balance-billing.

needing to be done to try to make Aetna's network options in Alaska "more accessible" to Plan members.

The DRB could have easily avoided that problem and the resulting diminishments and impairments it caused. The Beech Street website specifically states that it is available for use as both a primary and complimentary network. EXH 3, p. 5 The DRB could have continued to rent Beech Street as a complimentary or companion network to Aetna's. That solution would have allowed Plan members to continue receiving care and treatment by their established providers within the Beech Street Network without the threat of balance-billing. Plus, the addition of the Aetna network to the Plan also would have given Plan members a greater choice of providers who were at least in one of two provider networks who would then have been used by the Plan.

Instead, the DRB chose to put the State's own financial interests ahead of the interests of Plan members, forcing them to choose between giving up their valued, established doctor-patient relationships or continuing those relationships and face the risk of balance billing. That violated the Plan's promise of the "free choice" of hospital and provider[37] by exposing Plan members to financial consequences if their chosen provider was not within the Aetna network.

In these ways, the DRB's choice to drop the Beech Street Network and substitute the Aetna Network in its place resulted in diminishments and impairments of Plan benefits for the affected retirees.

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[37] *See* EXH 2, p. 173, (Booklet page 107)

### 2. The Addition of Numerous Precertification Requirements and Doubling of Penalties for Failing to Obtain Precertifications

Another one of the “several issues” addressed in the DRB’s February 2014 newsletter as a result of the 50,000 calls Plan members made the previous month was the expanded precertification list. EXH 2, p. 19

#### a.) Required Precertifications and Penalties Before the Amendment

Before 2014, the Plan specified that “to receive full benefits,” Plan members were required to get “certification” (meaning “pre-certification” or “pre-authorizations”[38]) for the following:

- Confinement in a hospital, treatment facility, or skilled nursing
- Mental health or chemical dependency treatment;
- Home health care or skilled nursing care services;
- Two outpatient procedures (MRI of the knee and MRI of the spine); and
- Travel expenses for purposes of medical care, with certain exceptions.[39]

EXH 1, p. 94-95 ( Booklet p. 27-28), as amended EXH 1, p. 53 (Booklet p. xlvii)

Failing to obtain a required precertification before 2014 resulted in a financial penalty in the form of a $200 reduction in the benefit except for two benefits that required precertification where the financial penalties were greater.[40]

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[38] *See* EXH 1, pp. 11-12.

[39] The Plan provided that preauthorization for travel was waived for emergencies and when travel was for surgery “which is provided less expensively in another location.” EXH 1, p. 107-109 ( Booklet pp. 41-43)

[40] The financial penalty for failing to obtain a required precertification for a hospital stay was $400. EXH 1, p. 96 ( Booklet p. 30) For failing to obtain required precertification for travel, the penalty was the forfeiture of any coverage provided for the costs of that travel. EXH 1, p. 107 ( Booklet p. 41)

### b.) Required Precertifications and Penalties Added by the Amendment

The Amendment added 27 new precertification requirements and doubled the $200 financial penalties for failing to obtain a required precertification to $400. The 27 procedures and treatments added to the precertification list include:

- Autologous chondrocyte implantation, carticel (injection into the knee of cartilage cells grown from tissue cultures)
- Cochlear implant (surgical implant of a device into the ear to try to improve hearing)
- Cognitive skills development
- Customized braces (physical – i.e., non-orthodontic braces)
- Dental implants and oral appliances
- Dialysis visits
- Dorsal column (lumbar) neurostimulators: trial or implantation (for relief of severe pain)
- Electric or motorized wheelchairs and scooters
- Gastrointestinal tract imaging through capsule endoscopy
- Hyperbaric oxygen therapy
- Limb prosthetics
- Oncotype DX (a method for testing for genes that are in cancer cells)
- Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint (reconstructive surgeries to attempt to correct structural abnormalities of the jaw bones)
- Organ transplants

- Osseointegrated implant

- Osteochondral allograft/knee (grafting of cartilage and bone from a cadaver to the knee joint)

- Proton beam radiotherapy

- Reconstruction or other procedures that may be considered cosmetic

- Surgical spinal procedures

- Uvulopalatopharyngoplasty, including laser-assisted procedures (surgery to reconfigure the soft palate to try to help with sleep apnea)

- Ventricular assist devices

- Intensive outpatient programs for treatment of mental disorders and substance abuse, including:
  — Psychological testing
  — Amytal interview
  — Electroconvulsive therapy
  — Neuropsychological testing
  — Outpatient detoxification
  — Psychiatric home care services

EXH 1, pp. 18-20 ( Booklet pp. xii – xiv)[41]

As described above, Plan members were told that they were responsible for obtaining the necessary precertifications unless they chose to use a health care provider who was within the Aetna Network.

By adding the 27 procedures and treatments to the precertification list and doubling the financial penalties for failing to obtain the required precertification before receiving the

[41] Two years after the Amendment, the DRB removed the precertification requirement for the "Amytal interview" and "Electroconvulsive therapy" EXH 1, p. 8 ( Booklet p. ii)

procedure, treatment or other benefit, the Amendment provided substantial coercive pressure on Plan members to "steer" them to obtain medical care from providers and hospitals within Aetna's network.

"Steering" in the context of health insurance is the term used by insurers and plan administrators to describe the two methods—carrot and stick—used to attract or coerce insureds into using an insurer's network of providers.

Telling Plan members that they if they use a provider within a network utilized by AlaskaCare, they will avoid the risk of being "balance billed," is a "carrot" form of steerage. It involves no threat of reduction in Plan benefits.

On the other hand, telling Plan members that if they do not use an Aetna network provider, they will have to do more work to obtain certain Plan benefits (*i.e.*, be responsible for getting the required precertifications), and will suffer substantial financial penalties if they fail to do so, is a coercive "stick" form of steerage. Beginning in 2014, the DRB used the "stick" form of steerage.

The DRB was unquestionably aware that the expanded precertification requirements, and substantially increased financial penalties for failing to comply would coercively pressure Plan members into using providers and hospitals in Aetna's network. In an August 2013 memo that specifically concerned the expanded precertification requirements, James Puckett, then the Director of the DRB, wrote:

> [T]he significant expansion of the precertification list [will result in] waves of unhappy phone calls, especially from [Plan] members using out-of-network providers or in areas of few or no [Aetna] in-network providers.

EXH 13, p. 1.

This establishes that the DRB was aware of the issue and the negative impact the change would have on Plan members. His main concern, however, was not the impact the change would have on retirees. Instead, it was the "high impact" the expanded precertification list

would have on the DRB's Member Service Call Center because it was "very possible supervisors [would] be negatively impacted by the volume of escalated calls." *Id.*

Mr. Puckett's memo also reveals the real reason for the expanded precertification requirements. He observed that because the Amendment would require Plan members whose providers were not in Aetna's network to contact Aetna in advance to get precertification for those procedures and treatments, it would give "Aetna an opportunity to steer members to an [Aetna] in-network provider." *Id.* He also noted that the expanded precertification would give Aetna more opportunities to discourage Plan members from getting medical procedures and treatments that, in Aetna's opinion as expressed in its CPBs, were "unnecessary." *Id.* at p. 2

Mr. Puckett expressly recognized that the expanded precertifications raised the issue of diminishment of benefits. He wrote that it was "undetermined" if the change would be considered a diminishment of benefits and that "[f]urther clarification was needed." *Id.* at p. 3 There is no evidence that any "further clarification" was ever obtained by the DRB.

The State's Chief Medical Officer, Ward Hurlburt, M.D., who was actively involved in the 2014 Plan changes, argued that both the expanded precertifications and the increased penalties did not go far enough. He urged the DRB to incorporate all of "Aetna's list of precertification requirements including the special programs list" into the Plan. He felt that should be done because it would "be easier for Aetna to administer [the Plan] on our behalf and also is broader than the proposed list" of procedures requiring expanded precertification. EXH 15.

In addition, Dr. Hurlburt urged that the $200 penalty for failing to obtain a required precertification was too low. *Id.* In his view, it was "so low" that it would "not deter unwanted behavior (use of non-network providers)." *Id.* He wrote that the DRB needed to "foster meaningful steerage" of Plan members to Aetna network providers "to be in good faith with our contracted [Aetna] network providers." *Id.* He also expressed concern that a "non-network provider could agree with their patient to accept what the state normally pays

– and thus subvert the intent to steer." *Id*. He argued that a "larger co-insurance provision in addition to" an increased financial penalty for failing to obtain certification would "help assure steerage." *Id*.

The fact that the Amendment doubled the penalty imposed on Plan members for failing to obtain precertification from $200 to $400 is evidence that the DRB adopted Dr. Hurlburt's recommendation.

Confirmation that the main purpose of the "expanded precertification list" was to "steer" Plan members to Aetna's network providers is provided by the uncontroverted evidence of what Plan members were told during the DRB's "town hall" meeting held with retirees in the spring of 2014, shortly after the Amendment was promulgated. A Powerpoint slide shown during those presentations assured retirees that once Aetna network usage by Plan members was "sufficient," the expanded list of required precertifications would be eliminated. EXH 16, p. 10 (Slide 20)

For these reasons, the expanded precertification requirements, along with the doubling of the penalties from $200 to $400 for failing to obtain a required precertification, were diminishments and impairments to Plan benefits. They were impairments because they imposed new barriers that Plan members needed to surmount to receive full Plan benefits if their providers were not in Aetna's network. Plan members who had long-established and trusted relationships with health care providers who were in Beech Street Network and not in Aetna's network were pressured to make a difficult choice. They were forced to choose between either: 1) staying with their trusted providers and the continuity of care they provided and being exposed to balance billing and the burden of getting required precertifications or suffering substantial financial penalties; or 2) giving up their established doctor-patient relationships with healthcare providers outside Aetna's network and trying to find and establish new doctor-patient relationships with providers who were in Aetna's network. Forcing that choice is another way the DRB's substitution of the Aetna Network

in place of the Beech Street Network diminished and impaired the free choice of hospital and provider promised by the Plan.

For all these reasons, the expanded precertification list and increased penalties for failing to obtain the required precertifications resulted in the diminishment and impairment of benefits.

### 3. Diminishment of Benefits for Transplant Surgeries

The Amendment substantially reduced benefits provided for transplant surgeries needed by Plan members if they chose to have the transplant performed at hospital that was not within Aetna's network. That diminished and impaired Plan members' free choice of physician and hospital for transplant surgeries. For those Plan members who chose to have the surgery done at a hospital that was not part of Aetna's network, the Amendment imposed serious financial consequences that were also diminishments in the benefits provided for those surgeries.

As discussed above, before 2014, the Plan provided members with the free choice of hospital and doctor for all medical services. *See* EXH 2, p. 173, ( Booklet page 107) The freedom to choose one's health care provider and hospital is a contractual right and an important Plan benefit regardless of the medical condition or treatment. A free choice of providers and hospitals can provide Plan members with the increased peace of mind that comes from having a broad choice of medical professionals and facilities to diagnose medical issues and provide treatment and care, especially for serious illnesses and conditions. In cases involving transplant surgeries, the choice of hospital and doctor may be influenced by additional factors not often involved in other types of surgeries.[42]

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[42] For example, a Plan member patient receiving a transplant from a living donor might want the surgery performed in the city where the donor lives to make it as convenient as possible for the donor. The Plan member might also choose a location where family members or close friends live who can provide post-surgery housing and care during recovery. The patient might also choose to

Before the Amendment, after the deductible and $800 annual out-of-pocket expenses were satisfied by the Plan member, medically necessary transplant surgeries were covered like other surgeries in accordance with the terms of the Plan, which provides coverage for 100% of the "Recognized Charge" for the medical services and supplies associated with those surgeries.

The Amendment changed that. It required Plan members to have transplant surgeries done at one of Aetna's network hospitals as a condition of receiving the full benefits that the Plan, as amended, provided for transplant surgeries.[43] It provided that if a Plan member chooses to have the transplant done at an Aetna network hospital, then the Plan provides an 80% co-pay for the procedure and up to $10,000 in covered travel expenses. EXH 1 p. 13 ( Booklet p. vii); EXH 15, p, 9 (Slide 19)

The Amendment does not stop there. It also penalizes Plan members who choose to have their transplant surgery done at a hospital *not* within Aetna's network by reducing the amount of the co-pay a full 25% (from 80% to 60%), and by eliminating coverage for travel expenses, even though before 2014, with preauthorization, the Plan covered certain travel expenses to receive treatment "not available in the area you are currently located in to obtain treatment." This fact was admitted by former Dept. Of Administration Commissioner Curtis Thayer. EXH. 11, P. 1. *And see*, EXH 1 p. 13 ( Booklet p. vii); EXH 16, p. 9 (Slide 19); EXH 1, 108; Booklet pp. 42-43 The DRB reduced the co-pay from 80% to 60% for

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have the surgery done by a surgeon who the patient knows personally or who has been highly recommended by a trusted physician, family member or other source the patient considers reliable.

[43] Aetna calls its network hospitals where transplant can be performed its "Institutes of Excellence" ("IOE"). Plan members are told that to get full Plan benefits for their transplant surgeries, they must have the transplant done at a hospital designated by Aetna as an Institute of Excellence, implying that any other hospital they might be considering that is not an Aetna designated "IOE" network hospital does not provide as high a quality of surgery or care as an Aetna network hospital. That is another subtle way, and a misleading one, that Plan members are being "steered" to use an Aetna network hospital as a result of the Plan administration changes implementing Amendment.

transplants done outside the Aetna network because Aetna "recommended" that it do so. EXH 8, p. 13.

Transplant surgeries are expensive. The results of a survey published in *Fortune* magazine in 2017 show the average costs of various organ transplants in the U.S. at that time. It reveals that the average cost of a kidney transplant, the most common of organ transplants, was $414,800.[44] A reduction in the Plan co-pay from 80% to 60% of the cost of a kidney transplant is a substantial financial consequence. Based on the average cost of a kidney transplant as reported in the *Fortune* article, a Plan member who wanted to have the transplant done at a hospital and by a physician *not* in the Aetna network faced the prospect of having to pay $83,000 *more* out-of-pocket than if the Plan member chose a hospital and physician within the Aetna network.

Mike Barnhill, the former Deputy Commissioner of the Alaska Dept. of Administration, acknowledged to Plan members during town DRB's "hall meetings" in the spring of 2014 that the Amendment reduced the Plan's co-pay share of the transplant surgery costs from 80% to 60% if the Plan member had the transplant done at a hospital not in Aetna's network. EXH 8, pp. 9-10, 13-14. *See also*, EXH 9 and EXH 13, p. 5. EXH 16, p. 9 (Slide 19) He also stated that one of the main purposes of the penalty was to "steer" Plan members to Aetna hospitals. EXH 8, p. 14.

Warning Plan members who need a transplant that their Plan co-pay benefits will be reduced 25% and that they will not be entitled to travel benefits if they do not have the transplant done at an Aetna network hospital is coercive and diminishes and impairs the Plan benefits for transplants in two ways. First, it diminishes and impairs the benefit of "free choice of hospital and provider." Second, for those Plan members who choose to have

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[44] *See*, https://fortune.com/2017/09/14/organ-transplant-cost/ (last accessed Jan. 27, 2022). During one DRB "town hall" meeting with retirees, former Dep. Commissioner Barnhill included transplants in the category of "high-cost" care. EXH 8, p. 23

their transplant surgery at a hospital not in Aetna's network, the Plan's co-pay is reduced from 80% to 60% and they are denied the travel benefits that were payable before the Amendment. That was another substantial diminishment of a Plan benefit.

### 4. Payment for the Services of Assistant Surgeons

Before the DRB made Aetna the Plan TPA, the amount the Plan reportedly paid assistant surgeons was up to 25% of the amount the Plan paid the principal surgeon who performed the surgery. This Court deemed that fact admitted in its Order of Nov. 8, 2021, at p. 1. After Aetna became the Plan TPA, the Plan only paid assistant surgeons up to 16% of the amount it paid to the principal surgeon. EXH 17

The change was a substantial diminishment. It exposed Plan members to the risk of having to pay a substantially greater portion of the fees charged by assistant surgeons whose services are medically necessary but who are not within Aetna's network.

Consider, for example, a surgery where the services of an assistant surgeon are medically necessary and the Plan pays principal surgeon $10,000. Until 2014, the Plan paid the assistant surgeon up to 25% of the amount it paid the principal surgeon, or $2500. Assume the assistant surgeon charged $6000 for the surgery and, because she was not part of an applicable Plan network, she was free to "balance bill" the Plan member for the amount not paid by the Plan. In that example, the Plan member would be responsible for paying the remaining $3500.

When Aetna became the Plan TPA, it reduced the maximum amount the Plan paid for medically necessary assistant surgeons from 25% to 16% of what it paid the principal surgeon. In the same example, with Aetna as the TPA, the Plan would pay no more than $1600 of the assistant surgeon's fees. That change effectively increased the amount the Plan member would have to pay the assistant surgeon from $3500 to $4400. This illustrates why the change constituted a diminishment of a Plan benefit.

The example also demonstrates how the change operates coercively to diminish the "free choice" of provider that the Plan provided before 2014. It was another way of coercing Plan members with financial threats into choosing assistant surgeons within Aetna's network.

In opposing the RPEA motion to have certain of its requests for admission deemed admitted, the State argued that the reduction in the maximum amount the Plan pays for assistant surgeons was not a diminishment because the Plan does not specifically address how assistant surgeons are to be paid. Based on that, the State argued that the Plan administrator has the discretion to pay whatever it decides the Plan should pay toward satisfying the fees of assistant surgeons who are medically necessary for the surgery but who are not in a network used by AlaskaCare.

That is a false premise. Yet, the State relies on it to argue that the DRB has historically delegated its discretionary authority to the Plan TPA to determine how much the Plan pays for those assistant surgeons, and that the amount TPAs have paid has "fluctuated."[45] According to the State, because the amount paid to assistant surgeons has allegedly "fluctuated," the fluctuation "down" cannot be considered a diminishment of a benefit.

The State's argument is obviously specious. The example provided above showing how the change increases the Plan member's share of the assistant surgeon's fees is one reason. It is also specious because the false premise concerning the TPA's discretion to determine the amount of payment, if accepted, would render the protections under Art. XII § 7 of the Alaska Constitution essentially meaningless with respect to Plan benefits provided for assistant surgeons whose services are medically necessary for certain types of surgeries.

This leads to a third and more fundamental reason the State's argument is specious.

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[45] The State has not disclosed how much the amount has allegedly fluctuated over the years; when those fluctuations occurred; the reasons for those alleged fluctuations, and whether the amount paid has ever "fluctuated" upwards.

Like the coverages for the fees of assistant surgeons, there are untold numbers of other medically necessary services, procedures and treatments covered by the Plan where the amount the Plan covers is not specifically addressed in the Plan. Instead, the amount the Plan pays is based on what the Plan now calls the "Recognized Charge" for the medical service or supply at issue.

For providers in Aetna's network, the "Recognized Charge" is the negotiated amount that Aetna and the provider have agreed upon for the specific procedure or treatment. According to the Amendment, if the provider is *not* within Aetna's network, then the Recognized Charge is determined using formula that looks at the billings of all the providers in a geographic area for the particular medical service or supply, excludes the highest and lowest, and then finds the amount that would satisfy the fees charged by 90% of the providers for that procedure in that geographic area. That is the "Recognized Charge" for providers not in Aetna's network.

After the Plan member satisfies her annual deductible, the Plan then pays 80% of the Recognized Charge of the provider outside Aetna's network until the Plan member has paid a co-pay amount of $800 (meaning the Plan has paid 80% of the first $4000). Then the Plan pays 100% of the remaining amount that is the Recognized Charge. EXH 1, p. 78, ( Booklet p. 12)

In the example above, where the Recognized Charge for assistant surgeons in Alaska who are not in Aetna's network is $6000 for the particular type of surgery, then like all other covered medical services that are medically necessary, after the $150 deductible is satisfied and the Plan member has paid an additional $800 in out-of-pocket expenses (total $950), the Plan pays 100% of the remaining Recognized Charge of the assistant surgeon's $6000 fee, or $5050. For this reason alone, the DRB's decision to allow Aetna to reduce the Plan coverage for fees charged by assistant surgeons who are medically necessary for a surgery from 25% to 16% of what the Plan pays the principal surgeon is even more of a diminishment in benefits that it first appears to be.

In *Metcalfe*, the Court made clear that when evaluating Plan changes, the focus should be on the "practical effect" of the changes and their "impact" on retirees. *Metcalfe,* at 97-98 Here, the "practical effect" of the change that reduced the maximum the Plan pays assistant surgeons, not in Aetna's network, from 25% to 16% of the amount the Plan pays the principal surgeon was a decrease in coverage; that is, it shifted onto Plan members a greater share of the costs of assistant surgeons not in Aetna's network. That is not only a diminishment of a monetary benefit, it again is a means of placing coercive pressure on Plan members to use assistant surgeons in Aetna's network, diminishing the Plan's promise of free choice of provider.

For these reasons, the reduction in the limit of the of amount the Plan pays assistant surgeons who are not in Aetna's network was also a diminishment and impairment of a Plan benefit.

### 5. Diminishments and Impairments of Coverages for "Experimental and Investigational" Procedures and Treatments

#### a.) Coverages for Experimental Procedures and Treatments Before 2014

Before 2014, a medical procedure, treatment or device having any one of four characteristics was considered "experimental or investigational" (hereafter referred to collectively as "experimental").[46] The Plan provided that experimental medical services

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[46] The Plan stated that a medical service or supply having any one of the following four (4) characteristics would be considered "experimental or investigational":

— There is insufficient data available from controlled clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;

— Approval, as required by the FDA, has not been granted for marketing;

and supplies would not be covered unless certain exceptions applied. EXH 1, pp. 119-20 (Booklet pp. 53-54) What is important here are the changes to the exceptions that occurred as a result of the Amendment.

The exceptions where coverage for experimental medical procedures and treatments *would* be provided fell into two categories. One category was for *non-drug* medical procedures, treatments, and devices. *Id.* The other category was for experimental drugs. For each category, the Plan specified what conditions needed to be satisfied for coverage to be provided for the experimental medical service or supply. *Id*.

### i.) EXCEPTIONS FOR *NON-DRUG* EXPERIMENTAL PROCEDURES AND TREATMENTS *BEFORE* 2014

The Plan specified that coverage for non-drug experimental procedures or treatments would be provided in this category if two factors were present: 1) "death can be expected within one year in the absence of effective treatment;" and 2) the Plan administrator determined that the treatment "**show[ed] promise of being effective**" based on "demonstrated ... scientific data" and "the results of a review by a panel of independent medical professionals selected by the claims administrator." EXH 1 , p. 119 (Booklet p. 53) (emphasis added)

— A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or

— The written protocols or informed consent used by the treating facility or any other facility studying substantially the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

EXH 1 , p. 119 ( Booklet p. 53)

### ii.) EXCEPTIONS FOR EXPERIMENTAL DRUGS *BEFORE* 2014

The Plan provided coverage for any experimental drug that fell into *any one of* three separate categories:

> [T]his exclusion **will not apply** to drugs:
>
> 1. That have been granted treatment investigational new drug (IND) of Group c/treatment IND status;
> 2. That are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or
> 3. If the claims administrator determines that available scientific evidence demonstrates that the drug is effective or shows promise[47] of being effective for the disease.

EXH 1, p. 120 ( Booklet p. 54) (emphasis in original)

The word "or" in the list above is of key importance.

## b.) Coverages for Experimental Procedures and Treatments After 2014

The Amendment eliminated the two categories of exceptions (drug and non-drug) and imposed a new set of requirements, conditions and restrictions that substantially narrowed the exceptions to coverage for medical procedures and drugs that were considered experimental. That narrowed the opportunities Plan members had to obtain coverage for

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[47] For an experimental procedure or treatment to show "promise" of being successful does not mean it must be shown to be certain or even more likely than not to be effective at diagnosing, curing or arresting the development of a disease or condition. The *Merriam-Webster Online Dictionary* definition of the word "promise" makes clear that for a thing to "show promise" it must simply provide "*an indication of* future success or improvement." (emphasis added)

those medical procedures and drugs and in that way diminished and impaired Plan benefits. EXH 1, pp. 26-27 ( Booklet pp. xx-xxi)

For this discussion, however, it is important to note that the language of the Amendment concerning coverage for experimental treatments has been amended since 2014 and now reads:

> [T]his exclusion **will not apply** to charges made for experimental or investigational drugs, devices, treatments or procedures, provided that **<u>all</u>** of the following conditions are met: (Emphasis added to "**all**")
>
> • You have been diagnosed with cancer or you are terminally ill
>
> • Standard therapies have not been effective or are inappropriate
>
> • The claims administrator or pharmacy benefit manager determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment
>
> • There is an ongoing clinical trial. You are enrolled in a clinical trial that meets these criteria:
>
> o The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or group c/ treatment IND status
>
> o The clinical trial has passed independent scientific scrutiny and has been approved by an institutional review board that will oversee the investigation
>
> o The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food and Drug Administration or the Department of Defense) and conforms to the NCI standards
>
> o The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI designated cancer center
>
> o You are treated in accordance with protocol.

EXH 26.

Although the new language added "cancer diagnosis" as a qualifying condition and substituted "terminally ill" for "death can be expected within one year," that limited

broadening of the exception was substantially outweighed by the addition of new requirements and conditions—*all* of which have to be satisfied—for a Plan member to obtain coverage for experimental medical services and supplies.

The Amendment also added the threshold requirement that "standard therapies" must have been tried and failed before the Plan member would even be eligible to apply for coverage for a therapy still considered experimental.[48]

At first impression, that new requirement might seem reasonable. However, careful consideration reveals why it is a substantial and critical diminishment and impairment of benefits. In cases of fatal illnesses or other serious diseases and conditions, delay in treatment can make the difference between life and death or at least extending life with good quality. The Amendment requires Plan members to first try "standard therapies" before they are even *eligible* to apply for coverage for a newer therapy, even when the scientific evidence shows that the "standard therapies" have limited success and that a newer therapy, still considered experimental, shows "promise" of being substantially more effective and successful.

For example, before the Amendment, a Plan member diagnosed with a fast-growing cancer that was expected to be fatal within a year and was only rarely cured or arrested by "standard therapies" had a reasonable opportunity of quickly getting coverage for a new therapy, still considered "experimental," when "scientific evidence" or "scientific data" showed that it had the "promise" of being more effective than the "standard therapies" at curing or halting the growth of the cancer, especially if used early. The Amendment foreclosed that opportunity.

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[48] EXH 1, p. 26, ( Booklet p. xx) There is no definition of "standard therapies." This is one example of vague language in the Amendment that results in uncertainly that can cause delays in getting time-critical treatments that could be life-saving. New requirements and vagueness both erect barriers to benefits that are impairments and/or diminishments.

This is another way the Amendment resulted in a substantial and serious diminishment and/or impairment of a Plan benefit that was provided before 2014.

The Amendment also added the new restrictive condition that coverage for an experimental treatment would not be provided unless the Plan administrator or pharmacy benefits manager first determines that the Plan member "would likely benefit from the [experimental] treatment."

The critical words are "likely benefit."

Before 2014, when a case arose where, for example, "standard therapies" were successful only 10% of the time in curing or arresting the progress of the fatal or other serious disease, but "scientific data" existed showing that a new therapy cured or arrested the disease in 49% of the cases where it had been used—or even just showed "promise" of being more effective than the standard therapies—Plan members had the opportunity to obtain coverage for the new treatment.

The Amendment's addition of the "likely benefit" language eliminated the possibility of obtaining coverage in such a case. Even in a case where reliable scientific evidence shows that a new therapy is effective 49% of the time compared to a 10% success rate for the "standard therapies," because the new therapy is effective in less than 50% of the cases, coverage can be denied because the statistics show that it would be more likely than not that the Plan member would *not* benefit from the treatment.

Before 2014, the Plan provided Plan members with an opportunity for coverage when evidence showed that the new treatment showed "promise." The Amendment's addition of the "likely benefit" language eliminated that opportunity and, in that way, also diminished and impaired the Plan benefits.

The Amendment also added a new, across-the-board threshold requirement that bars coverage for an experimental treatment unless the affected Plan member is enrolled in an "ongoing clinical trial" that satisfies five criteria listed in the Amendment. The "five-criteria requirement" did not exist before 2014. Before then, Plan members had the opportunity to

get coverage for an experimental drug if there was scientific evidence that it showed "promise" of being effective. That type of evidence might come from an ongoing clinical trial that is closed to new participants which, of course, would mean it is closed to Plan members. The Amendment shut the door to the possibility of a Plan member getting coverage under those circumstances.

The Amendment's requirements also ignore the fact that even if an ongoing clinical trial exists that satisfies the Amendment's five criteria and still has openings for participants, a Plan member's acceptance into a clinical trial is never guaranteed. Many factors affect who is selected to participate. For example, according to the Memorial Sloan Kettering Cancer Center website:

> Clinical trials have guidelines, called eligibility criteria, that tell doctors who can participate. These criteria are stated in the trial listings and include things like sex, age, type of cancer, and how advanced the cancer is.

Source: https://www.mskcc.org/cancer-care/clinical-trials/how-to-join#step-2-review-eligibility-criteria- (last accessed January 27, 2022)

There is no evidence that the DRB made any effort to determine the impact these changes would have on Plan members or performed any equivalency analysis comparing the coverages provided for experimental procedures, treatments and devices before and after the Amendment.

In sum, the elimination of the previous opportunities for getting coverage for experimental procedures and treatments, and the imposition of new and greater threshold requirements for getting such coverage, is another way the Amendment diminished and impaired Plan benefits.

### 6. Replacing the Plan Standards for Determining "Medical Necessity" with Aetna's Standards

Claims for medical procedures, treatments or supplies that are within the penumbra of coverages provided by the Plan are denied if, in a particular case, they are not considered "medically necessary" as that term is defined by the Plan. EXH 1, pp. 82-83 (Booklet pp. 16-17) Therefore, the Plan's standards for determining whether a medical procedure, treatment or device is "medical necessary" are key to determining what claims will be paid. That, in turn, is a key to determining what benefits the Plan actually provides. Changing the standards for determining medical necessity in ways that result in the denials of types of claims that previously were covered by the Plan diminishes and impairs Plan benefits. To use the Court's term, those kinds of changes result in Plan "disadvantages."

That occurred in this case. Confirmation of that fact was provided by Mike Barnhill, the former Deputy Commissioner of the Alaska Dept. of Administration, during a DRB "town hall" meeting with retirees just two months after he signed the Amendment and made it effective the next day. Discussing the changes made by the Amendment, he stated:

> [O]ne thing that has changed with respect to the determination of medical necessity, is that unlike our prior plan administrators, Aetna defines what it thinks is medical necessity, through the clinical policy bulletins.
>
> So for the first time now, if a member has something denied on grounds of medical necessity, you can look at the clinical policy bulletins and determine, either through your own research or with the assistance of an attorney, whether Aetna's basis for medical necessity is accurate, has -- in the -- okay. I hear the sighs, but here's what it was before.
>
> HealthSmart, Premera determines that something's not medically necessary. Where do you go to find out the basis for that? Nowhere.

EXH 8, p. 8 (emphasis added)

The following subsections explain the changes the Amendment made to the definition and standards for determining medical necessity and describes some of the substantial ways those changes reduced benefits and negatively impacted Plan members.

### a.) PLAN STANDARDS OF MEDICAL NECESSITY *BEFORE* 2014

Before 2014, the Plan stated that medical services and supplies were considered "medically necessary" if they were for:

1. Care or treatment which is expected to improve or maintain your health or to ease pain and suffering without aggravating the condition or causing additional health problems;

2. A diagnostic procedure indicated by the health status of the patient and expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems; and

3. No more costly than another service or supply (taking into account all health expenses incurred in connection with the service or supply) which could fulfill these requirements.

EXH 1, pp. 82-83 ( Booklet pp. 16-17)

These criteria are simple, clear and straightforward. The questions that need to be answered to determine "medical necessity" in any given case are:

1) Was the prescribed diagnostic procedure "indicated" by the symptoms and expected to provide information to determine the course of treatment without causing additional harm?

2) Was the prescribed treatment expected to improve or maintain health **<u>or</u>** ease pain and suffering without causing additional harm?

3) Was there another less expensive treatment that was equally as effective without causing additional health problems?[49]

Those Plan standards were also flexible enough to accommodate changes as medical science evolves. If, for example, the FDA withdrew its approval of a drug, or its use for a

[49] Additional health problems could be in the form of a serious side effect or other consequence, such as the closing of a window of opportunity for an alternative treatment known to be more effective but more expensive.

particular purpose, because research showed that it was ineffective or had some serious side effect that justified the FDA withdrawing its approval, then the terms of the Plan justified immediately ceasing to provide coverage for that drug or its use for that purpose. EXH 1, p. 100, 119.

In cases where there was a reasonable, good faith basis for questioning whether a prescribed medical procedure, treatment or supply satisfied any of the Plan criteria, the 2003 Plan provided a list of factors the Plan administrator could consider to resolve the question. They were:

- Information provided on the affected person's health status;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- The opinion of health professionals in the generally recognized health specialty involved; and
- Any other relevant information brought to the claims administrator's attention.

EXH 1, p. 83 ( Booklet p. 17)

The Plan also gave the claims administrator the right to have a physician of its choice examine the Plan member—at a reasonable time while the claim is pending and at no cost to the Plan member—to determine if there was a reasonable, good faith basis for questioning whether a diagnosis was correct or answering any remaining questions concerning the medical necessity that might remain unanswered after consideration of all the factors the Plan specified for determining whether a medical treatment or procedure was medically necessary. EXH 1, p. 157 ( Booklet p. 91)

### b.) Plan Standards for Determining Medical Necessity *After* the Amendment

In place of the Plan's criteria determining medical necessity, the Amendment substituted what Aetna calls its "clinical policy bulletins" ("CPBs"). EXH 1, pp. 27-28 (Booklet pp. xxi-xxii). Among other things, the Amendment deleted the Plan language about "improving or maintaining health" and "easing pain and suffering." Instead, the Amendment stated:

> The medical plan will utilize Aetna's current Medical and Pharmacy Clinical Policy Bulletins for purposes of determining medical necessity.
>
> When Aetna's Clinical Policy Bulletins do not address the specific service or supply under review, a determination of medical necessity will be made <u>when Aetna determines</u> that the medical services and supplies or prescription drugs would be given to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, an injury, a disease, or its symptoms by a physician or other health care provider, exercising prudent clinical judgment. [Emphasis added]

EXH 1, p. 27 (Booklet p. xxi)

Aetna's CPBs are posted online. To access them, Aetna requires persons to "agree" to certain terms and conditions that appear in a small box on the opening page that the reader must scroll through to read, although the reader can simply "click" an on-screen button to "agree" without reading it.[50]

EXH 18 is the "agreement." It makes clear that Aetna's CPB's express Aetna's "opinion" and "determination" whether certain services or supplies are medically necessary, experimental and investigational, or cosmetic. EXH 18, p. 1. It also states—twice—that

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[50] See the webpage at: https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html
(last accessed Feb. 5, 2022) The "agreement" pops up after clicking on "Medical Clinical Policy Bulletins" on that webpage.

the terms of each plan determine coverage, and that if there is "a discrepancy" between the Aetna's CPBs and a particular plan, "the plan will govern." *Id.*

The "agreement" also advises the reader that the CPBs can be "highly technical and are designed to be used by our professional staff in making clinical determinations in connection with coverage decisions." *Id.* at p. 2 Aetna cautions that although its CPBs "define Aetna's clinical policy, medical necessity determinations in connection with coverage decisions are made on a case by case basis." *Id.*

As of the writing of this memorandum, there are a total of 998 Aetna medical CPBs.[51] Despite the Amendment's reference to Aetna's "Pharmacy Clinical Policy Bulletins," as of the writing of this memorandum, based on information and belief, there is no document on the Aetna website titled "Pharmacy Clinical Policy Bulletins."[52]

The Amendment's substitution of Aetna's CPBs in place of the Plan's criteria and standards for determining medical necessity has resulted in the denial of types of claims that had been covered by the Plan before 2013. Evidence confirming that is found in certain letters that the DRB wrote to Plan members who had the self-confidence, energy, determination and stamina to appeal denials of their claims all the way through the appeal process to the point of giving notice that they wanted to appeal to the Alaska Office of Administrative Hearings ("OAH").

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[51] *See* https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins/numeric-order.html (last accessed January 31, 2022)

[52] A page on Aetna's website, (found at: https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html), contains a "button" to link to what Aetna calls its "pharmacy clinical policy bulletins." Clicking on the link brings up a page (https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/pharmacy-clinical-policy-bulletins.html ) that contains links to Aetna's numerous drug formularies that identify what drugs are covered under each of Aetna's numerous health care plans. No webpage has been discovered that contains a link to any document titled "pharmacy clinical policy bulletin."

The DRB knows that OAH decisions are publicly posted on State's website and that therefore OAH decisions favorable to Plan members on coverage issues are likely to result in more appeals of denials of claims that concern those issues. In cases where the DRB's staff believed that a Plan member's appeal to the OAH posed a significant risk of that occurring, the DRB "settled" the appeal before the matter reached the OAH. It did so by sending those Plan member/appellants what the DRB calls "pay and educate" ("P&E") letters. A P&E letter notifies the Plan member that the DRB will pay the claim(s) at issue, usually stating that it is doing so "in this case only" or similar words. *See* examples at EXH 23.

Most of the P&E letters make clear that the Plan has adopted Aetna's CPBs as the standards for determining medical necessity. Some of them reveal that the Plan member had appealed—at least in part—on the grounds that before 2014, the Plan provided coverage for types of claims that now were being denied by Aetna.[53]

Many of the P&E letters tell Plan members that the Plan does not provide coverage for "maintenance" care.[54] Before the Amendment, the Plan provided coverage for a medical treatment or procedure "necessary to diagnose, care for or treat **a physical or** medical condition" that must be for "care or treatment which is expected to improve **or maintain ... health** or ease pain and suffering without aggravating the condition or causing additional health problems." EXH 1, p. 82 (Booklet p. 16) (Emphasis added)

Less than a year before the Amendment was promulgated, the former Director of the DRB wrote a benefit clarification that made a point of the fact that the Plan provided coverage for care or treatment expected to *maintain* health. *See* EXH 10, pp. 10-12. He squarely acknowledged that "the Plan's definition of medical necessity includes a maintenance element." *Id.* at p. 11. Despite this, after the Amendment, the DRB ignored

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[53] *See e.g.*, EXH 23 at pp. 1, 3, 4, 5, 16, 221, 23, 36, 42, 54, 61, 69.

[54] *See e.g.*, EXH 23, pp. 7, 9, 13, 16, 26, 28, 32, 41, 47, 58, 64.

the "maintenance element" and allowed Aetna to deny types of claims—previously covered by the Plan—on the grounds that the Plan did not provide coverage for treatments to maintain health.[55] The denials were focused on Plan members who suffered from chronic spinal and other muscular-skeletal conditions.[56]

In addition to this evidence, it is important to consider—and for the record to be clear—that as a practical matter, it is virtually impossible to determine all the types and numbers of claims that have been denied since 2014 as a result of Amendment's substitution of Aetna's CPBs in place of the Plan standards for determining medical necessity. There are three main reasons for this.

First, the substitution of Aetna's CPB's was a broad and fundamental change to the Plan that was, in reality, at least 998 changes. Claims submitted to Aetna under the Plan are "auto-adjudicated," meaning they are electronically processed using Aetna's proprietary computer programs to determine what claims will be paid and what claims will be rejected.[57] As a result of the Amendment, every claim for medical services submitted under the Plan,

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[55] ***See*** EXH 1, pp. 7 and 9. Many P&E letters in EXH 23 cite to an April 2015 DRB newsletter (*see* EXH 2, pp. 34-45), as authority for stating that the Plan does not provide coverage for medical services and supplies "necessary to diagnose, care for or treat a physical or medical condition and that is expected to improve or maintain health. *See*, EXH 23, pp. pp. 13, 16, 26, 28, 32, 41, 47, and 64. One letter found cites a May 2017 DRB newsletter as authority for denial of coverage. EXH 23, p. 58. The DRB's newsletters contain a disclaimer stating that the information in the newsletter does not supersede the applicable provisions in the Booklet. *See e.g.*, EXH 2, pp. 8, 45. Other DRB newsletters state that "[i]n case of a conflict between this newsletter and the official plan documents, the plan documents will determine your benefits." *See e.g.*, EXH 2, p. 9. *See also,* the email from Steve Ramos, DRB's Vendor Manager, telling a Plan member: "[T]he CPBs are do not translate to AlaskaCare benefits. The benefits are communicated in the plan document/plan booklet." EXH 6 That same email contains the boilerplate "Disclaimer": "Where this email conflicts with the relevant Plan Document, the Plan Document controls." *Id.*

[56] *Id.*

[57] The Aetna CPBs are incorporated into the computer software programs that "auto-adjudicate" claims. *See* EXH 23, p. 3.

and every request for precertification, is subjected to the filter of Aetna's 998 CPBs to determine medical necessity.

Likewise, every claim for coverage for a prescription medication prescribed for a Plan member is filtered through whichever one of Aetna's proprietary drug formularies are used for adjudicating claims for determining the medical necessity and other parameters to determine coverage for prescription medications prescribed for Plan members.

Millions of claims are processed each year by Aetna through computer programs that apply its CPBs. Although it is likely that not every AlaskaCare claim that is denied based on a CPB would necessarily have been otherwise payable under the terms of the Plan, as a practical matter it is impossible to know all the AlaskaCare claims that would have been covered before 2014 have been denied because of the use of Aetna's CPBs in the auto-adjudication process. *See* discussion, *supra*.

Essentially, since 2013 the DRB and Aetna have been working to transform the AlaskaCare Plan into an Aetna commercial health care plan, presumably because the DRB thinks it can make any Plan changes it wants so long as what remains arguably resembles a mainstream public employee health Plan. The RPEA submits that violates art. XII, § 7 of the Alaska Constitution and the requirements, restrictions and limitations established by the Court in *Duncan*.

Second, the DRB's record-keeping practices have made it impossible to obtain some of the best evidence showing the types of claims that were covered before 2014 and then denied after the Amendment and Aetna becoming the Plan TPA. That evidence consists of the reports, complaints, and inquiries received by the DRB and Aetna from Plan members since claiming that types of claims were being denied that had been covered by the Plan before the Amendment. According to the DRB**,** during the first month after the Amendment and Aetna took over as the Plan TPA, the DRB, Aetna and Moda (the dental TPA) call centers received **50,000 calls** from Plan members. EXH. 2, p. 18. Apparently, no recordings, logs or transcriptions of those calls exist. There is evidence that "scripts" were

written for the staff at Aetna's call centers to use in dealing with calls from Plan members, but when asked to produce them, the State responded that there is no record of those scripts.

Emily Ricci, the DRB's Chief Health Administrator, testified that the DRB did have records of emails sent by Plan members that contained such assertions, and that records of phone calls from the members were placed into the individual file of each Plan member who called. EXH 4, p. 51 According to her, as a practical matter that evidence could not be provided because it would require going through the "file" of every one of the tens of thousands of Plan members to search for evidence of those reports, which "would be tremendously costly and time intensive." *Id*.

Third, Plan members either trust what they are told when coverages are denied or often do not have the self-confidence, knowledge, determination and stamina to challenge the denial. As a result, many wrongful denials go unquestioned by Plan members and/or unrecorded by Aetna and the DRB unless there is an appeal beyond just a phone inquiry. Therefore, there is no record of those denials.

Plan members cannot fairly be blamed for simply accepting wrongful denials of claims and, for those who might make an initial inquiry into the reasons, for accepting what they are told. Their lack of lack of knowledge of the fine points of insurance coverage, or their lack of the self-confidence, or their lack of stamina is not their fault. Likewise, they cannot be faulted for trusting that the State government they served for years will fulfill its part of the bargain honestly and completely, especially when the state agency administering the Plan tells them it has a fiduciary duty to provide them with information about their benefits and claims to be "transparent." *See .e.g*., DRB newsletters in EXH 2 at pp. 8, 16, and 47; EXH 11, p. 10; EXH 4. p. 3 (transcript .p 70, ln 24); EXH 2. P. 35

Evidence that types of claims that were covered by the Plan before 2014 that were not covered based on Aetna's CPB are contained in EXH 7, p. 20 and EXH 23, pp. 3, 4, 5, 16, 21, 23, 36, 54, 61.

The fact that AlaskaCare claims are processed by Aetna using software that incorporates Aetna's CPBs is revealed in EXH 23, p. 3.

### 7. Diminishments and Impairments by Failure to Disclose Important Plan Coverage Information

Since January 1, 2014, Plan members have been told that Aetna's CPBs are being used to determine the "medical necessity" of procedures and treatments. EXH 1, p 27 (Booklet xxi) The evidence shows that Aetna also uses its CPBs to decide whether grounds exist for denying claims on the basis that the medical procedure and treatment involved can be classified as "experimental" or "investigational."

When Aetna denies a claim on the grounds that, according to its CPBs, the procedure or treatment is "experimental" for treating a particular disease or medical condition and the DRB overrules that decision, basis principles of fairness and equity, the contractual duty of good faith and fair dealing, and the fiduciary duty to fully disclose information which might affect the other person's rights and influence their actions,[58] all require the DRB to do two things.

First, it must instruct Aetna to cease automatically denying all claims for that type of treatment or procedure on the grounds that it is experimental and inform Plan members or their healthcare providers of the circumstances where it is *not* considered experimental.

Second, the DRB must take reasonable steps to timely notify Plan members of the exception so that they are aware of exceptions to an Aetna CPB that might not appear on the face of the CPB itself.

It is unknown what safeguard measures the DRB has in place, if any, to ensure that Aetna stops denying types of claims that the DRB has determined *are* covered by the Plan regardless of Aetna's CPBs or other parameters that are part of the auto-adjudication

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[58] *Carter v. Hoblit*, 755 P.2d 1084, 1086 (Alaska 1988)

computer programs it uses to process claims. The evidence is clear, however, that the DRB has not been notifying Plan members when it overrides Aetna's CBPs of its "benefit notifications" or its decisions overruling Aetna denials of claims for certain types of coverage.

### a.) DRB FAILURE TO PUBLISH AND PRESERVE PLAN BENEFIT CLARIFICATIONS

Since 2003, the DRB has issued numerous Plan "benefit clarifications" ("BCs"). The BCs represent the DRB's interpretation of the Plan and what coverages and benefits it does and does not provide.

Former DRB Plan Benefits Manager Freda Miller has stated under oath that during the years she worked for the DRB as its benefits manager until she resigned in 2008, there were three wide lateral file drawers at the DRB offices filled with benefit clarifications. EXH 5, p. 7

A letter written in 2014 by Curtis Thayer, the former Alaska Commissioner of Administration, provides support for Ms. Miller's testimony. One of the answers he provided to the FAQs reportedly asked by Plan members states that "a large volume of unpublished benefit clarifications were issued by Division staff during this time period [2003-14]." EXH 11

During one of the so-called "town hall" meetings the DRB held with retirees in the spring of 2014, then Deputy Commissioner Mike Barnhill stated that "a stack of benefit clarifications [had] been issued over the past ten years" by the DRB. EXH 8 Mr. Barnhill acknowledged that the DRB should have published those BCs or in some other way informed Plan members about them. *Id*. He went on to admit that the DRB had not done so and revealed that those BCs had since been "repealed" by the DRB. *Id*

The DRB's failure to notify Plan members about the BCs it issued that affirmatively answered coverage questions deprived Plan members of knowledge that impaired their access to Plan benefits. The repeal of those BCs resulted in the diminishment of Plan benefits that had been provided since 2003 as a result of those BCs and that ceased being provided when the BCs were repealed.

Mr. Barnhill's statements during the DRB "town hall" meeting reveal that the DRB knew that it was important to tell Plan members about the BCs and how they affected Plan benefits.[59]

His statements also show that the DRB knew it was important to alert Plan members when 1) the DRB became aware of and reversed an Aetna denial of coverage of a type of claim that had previously been covered by the Plan; and 2) the DRB disagreed with an Aetna CPB and "overrode" Aetna's denial of a claim based on that CPB. Here are the relevant parts of his statements during the DRB "town hall" meeting with retirees held in Anchorage on March 3, 2014:

> What has changed [since 2013] is in the past, the division has drafted what we call benefit clarifications that give instruction to the third-party administrator. And there's a stack of benefit clarifications that have been issued over the past ten years. The issue that we have with those plan clarifications is they have not been published or somehow communicated to the membership. And that's going to change.
>
> So one of the things that the plan – the draft plan document does is it says all – all documents such as benefit clarifications are now repealed. When we make a change to plan administration, we're going to figure a way to get that communicated to the membership. [...]
>
> [W]e need to get away from an administrative practice where changes get made but they're not published. The division will still be in day-to-day contact with Aetna when questions arise. If they're addressed in a way that impacts all members of the plan, it's going to be published. It'll either be published

[59] The DRB's awareness of its fiduciary duty to provide that information is also shown by the statements it has made to Plan members for the years in its news letters concerning its fiduciary duty to educate and inform them about Plan benefits. *See .e.g.*, DRB newsletters in EXH 2 at pp. 8, 16, and 47.

> through a plan amendment or through something on the Web site [sic] that says, okay, here are changes that are being made that may impact you.
>
> We've had a handful of situations come up since January 1st [2014] where Aetna has processed a procedure differently than HealthSmart. In one case, it was a diagnostic procedure for a certain type of cancer. HealthSmart covered it; Aetna didn't. Aetna said it was experimental; HealthSmart didn't. Aetna had a basis for why they said it was experimental.
>
> We got involved, looked at it, reviewed it with some medical expertise in this building, and decided that we would override what Aetna's decision was. And so that's a change. Now, the next step, we've never done this before, is we need to figure out how to publish that so folks are aware of it.

EXH 8, p. 7.

The evidence shows that in one very,important case, most likely the case that Mr. Barnhill was referring to in the excerpt of the town hall meeting transcript above, that the DRB has failed to notify Plan members overrides an Aetna CPB.

**Example: Failure to Disclose Coverage for C-11 PET Scans for Recurrent Prostate Cancer**

In January of early February of 2014, Aetna relied on its CPB 0077 to deny coverage for a diagnostic procedure known as a C-11 Positron Emission Tomography ("PET") Scan procedure (hereafter, the "C-11 PET scan"). The procedure was developed for use in the early detection and treatment of metastasized prostate cancer. Published studies from as far back as 2004 showed that early detection of recurrent prostate cancer, followed by focused radiation therapy, "offered the possibility of cure for a substantial proportion of patients with a rapid PSADT[60] and high-grade cancer." *See e.g.*, EXH 7, p. 18-19. By 2014, the

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[60] PSADT is an initialism for "prostate specific antigen doubling time." A faster PSA doubling time indicates faster-growing prostate cancer cells. After a successful prostatectomy, there should be no PSA in the body. When a post-surgery PSA test is positive, it indicates that prostate cells are still present and might be malignant. If those cells are at the site of the prostate, they can be eliminated by focused radiation therapy if treated early. If they are metastasized cells, they need to be found so an effort can be made to eliminate them with a targeted therapy such as focused radiation therapy. *See* EXH 7, pp. 18-19 (article links on p, 19); see also:

Mayo Clinic had obtained FDA approval to use the procedure for that purpose.[61] Also by then, published, peer-reviewed studies showed that C-11 PET scans were an effective at such early detection.[62]

Before 2014, the Plan provided coverage for C-11 PET scans for Plan members who had PSA readings after having had a prostatectomy.[63] When Aetna became the TPA in 2014, it began denying coverage based on its CBP 0071. EXH 7, pp. 1-2

A Plan member whose claim was denied was a member of the Alaska House of Representatives. EXH 7, pp. 5-10 He appealed the denial of the claim and also met with and sent emails to senior officials in the DRB and the Dept. of Administration objecting to the denial of the claim. He stated that the Plan had previously provided coverage for the procedure "without question,"[64] an assertion that the was confirmed by Mr. Barnhill.[65]

Based on that fact and a review of the medical literature, and based on the fact that Aetna's own CPB acknowledged the existence of evidence showing the C-11 PET scan therapy was effective in locating and treating early metastasized prostate cancer cell, Mr. Barnhill (apparently at the suggestion of Aetna[66]) directed Aetna to implement a "temporary

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https://pubmed.ncbi.nlm.nih.gov/23579863/ Early detection and location of prostate cells remaining after a prostatectomy is therefore critical. By 2014, C-11 PET scans had proven useful for those purposes and for that reason were covered by the Plan when HealthSmart was the Plan TPA before 2014. Before then, there was no other way to detect at the early stages the location of metastasized prostate cancer cells.

[61] EXH 7, p. 2, 10

[62] *See* EXH 7, p. 20

[63] EXH 7, p. 20*

[64] EXH 7, pp. 20, 21

[65] EXH 8, p. 7, lns 11-18

[66] EXH 7, p. 31

override" to its CPBs and to provide coverage for the procedure. EXH 7, p. 28, 35. Mr. Barnhill stated that the DRB would "monitor [the situation] over the course of the next year for determination as to whether to continue the override." *Id.* at p. 30.

In subsequent emails, Mr. Barnhill and DRB manager Michaud discussed creating and issuing a benefit clarification to alert Plan members of this important override, presumably so that other Plan members with metastasized prostate cancer and their providers would be aware that at least in some circumstances, this important diagnostic procedure *would* be covered by the Plan, contrary to what they would otherwise believe if they relied on the applicable Aetna CPB that they had been told would be used to determine Plan coverages like all other Aetna CPBs. EXH 7, p. 37, 40.

A year later, Mr. Barnhill's temporary override was still in place and no benefit clarification had been issued or even written by the DRB. EXH 7, p. 40.

There is no evidence that any "benefit clarification" on the subject was ever issued by the DRB, and the RPEA has been able to find no evidence that the DRB gave Plan members any other notice that C-11 Choline PET scans were covered by the Plan for diagnosing and pin-pointing the location of metastasized prostate cancer so it could be treated at those sites. It is also unknown how long Mr. Barnhill's "override" of the Aetna CPB remained in place.

According to Aetna's website and its applicable CPBs, Aetna eventually amended its CPBs to provide that the C-11 Choline PET scan diagnostic procedure was appropriate for diagnosing and pin-pointing the location of metastasized prostate cancer and would be covered under Aetna plans. That occurred in April 2021, **over 7 years** after Mr. Barnhill's override of the CPB.

### b.) The DRB Failure to Notify Plan Members of the Court Ruling that the "Juneau-Only" Filing Provision in the Plan is Invalid

On December 4, 2019, Judge Aarseth denied the State's "Motion to Compel Venue." The motion sought to have the Court transfer the case to Juneau based on a provision in the Booklet stating that "[a]ny and all suits or legal proceedings of any kind that are brought against the State must be filed in the First Judicial District, Juneau, Alaska." The Court ruled that the provision was invalid because the DRB had no statutory authority to impose the venue restriction. The Court concluded:

> Requiring State of Alaska residents to litigate a dispute outside of the judicial district in which they live is offensive to the notion of employees and retirees being treated fairly. Theoretically, a person may work their entire career, earn their retirement, and then enjoy their retirement in rural Alaska. DRB provides no justification why that individual must bear the cost of litigating his or her dispute in Juneau.

Order, at pp. 2-3

The State did not seek a stay of that order and did not file a petition for review. As a result, it became the law of the State and remains the law unless overturned by the Alaska Supreme Court. At the point where the State decided not to ask for a stay or to petition for review, the DRB had a fiduciary duty to notify Plan members that they could file an appeal concerning the Plan's Administrator's final decision on a Plan benefits decision in any Superior Court location in the State. Not only did the DRB fail to do that, but it has continued to include the invalid provision in every rewritten and revised edition of the Booklet since then, including the most recent Booklet (January 2022). This is especially concerning because the DRB repeatedly tells Plan members that the terms of Plan control.

Informing Plan members, that if they want to file an appeal in the Superior Court, they must file it in Juneau, is not only a breach of fiduciary duty, it is an impairment of Plan benefits in that it discourages Plan members from exercising their right to appeal denials of

claims which, in turn, can cause them to abandon meritorious appeals, not only impairing their statutory right to appeal to the Superior Court under AS 39.35, 006 but also impairing their ability to receive benefits that were wrongly denied.

## B. Breach of Fiduciary Duties and Breach of Contract

### 1. Every Diminishment and Impairment of a Benefit in Violation of the Requirements, Limits and Conditions Established by the Duncan Opinion Was a Breach of Fiduciary Duties and a Breach of Contract by the State

Every change made by the DRB that resulted in a diminishment and impairment of a Plan benefit in violation of the dictates of the *Duncan* opinion and related opinions of the Alaska Supreme Court was a breach of contract and a breach of the fiduciary duties of loyalty and disavowal of self-interest.

### 2. Failure to Provide Plan Members With Notice and Opportunity to Be Heard

State action diminishing and impairing Plan benefits deprives Plan members of valuable personal property without notice and opportunity to be heard. That not only violates the constitutional rights of Due Process provided by the Alaska and United States constitutions, but the failure to give notice and opportunity to be heard breaches the fiduciary duty the State owes to Plan members under the common law[67] to provide them with important information about the Plan and Plan changes, a fiduciary duty the DRB told Plan members it owed them and assured them it would fulfill. EXH 8

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[67] *Carter v. Hoblit*, 755 P.2d 1084, 1086 (Alaska 1988); *Area Inc. v. Bookman*, 657 P.2d 828, 830 (Alaska 1982)

### C. The State's Evidence Does Not Support or Justify Summary Judgment Being Granted to the State

#### 1. The Actuarial Report and Affidavit of Richard Ward Does Not Support an Award of Summary Judgment to the State

The State has offered an actuarial report and affidavit of actuary Richard Ward in support of its motion. At first blush, it seems odd that the State chose Mr. Ward as its expert. The State has used Mr. Ward as its actuarial expert in a recent, closely related case brought by the RPEA that challenged changes made by the DRB to the part of the Plan that provides retirees with the option of purchasing coverage for dental, visual and auditory/hearing care. Judge Aarseth, who presided over that case through the bench trial, soundly rejected Mr. Ward's testimony.

In his April 2019 "Findings and Conclusions" ("FaC"), Judge Aarseth stated that he did "not find that Mr. Ward's testimony (summarized in his Exhibit 2046) supports a conclusion that the enhancements in the 2014 plan are equivalent to the diminishments."[68] He wrote that it was "essential" for Mr. Ward to have "an accurate understanding of the [Plan] changes" and that "Mr. Ward's understanding was not accurate."[69] He noted that Mr. Ward had "found no changes as to particular services when there were in fact diminishments" and that Mr. Ward had "found enhancements in coverage of particular services when there were in fact no changes." Judge Aarseth concluded that Mr. Ward's

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[68] FaC at p. 14, para. 50.

[69] FaC at p. 16, para. 52(e)

"errors in listing the actual diminishments and enhancements" made his analysis "unreliable."[70]

Mr. Ward's CV shows him to be an intelligent person who has considerable experience working as an actuary for twenty-five years providing "actuarial and consulting services to state-level health care plans in twenty-five states." Judge Aarseth, who by all accounts is careful, measured and judicious, based his decision to reject Mr. Ward's testimony and report based on what he termed were Mr. Ward's "errors" and his conclusion that Mr. Ward's "understanding" was "not accurate." Given the fact that Mr. Ward is intelligent, experienced and has devoted his career to serving "state-level health care plans" throughout the country, it is difficult to believe that Mr. Ward did not accurately understand the facts and the issues and that the "errors" in his analyses were the result of accidental oversights. Whether they were or were not the product of inadvertent "errors" or accidental oversights, Judge Aarseth's opinion calls into serious question Mr. Ward's reliability as an expert witness as an actuary. Under the circumstances, the State's decision to use him again as its expert actuary in this case suggests that the State may have not been able to find another actuary to support its defense.

Ward's actuarial report and affidavit do not support the State's motion for summary judgment. His affidavit states that he assessed the "impact" of "certain measures that took effect on January 1, 2014 on the Plan's actuarial value." At paragraph 4 of his affidavit, he states that in his opinion, "none of the changes identified by Plaintiff in its complaint affected the actuarial value of the Plan." His statement notes that that opinion was based on "the changes identified by Plaintiff in its complaint," suggesting that there may have been changes made to the Plan that *did* negatively affect its actuarial value.

Ward adds that he *did* consider a Plan change that he stated was *not* referred to in the RPEA's complaint and claimed was a "plan enhancement," but that still leaves open the

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[70] FaC at p. 16, para. 53.

question whether there were other Plan changes that Mr. Ward did not incorporate into his analysis.

He appears to acknowledge that the changes *did* result in some change in actuarial value, because "the value of the Plan before the amendments remained within an acceptable tolerance of variation." He does not state what he considers to be to an "acceptable tolerance of variation." He simply concludes that "there was no diminishment impact on the actuarial value of the Plan between 2013 and 2014."

Finally, contrary to what the State seems to believe, the Alaska Supreme Court has never stated that the DRB could make whatever changes it wants to the Plan as long as some actuary determined that the net effect of the changes did not diminish the actuarial value of the Plan.

*Duncan* makes clear that the Plan can be changed in ways that result in the diminishment or impairment of medical benefits only when necessary to add coverages to prevent the Plan coverage from becoming obsolete as medical science evolves. When that is necessary, *Duncan* makes clear that art. XII, section 7 of the Alaska Constitution restricts the State's ability to diminish Plan benefits or, as described by the Court, "advantages." *Duncan* establishes certain guidelines, limitations and conditions the State must satisfy when making changes that diminish or impair any Plan benefit. One of those is that the coverages added and diminished or "deleted" must be of a comparable in type and must be of "equivalent value." *Duncan*, 71 P.3d at 892. The Court stated plainly that for these purposes, equivalent value "must be proven by a comparison of benefits provided—merely comparing old and new premium costs does not establish equivalency."

In the insurance context, premium costs are based on policy value. There are no "premiums" that Plan members pay, and the Court's statement about premium costs was another way of stating that equivalent value would not be established merely by comparing the "actuarial value" of the Plan before and after the changes.

The Court has made clear that Plan changes must be measured by the actual impacts they will have on retirees as a group. In *Duncan*, it established that the assessment of the impacts must include an analysis using "solid statistical data drawn from actual experience" and not be based on "unsupported hypothetical projections." *Duncan*, 71 P.3d at 892. The Court's reference to "solid statistical data" does not mention money. The Court's concern is how proposed changes to the Plan are going effect Plan members based on data showing the actual experience concerning the types of claims and their numbers which, in turn, will show how the proposed reductions in coverages and other benefits would actually impact Plan members.

An examination of pages 14 and 15 of Exhibit A to Mr. Ward's report reveals the reasons why the State's use an actuary's opinion concerning the "actuarial value" of the Plan before and after Plan changes as satisfying the "equivalent value" test is a flawed and self-serving interpretation of the *Duncan* opinion.

For example, consider how the expansion of precertification requirements and the doubling of penalties in 2014 impacted Plan members who had established trusted doctor-patient relationships with providers who were in the Beech Street Network, discussed above. It is undeniable that those Plan members experienced substantial negative impacts as a result of the expanded precertification requirements and increased financial penalties imposed on them for failing to obtain precertification, as well as the elimination of the "advantages" provided to Plan members who had chosen health care providers in the Beech Street Network of providers that those changes resulted is Plan "disadvantages" for those Plan members. Yet, despite that fact, Mr. Ward's opinion letter indicates that, according to at least some branch of actuarial science, the "Impact on Actuarial Value" of those changes was "None." Ward report, Exhibit A, p. 14

Likewise, Mr. Ward's Exhibit A at p. 14 also shows that there was no impact on the actuarial value of the Plan as a result of the changes made to "[t]he manner in which amounts payable for covered services are determined and payable under the Plan." Yet, as discussed above, those changes had serious financial impacts on Plan members who had transplants

at hospitals outside Aetna's network, or those who had any other surgeries requiring an assistant surgeon if the assistant surgeon was not within Aetna's network. Ward's report shows the same conclusion concerning the changes in "coverage for treatment for chiropractors, physical therapists, and massage therapists" and for changes to "coverage for experimental and investigative procedures." Ward report, Exhibit A, p. 14.

The point is, regardless of whether Mr. Ward is correct in concluding that none of those changes "impacted" the overall "actuarial value" of the Plan, the changes certainly were—to use the Court's term—Plan "disadvantages" that had negative impacts on Plan members.

For these reasons, Mr. Ward's report and opinions concerning the overall "actuarial value" of the Plan before and after the changes made since January 1, 2014 are not only unreliable, they are irrelevant to the determination whether the changes satisfy the standards for determining "equivalent value" established by *Duncan*.

### 2. The Broome Affidavit Is Misleading and Does Not Support the State's Motion for Summary Judgment

The David Broome affidavit contains ambiguous, vague and conclusory statements that do not support summary judgment. A careful reading also shows that they are also, at least, potentially misleading. He states that he has "personal knowledge of all matters contained herein," but evidence belies that assertion. Apart from the ambiguity of the sentence that makes it unclear if his "personal knowledge" concerns what the affidavit contains or concerns the facts presented in the affidavit, Mr. Broome's was not employed by Aetna until September of 2014, 9 months *after* Aetna took over as the Plan TPA.

In paragraph 4, he states that Aetna's records "indicate" that it was the Plan TPA from "approximately" 1999 to 2006 and that back then, "Aetna used its CPBs to make medical necessity decisions on behalf of the Plan." Ignoring the qualifying word "indicate" and his alleged reliance on some unidentified Aetna records that have never been produced,

even assuming that Aetna used its CPBs from 1999 to 2006 to decide questions of medical necessity says nothing about whether those CPBs were used in place of the Plan's standards for determining medical necessity as they are now or were used to determine medical necessity in a case where there was a good faith basis for questioning if a particular medical procedure or treatment satisfied the Plans standards for medical necessity. It also leaves open the questions whether, back then, the Aetna CPBs for medical necessity were broader or stricter than the standards contained in the Plan.

In paragraphs 8 and 9 of his affidavit, Mr. Broome states what Aetna "understood" when it bid on the Plan's administrative services contract. He was not employed by Aetna until almost two years *after* Aetna bid on the TPA contract, so he cannot have first-hand knowledge of what Aetna "understood" when it bid on the contract, assuming the Court were to accept the assertion that a legal entity can "understand" anything.[71]

Furthermore, even if the State were to provide an affidavit from an Aetna employee—one who was directly involved in the bidding and negotiation of the TPA letters of agreement and contract—alleging that Aetna "understood" when it bid on the contract that there would be "no material change in the Plan's medical necessity provision from the prior engagement," that does not mean that Aetna would not be applying different standards for interpreting and applying the Plan's medical necessity provision." In fact, read carefully, Mr. Broome's affidavit essentially admits in para. 9 that that is what has occurred.

Finally, Mr. Broome states that "Aetna does not receive compensation if a service is denied." Again, the sentence is ambiguous and for that reason is misleading. It appears to suggest that under the terms of the contract, Aetna has no financial incentive to deny claims. But read carefully, that is not what it states. It states that "Aetna does not receive compensation if a *service* is denied." It is unclear what that means, and it leaves unanswered the question whether the contract or any "understanding" between Aetna and the State

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[71] See gen. *Nelson v. Northland Ins. Co.*, 18 F. Supp. 3d 1282, 1287 (N.D. Ala. 2014) ("[C]orporations cannot think or act except through human instrumentalities.")

provides Aetna with any motive to do anything that might result in the diminishment or impairment of Plan benefits in order to reduce expenditures from the State's health trust funding for the Plan which, in turn, would save the State money.

For these reasons, the Broome affidavit does not support the State's motion and the statement contained in it that are not based on his personal knowledge should be rejected.

### 3. The McDonough Affidavit Does Not Support the State's Motion for Summary Judgment

The affidavit of Aetna employee Robert McDonough, MD also does not support summary judgment in favor of the State. It simply describes the process by which Aetna's CPBs are created. He admits that Aetna's CPBs are used by Aetna for purposes of its own plans, which supports the conclusion that the State is seeking to transform the Plan into what the State will claim "resemble[s] a mainstream public employee health Plan."

In paragraphs 7 and 8, he describes what things are considered by Aetna in developing its CPBs. Conspicuously absent is any explanation of the factors that are weighed and considered when there are published, peer-reviewed studies concerning the efficacy of certain medical procedures and treatments that conflict with one another. That, of course, is critical information that needs to be considered when evaluating the fairness and objectivity of Aetna's CPBs and how their use affects claims adjudication and ultimately, the benefits provided—in this case, the benefits provided by the AlaskaCare Plan.

Also, his affidavit sheds no light on the critical issue of the differences in coverages that can result depending upon whether a medical procedure or treatment is adjudged to be "medically necessary" or "experimental" based on the standards of the AlaskaCare Plan or the opinions and conclusions contained in Aetna's CPBs.

This is important because there is no evidence that the substitution of Aetna's CPBs in place of the Plan's standards for determining these two key issues has enhanced or

expanded Plan benefits. On the contrary, as shown throughout this memorandum, ample undisputed evidence shows that the substitution of Aetna's CPB's in place of the Plan's standards has resulted in diminishments in Plan coverages and benefits provided before 2014.

### 4. The Paralkhar Affidavit and Report Does Not Support Summary Judgment

The State also submitted with its motion an affidavit of Sadhna Paralkar, MD, a vice president and medical director of the Segal Consulting Group. According to her affidavit and report, the State asked the Segal Group 1) "to provide an expert opinion on how health insurers make medical necessity determinations;"[72] 2) "to describe the function of "medical necessity" determinations in the administration of health plans and how Third Party Administrators ("TPA") make them; and 3) to compare Aetna's use of CPBs with the industry standards and whether using CPBs represents a departure from the say other TPAs of health plan would manage those plans."[73] At p. 2 of her report, she says she also "was specifically asked to opine on whether every other or a significant number of other major TPA providers use a similar process as Aetna when applying their medical policies to a plan like Alaska Care [sic]." She does not state what she considers to be "a significant number" or what she thinks is "a similar process as Aetna" or what to her mind would make another health plan "like" AlaskaCare.

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[72] The RPEA assumes here that Dr. Paralkhar's use of the word "how" in this context refers to the standards other insurer use for making medical necessity decisions, as opposed to the method of applying those standards, such as the use of computer programs to "auto-adjudicate" claims.

[73] Her cover letter states she was asked to opine on whether every other or a significant number of other major TPA providers use a process similar to the one used by Aetna to administer a Plan like AlaskaCare, which is a different issue. Exhibit A to Paralkhar affidavit at p. 4.

Dr. Paralkhar's opinions on those subjects are irrelevant. How other health insurers make medical necessity decisions is not at issue in this case. Likewise, the "function" of medical necessity determinations in other plans is also not at issue. Here, one of the "functions" of medical necessity determinations under the AlaskaCare Plan is to make sure that when a correct diagnosis has been made, an appropriate treatment will be covered as being "medically necessary" if it "is expected to improve or maintain" health "or to ease pain and suffering without aggravating the condition or causing additional health problems." EXH 1, p. 82 (Booklet page 16).

Dr. Paralkhar's views on how Aetna's CPBs "compare" with "the industry standard"—whatever the "industry standard is, assuming there is such a thing—is also irrelevant. To the extent Aetna's CPBs are being used to determine medical necessity in cases that arise where there is a good faith basis for questioning whether a particular medical procedure of treatment is "medically necessary" under the standards provided by the Plan, it would be relevant to determine how the Aetna CPB standards compare to the Milliman Care Guidelines ("MCGs") that were used to make those decisions by HealthSmart, the previous Plan TPA. If the standards are stricter under the Aetna CPBs than the MCGs, then the use of the Aetna CPBs in place of the MCGs would be resulting in denials of claims that would have been considered medically necessary when HealthSmart was administering the Plan. In this way, the substitution of the Aetna CPBs would have resulted in a narrowing of coverages. A narrowing of coverages would be a diminishment of benefits and a Plan "disadvantage." Dr. Paralkhar provides no evidence that she specifically compared Aetna's 998 CPBs and the corresponding MCGs, much less a summary of the differences and an opinion how those differences would affect medical necessity determinations under the AlaskaCare Plan.

Dr. Paralkhar notes at p. 12 of Exhibit A to her affidavit that a treatment can be beneficial but not medically necessary. She uses massage therapy applied after physical exhaustion (presumably, vigorous exercise) as an example. The fallacy of her reasoning is

that "physical exhaustion" is not a disease or a medical condition. On the other hand, when, for example, massage therapy is used to treat the symptoms of fibromyalgia or multiple sclerosis, it is not a cure but eases pain and suffering. In the case of MS, massage therapy can also have a "maintenance" function, helping to maintain health by slowing the progression of the impairments of the disease and preventing or minimizing certain serious sequalae.[74] Another reason why her reasoning fails is illustrated by hospice care provided for terminally ill patients at the end stages of life. It is not "medically necessary," but it eases pain and suffering. The AlaskaCare Plan states that treatment "which is expected to improve or maintain" health "or to ease pain and suffering" is medically necessary. EXH 1, p. 82 (Booklet page 16). Those are certainly Plan "advantages." Whether other health plans provide all those advantages is irrelevant. Both the DRB and Aetna's CPBs make clear that terms of the AlaskaCare Plan control.

For these reasons, Dr. Paralkhar's final conclusion "that Aetna's use of [its] Clinical Policy Bulletins is *not* a deviation of industry standard" and that "[u]sing [its] CPBs do not represent a departure from the way any other TPA would manage the plan" are irrelevant and do not support the State's motion.[75]

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[74] See e.g., *Kennedy v. Lilly Extended Disability Plan,* 856 F.3d 1136, 1136–38 (7th Cir. 2017). Concerning the uses of massage therapy to treat symptoms and prevent sequalae of the disease, *see* https://www.nationalmssociety.org/Treating-MS/Complementary-Alternative-Medicines/Massage-and-Body-Work

[75] Her use of the phrase, "any other TPA" raises a substantial question concerning the credibility and value of her final conclusion. Her cover letter to Alaska Asst. Atty Gen. Kevin Dilg, which was submitted with her report and is part of the State's Exhibit, states that she worked for UnitedHealthCare ("UHC") and is "very familiar with UHC's medical management practices." Nowhere does she state when she worked for UHC or for how long. However, her "LinkedIn" webpage reveals that she worked for UHC (then known as "UnitedHealth Group") for three years as the VP of its wholly-owned subsidiary, "Ingenix." *See* https://www.linkedin.com/in/sadhna-paralkar-md-144a396/ She left that position in 2008, 14 years ago. *Id.* It is unclear if she is claiming to be "very familiar" with UHC's *current* medical management practices or its practices during the time she worked for Ingenix 14 years ago. She states in her March 2021 letter that at that point ("now") she had worked as a "consultant" for Segal for "about 10 years" (Paralkhar report, Exhibit A, p. 4), but her LinkedIn page reveals that as of the date of this memo (February

### 5. The Ricci Affidavits Do Not Support the State's Motion for Summary Judgment

The affidavits of Emily Ricci do not support the State's motion for summary judgment. Like the Broome affidavit, Ms. Ricci makes statements and allegations about "historical" Plan administration and events that occurred and methods of Plan administration going back to 1997, 16 years before she went to work for the DRB. Her statements about her "understanding" of how prior Plan TPAs administered the Plan; how Aetna's CPBs were and are developed; and how the CPBs were used in 2003, are not on based on first-hand knowledge, are hearsay and on their face are not reliable. The same applies for her statements that are qualified with terms and phrases such as her "belief" about industry practices and how "entity selected to be the TPA of the Plan would determine medical necessity." For these reasons, on all those matters she is not competent to testify.[76]

Paragraph 11 of her affidavit is ambiguous. There she states that "according to the terms of the Plan, the Division's TPA is required to make initial medical necessity decisions." The RPEA contends that all determinations of the "medical necessity" of a

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1, 2022), she has only worked for Segal for 7 years and 3 months. She states that she has "experience in dealing with medical management practices of several different national health plans such as Blue Cross, UHC. Cigna and Aetna." That experience does not support her opinion that Aetna's use of its CPBs does not "represent a departure from the way *any* other TPA would manage the plan." (Emphasis added) It is established that when HealthSmart was the Plan TPA, the Plan covered types of claims that have been denied by Aetna as not medically necessary according to its CPBs. Dr. Paralkhar does not mention HealthSmart in either her affidavit or her report, much less state that she has knowledge or even any familiarity with how it managed the AlaskaCare Plan as its TPA.

[76] Ms. Ricci's statement that HealthSmart used the Milliman Care Guidelines ("MCG") is an admission that supports the RPEA's contention that HealthSmart used the MCG standards to resolve questions about whether a particular medical procedure or treatment was "medically necessary" or "experimental" in cases where the application of the Plan standards left the TPA with a good faith basis for questioning whether the procedure or treatment was medically necessary or experimental.

medical procedure of treatment, whether they are "initial" or later, must be based on the terms of the Plan as stated on pages 16-17 of the 2013 version of the Plan Booklet. Read one way, the Ricci affidavit supports that contention.

On the other hand, her statement can also be read as stating that the DRB interprets the Plan as giving the DRB the right to allow Aetna to make "initial medical necessity decisions" using its CPBs rather than the Plan's standards for determining medical necessity.

## V. CONCLUSION

The State observed at p. 2 of its memo that "perhaps no component of the state's retirement system is more important to its participants than the major medical insurance offered to retirees through the health plan known as AlaskaCare (the "Plan")." The RPEA agrees.

The State concedes that the DRB "must administer the Plan in a manner that confers the 'system benefits' retirees bargained for when they joined state service while at the same time accounting for the advancements in medical knowledge, technology, techniques, treatments …" *Id*.

The RPEA's Interrogatory No. 24 asked the State whether the adoption of Aetna's clinical policy bulletins into the Plan resulted in denials of coverage or reductions in coverage (*e. g*. limitations of the number of treatments allow for certain types of conditions or reductions in the amounts paid for medical services and supplies of out-of-network providers), that at any time between 2003 and 2014 had been covered by the Plan. It was a simple and straightforward "Yes or No" question. The after first responding with numerous boilerplate objections, the State's substantive response was the following:

> Without waiving these objections, the Division responds as follows: Aetna's use of the industry standard clinical policy bulletin ("CPB")

> mechanism to administer the terms of the Plan has not resulted in any categorical or broad-based changes in "coverage" or reimbursements. The Division does not agree that there has been a "reduction" in "coverage" or reimbursements as a result of Aetna's use of CPBs, as it understands those terms—terms which RPEA has failed to define.

The State admits that it did no "formal analysis" to determine if any diminishment in benefits occurred as a result of the changes made to the Plan. The evidence presented here explains why that analysis was not done. It was not done because the State knew that an honest analysis of the changes proposed in 2013 and subsequently implemented on and after January 1, 2014 would result in substantial diminishments and impairments of Plan coverages and other benefits.

Some of the most significant and obvious diminishments and impairments that have occurred are described in this memorandum. However, there are likely thousands of Plan members who have had types of claims denied—previously covered by the Plan—based on the substitution of Aetna's CPBs in place of the Plan's standards for determining whether medical procedures and treatments are "medically necessary" and determining if they are "experimental."

These Plan changes not only violated art. XII, § 7 of the Alaska Constitution and the requirements, limitations, and conditions that the Alaska Supreme Court established for the State to follow if it wanted to make Plan changes that would result in the diminishment or impairment of Plan benefits. The changes resulted in the taking of property in violation of the Taking provisions of the Alaska and U.S. Constitution and were done without giving Plan members reasonable notice and opportunity to be heard in violation of state and federal constitutional rights of Due Process. The changes and the methods of making them also breached the fiduciary and contractual duties that the State owes to the retired public employees of Alaska who earned vested retirement benefits under the AlaskaCare Retiree Health Plan of 2003 to ensure that they receive the benefits that the Plan provides.

For these reasons, the RPEA respectfully asks this Court to find that there is no genuine issue of fact concerning each of the following:

1. The summary and sudden promulgation of Plan Amendment 2014-1 and associated changes in how the Plan has been administered since 2013 resulted in substantial reductions in Plan coverages and other benefits that are "disadvantages" that have had and will continue to have a substantial negative impact on the health and the finances of Plan members.

2. Among the most substantial and far-reaching of the negative changes made to the Plan by the Amendment were a) the substitution of Aetna's CPBs in place of the Plan's standards for determining the medical necessity of medical procedures, treatment and supplies; b.) a substantial expansion of the requirements that must be satisfied by a Plan member before coverage will be provided for medical procedures, treatments or supplies that are considered experimental or investigational; c) the abandonment of the Beech Street Network of providers as the Plan's network and the substitution of Aetna's network which the State knew was inadequate in Alaska and needed development, with negative impacts on Plan members who had developed trusted relationships with providers in the Beech Street Network in reliance on the assurances and encouragement the DRB had historically provided to them concerning the advantages of choosing a provider in the Beech Street Network; d.) the substantial expansion of the precertification requirements and the doubling of the financial penalties for Plan members using non-Aetna providers who fail to obtain the required precertifications; e.) the substantial reduction in the coverage provided to Plan members who had transplant surgeries at hospitals that were not in Aetna's network; and f) the substantial reduction in the coverage provided to Plan members for the fees charged by assistant surgeons who were necessary for a surgery but who were not within Aetna's network.

3 The negative Plan changes were not necessary to prevent the Plan coverages from becoming obsolete as the science of medicine and health care evolve.

4. The negative Plan changes were made without any formal analysis being done by the State to determine their impact on Plan members.

5. Before the Amendment was promulgated, managerial level employees of the DRB and the Alaska Dept. of Administration knew and had reason to know that the negative Plan changes that would be caused by the implementation of the Amendment would result in substantial diminishments and impairments of Plan coverages and other benefits that would have a substantial negative impact on the health and the finances of affected Plan members going forward.

6. The Amendment was promulgated on December 31, 2013 and made effective the following day.

7. Plan members were not given reasonable notice or opportunity to be heard before the Amendment and associated changes in Plan administration were implemented. Specifically, they were not given the opportunity to review the specific wording of Amendment or even provided with a fair and reasonable description of all of its contents. They were not told of the specific reasons for the Amendment. They were not told of all the negative impacts the changes were expected to have on Plan members and the nature and scope of the coverages and other benefits ("advantages"), previously provided by the Plan, that would be reduced, impaired or eliminated.

8. The State made no effort to determine if any diminishments or impairments in coverage would result in serious hardship to a certain Plan members.

9. The DRB added no new Plan "advantages" of comparable type and of equivalent value to the Plan to offset the reductions in coverages and other benefits that occurred as a result of the Amendment.

Based on these facts, the RPEA respectfully requests that the Court enter summary judgment in its favor on the grounds that the promulgation and implementation of Plan Amendment 2014-1 resulted in substantial diminishments and impairments of Plan coverages and other benefits that were Plan "disadvantages" and has substantially and

negatively impacted Plan members, holding that the promulgation and implementation of the Amendment Plan 1) violated art. I, § 7 of the Alaska constitution; 2) violated the restrictions, limitations and conditions established for making such changes that have been established by the Alaska Supreme Court; 3) deprived Plan members of valuable property in violation of Plan members' rights of Due Process and the protections provided to them by the Takings provisions of Alaska Constitution and the Constitution of the United States; and 4) that both the substance of the Amendment and its method of implementation were a breach of contract and a breach of the fiduciary duties that the DRB owes to the retired public employees of Alaska who earned and have a right to receive, undiminished and unimpaired, the benefits provided by the AlaskaCare Retiree Health Plan of 2003.

A proposed order is attached.

DATED this 8th day of February 2022.

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