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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-18-06722 CI

PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT

DECLARING "RETIREE HEALTH PLAN AMENDMENT 2016-2" NULL AND VOID; FOR AN ORDER ENJOINING THE DEFENDANT FROM REQUIRING PLAN MEMBERS TO PAY A SECOND ANNUAL DEDUCTIBLE AS A CONDITION OF RECEIVING HEALTH PLAN BENEFITS THAT ARE SUPPLEMENTAL TO MEDICARE AND DIRECTING THE DEFENDANT TO PROVIDE RESTITUTION

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I. SUMMARY OF MOTION AND RELIEF REQUESTED

This motion concerns an issue affecting members of the AlaskaCare Retiree Health Plan ("Plan") over the age of 65 whose primary medical insurance is provided by Medicare and who have paid their annual Medicare deductible. For those Plan members, the AlaskaCare Plan only provides medical coverage that is supplemental to Medicare.[1]

The issue arose after a Plan member over age 65 paid his annual Medicare deductible and then was informed by the Alaska Division of Retirement and Benefits ("DRB") that he would be required to pay a second deductible as a condition of receiving Plan medical benefits he needed that were supplemental to Medicare. After reviewing the Plan, he appealed to the Alaska Office of Administrative Hearings ("OAH").

AS 39.35.006 gives the OAH jurisdiction and the final authority within the executive branch to hear and decide appeals of decisions made by the Plan administrator concerning Plan terms and benefits. If the Plan member or the Plan administrator disagrees with the resulting OAH decision, that party has the right to appeal to the Superior Court within 30 days. See AS 39.35.006; Alaska Appellate Rule 602(a)(2).

The OAH ruled that Plan members who had paid their annual Medicare deductible were **not** required by the terms of the AlaskaCare Plan to pay a second annual deductible as a condition of receiving the Plan benefits that are supplemental to Medicare. Therefore, it reversed the Plan administrator's (i.e., the DRB's) decision.[2]

The OAH decision expressly notified the DRB of its right to appeal the decision to the Superior Court.[3]

The DRB chose not to appeal. It also did not notify Plan members of the OAH ruling or the DRB's plans for dealing with it.[4]

Instead, the DRB summarily and unilaterally issued "AlaskaCare Retiree Health Plan Amendment 2016-2" and then relied on it as authority for requiring retirees to pay a

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[1] See Exhibit 1, AlaskaCare Retiree Health Plan Information Booklet May 2003, p. 16.

[2] Exhibit 2: In the Matter of C.P., OAH No. 15-0283-PER (April 16, 2016), p. 7.

[3] Id. at p. 7.

[4] Exhibit 3: Affidavit of RPEA President Sharon Hoffbeck at p. 2, ¶ 4.

second deductible that the OAH had ruled the DRB was not authorized to do.[5]

In this motion, the RPEA contends:

1. the unappealed OAH ruling was a final decision establishing that under the terms of the Plan, retirees who pay their annual Medicare deductible have the right to receive Plan benefits that are supplemental to Medicare without having to pay a second annual deductible;

2. the DRB's "amendment" of the Plan is null and void because a) it violates Art. XII, § 7 of the Alaska Constitution and common law protections of contract rights; and b) was created and implemented in violation of the limitations and requirements specified by the Alaska Supreme Court in the Duncan[6] opinion and without providing retirees with any notice and or opportunity to be heard as required by Due Process. and

3. the DRB's conduct, after the OAH decision, of continuing to require Plan members who paid their annual Medicare deductible to pay a second annual deductible as a condition of receiving Plan benefits supplemental to Medicare is a diminishment and impairment of a vested retirement benefit in violation of Art. XII, §7 of the Alaska Constitution and an on-going violation of Due Process and the Takings provisions of the constitutions of Alaska and the United States.

For these reasons, the RPEA asks the Court to 1) declare the amendment null and void; 2) enjoin the State from requiring retirees to pay a second deductible as a condition of receiving Plan medical benefits that are supplemental to Medicare; and 3) order the State to reimburse, with interest, all the monies any Plan member paid since April 13, 2016 toward satisfying a second deductible imposed by the DRB as a requirement for receiving Plan benefits that are supplemental to Medicare.[7]

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[5] Exhibit 4: "AlaskaCare Retiree Health Plan Amendment No. 2016-2"

[6] Duncan v. Retired Public Employees of Alaska, Inc., 71 P.3d 882 (Alaska 2003)

[7] **N.B:** The RPEA is **not** asking the Court to revisit the issue of the second deductible that was decided by the OAH. The OAH decision that the Plan does not require retirees to pay a second deductible was not appealed by the DRB and therefore under AS 39.35.006 became the final decision on the matter.

II. Constitutional and Common Law Provisions that Protect the Vested Retirement Benefits of Retired Public Employees of Alaska

A. Introduction. The vested retirement benefits earned by and promised to the retired public employees of Alaska in return for their public service are expressly protected against diminishment and impairment by Art XII, § 7 of the Alaska Constitution.

Because vested retirement benefits are valuable property,[8] they are also protected by the Due Process[9] and the Takings[10] provisions of the Alaska and U.S. constitutions.

Also, because the retirement benefits arose from contract and vested when each retiree performed their end of the contractual bargain, the common law of contracts prohibits the State from unilaterally amending the contract to deprive the other parties—i.e., retirees—of their vested contractual rights[11] or doing anything else to injure the rights of the Plan beneficiaries to receive the benefits of the contract.[12]

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[8] The parties agree that vested retirement benefits are valuable property. See Amended complaint, ¶ 44, p. 13; Answer to amended complaint, ¶ 44, p. 9.

[9] Alaska Constitution, Art. I, § 7; Fifth and Fourteenth Amendment to the United States Constitution.

[10] 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."

[11] See Zuelsdorf v. University of Alaska, 794 P.2d 932, 935 (Alaska 1990) ("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")

[12] Guin v. Ha, 591 P.2d 1281, 1291 (Alaska 1979) ("In every contract, including policies of insurance, there is 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."); see gen. Restatement (Second) of Contracts § 205 (1979).

B. Art. XII § 7 of the Alaska Constitution – Protection of Vested Retirement Benefits

Art. XII § 7 of the Alaska Constitution states that retirement benefits arise by contract and that once those benefits have accrued,[13] they "shall not be diminished or impaired."[14]

The provision is a constitutional command, a promise and a guarantee.

The Alaska Supreme Court has consistently rejected efforts by the State to erode or circumvent that constitutional provision. In particular, it has stated clearly that it rejects the State's argument that concerns about rising medical costs can overcome or justify reinterpreting the plain meaning and intent of Art. XII, §7 of the Alaska Constitution. In fact, the Court made that point two separate times in the Duncan opinion:

> [W]e acknowledge that medical costs are rapidly rising, making health insurance increasingly difficult to provide. But we do not believe that this fact is of sufficient weight to change the meaning of the plain language of article XII, section 7.

Duncan, 71 P.3d at 888.

> The state's argument that the pension system may at some point be threatened by increasing costs of health care is a serious one. Again, however, we do not believe that this argument is sufficient to change the meaning of the constitutional language in question.

Duncan, 71 P.3d at 889.

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[13] 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)

[14] Art. XII § 7 of the Alaska Constitution states in its entirety:

> The 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.

1. The Exception: Changes to Prevent Plan Obsolescence

In Duncan, the Alaska Supreme Court recognized the potential risk that over time, some medical coverages and benefits provided by the Plan might become obsolete as the science of medicine evolves. To avoid that risk, the Court determined that the Plan should be allowed to evolve when necessary to keep pace with developments in medicine and the kinds of coverages provided by "mainstream" medical insurance plans.[15]

The Court recognized that those types of changes might necessitate replacing some existing Plan provisions that did not cover new medical treatments and supplies with new coverages and benefits that did. The problem was that doing so might result in the diminishment or impairment of existing coverages that some retirees might still need, and that would violate Art. XII, § 7 of the Alaska Constitution.

To resolve that dilemma, the Court in Duncan held that the State might be permitted to make those kinds of changes without violating Art. XII § 7 of the Alaska Constitution if the State first proved:

1. the proposed changes were necessary to prevent the current Plan from becoming obsolete by providing coverages for new medical treatments and supplies that the current Plan did not provide and that were covered by current "mainstream" major medical plans;

2. the State had undertaken and satisfactorily completed certain studies and analyses that showed by "reliable evidence" that the new benefits that the State proposed to provide were "comparable" to those that would be diminished or impaired and would "offset" the any benefits that would be diminished or impaired;[16] and

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[15] Duncan, 71 P.3d at 891("[W]e believe that health insurance benefits must be allowed to change as health care evolves.") and at 893 ("[W]e believe that the coverage that is offered should generally be "in keeping with the mainstream" of health insurance packages offered to active public employees in terms of scope and balance.")

[16] Duncan, 73 P.3d at 892 ("At the outset, we reiterate Hoffbeck's admonition that equivalent value must be proven by reliable evidence."); and at 889 ("[D]isadvantageous changes must be offset by comparable new beneficial changes."). Citing Hoffbeck, 627 P2d at 1057, the Court in footnote 26 noted that "the offsetting improvement must also 'relate generally to the benefit that has been diminished.'"

3. the State would take certain measures, specified by the Court, to ensure that if the State's proposals were permitted by the Court, no Plan members would suffer any serious hardship.[17]

The Court in Duncan anticipated the danger that its decision might be interpreted by the State as giving it grounds to argue that if "mainstream" plans offered less coverages and benefits than the AlaskaCare Plan, the State should be allowed to reduce Plan coverages and benefits to match those plans.

To prevent that, the Court went into considerable detail about what the State would need to prove before it would be allowed to make any changes to the Plan that would result in the diminishment or impairment of any medical coverage or benefit.

First, as previously noted, it made implicitly clear that the only allowable reason for changing the Plan was to prevent it from becoming obsolete and that the State bears the burden of proving that 1) the reason for its proposed changes is to provide coverages and benefits for new medical diagnoses, treatments and supplies that are not already covered by the existing Plan; and 2) that the proposed new coverages and benefits are consistent with coverages provided by so-called "mainstream" major medical plans.

Second, the Court made clear that the State must prove that it had undertaken and completed an "equivalency analysis" to determine whether the benefits and coverages it was proposing to change would be "offset" by comparable new medical coverages and benefits that would be added to the Plan. The Court described in considerable detail the nature and quality of the evidence that was, and was not, acceptable for the State to rely on to meet its burden of showing equivalent value:

> At the outset, we reiterate Hoffbeck's admonition that equivalent value must be proven by reliable evidence. Just as with an individual comparative analysis, offsetting advantages and disadvantages should be established under the group approach by solid, statistical data drawn from actual experience—including accepted actuarial sources—rather than by unsupported hypothetical projections. We also believe that, apart from the individualized approach, the other guidelines concerning equivalency analysis set out in Hoffbeck should continue to be generally applicable.

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[17] Duncan, 73 P.3d at 891-92.

> 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 also held that the State has an obligation to determine whether its proposed changes, if allowed, would eliminate coverage for the treatment of a particular disease or condition that would result in serious hardship to Plan members who suffer from that disease or condition. If any proposed change would cause such a hardship, then it should not be allowed. As stated by the Court:

> 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.

And Court went further. It recognized that there might be circumstances when the State might propose changes to the Plan that, if implemented, would predictably cause hardship to a significant number of Plan beneficiaries **who could not at the time be specifically identified**. The Court made clear that in such circumstances, the State must provide those affected beneficiaries with the option of keeping their existing Plan coverages unless the State first proves that there is a "compelling need" for the changes and that offering those Plan members the option of keeping their existing coverages is prevented by "impracticability."

> [I]f there should be changes that will predictably cause hardship to a significant number of beneficiaries who cannot at the time of the change be specifically identified, we believe that the option of providing an election to beneficiaries to retain existing coverage should be available, at least in the absence of a showing by the state of a compelling need for the change and the impracticability of providing for an election.

Duncan, 71 P.3d at 892.

Finally, the Court also recognized the possibility that there could be Plan members who the State might not have reason to know would "predictably" suffer hardship if the proposed changes were put into effect. The Court stated that in such circumstances, any Plan members who come forward and are able to show that the changes would them a "serious hardship" or "substantial detriment" that is not offset by a comparable new advantage should be allowed to keep the pre-change Plan coverages:

> Where there is 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. This is suggested by a distinction between Hoffbeck and the present case. [...] We believe that if there were an individual showing that substantial detriments were not offset by comparable advantages and that this resulted in a serious hardship, the affected individual should be protected from the change by article XII, section 7.

Duncan, 71 P.3d at 892.

The strict limitations and requirements specified in Duncan for the State to abide by and fulfill when asking the Court to reform the contract are consistent with the Court's "judicial policy [of] seek[ing] to maintain and enforce contracts, rather than enable parties to escape from the obligations they have chosen to incur.' "[18]

2. The State's Burden of Proof

Reformation of a contract is allowed only for limited reasons.[19] The Duncan opinion indicates that one of those reasons is to ensure that the intentions of the parties are fulfilled; that is, that the Plan will provide major medical coverages and benefits that

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[18] Recycling Ctr. v. Hobbs Indus., 228 P.3d 93, 98–99 (Alaska 2010), quoting Inman v. Clyde Hall Drilling Co., 369 P.2d 498, 500 (Alaska 1962). The limitations and requirements are also consistent with certain statutes applying to trustees in the administration of trusts in Alaska. See e.g., AS 13.36.350(a); AS 13.36.360(c)

[19] See Adams v. Adams, 89 P.3d 743, 752 (Alaska 2004),

will not be diminished or impaired, including by obsolescence, and will cover the medical treatments and supplies that major medical plans cover as medical science evolves.[20]

A party seeking to reform a contract has the burden of proving by clear and convincing evidence the facts necessary for the court to reform the contract.[21]

C. Due Process Protections

The State and the RPEA agree that vested retirement benefits are valuable property rights.[22]

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 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."[23]

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[20] The reasoning is akin to the Court approving reformation of a contract when "the words of the writing do not correctly express the meaning that the parties agreed upon." See Wasser & Winters Co. v. Ritchie Bros. Auctioneers (America), Inc., 185 P.3d 73, 78 (Alaska 2008). The Duncan opinion appears to follow that reasoning based on its recognition of the possibility that evolving medical science might lead to the development of means of medical diagnoses, treatments and supplies that might not be covered by the original wording of the AlaskaCare Plan. In that circumstance, the "words of the writing would no longer correctly express the meaning that the parties agreed upon." Id. "[I]n determining whether to reform a contract, the parties' intentions are dispositive." Simmons v. Insurance Co. of North America, 17 P.3d 56, 63 (Alaska 2001)

[21] Adams, 89 P.3d at 752 ("A party seeking reformation is required to prove the elements of reformation by clear and convincing evidence.")

[22] Amended complaint, ¶44, p. 13. Answer to amended complaint, ¶44, p. 9.

[23] 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

The fundamental requisite of Due Process reasonable notice and opportunity to be heard at a meaningful time and in a meaningful manner.[24]

> 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 ensures requires that all persons whose property rights the State proposes to take or infringe are given notice that candidly and fully informs them of the reason(s) for the proposed action and of the specific property rights that the State is attempting to take or infringe.[25]

Due process requirements also apply to administrative proceedings.[26]

(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).

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

[25] 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)

[26] Balough v. Fairbanks North Star Borough, 995 P.2d 245, 266 (Alaska 2000)

D. The Protections of the Takings Clauses

The Takings Clauses of the Alaska and U.S. constitutions are relevant to the restitutionary relief that the RPEA is asking the Court to provide.

Art. I, § 18 of the Alaska Constitution states that "[p]rivate property shall not be taken or damaged for public use without just compensation." Like its federal counterpart, it applies to personal property as well as real property.[27]

The Alaska Supreme Court has recognized that the Takings Clause of the Alaska Constitution is broader than the Takings Clause of the U.S. Constitution because it includes the words "or damaged," after the word "taken."[28]

The Court has also stated that it liberally interprets the Alaska Takings Clause in favor of the property owner, whom it protects "more broadly" than the federal Takings Clause.[29]

Vested retirement benefits are property rights protected by the Takings provisions of the Constitution of Alaska and the Constitution of the United States. Therefore, retirees who have been wrongfully deprived of any of those benefits by government action are entitled to just compensation, including interest.[30]

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[27] 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. __, __, 135 S.Ct. 2419, 2426 (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.")

[28] Anchorage v. Sandberg, 861 P.2d 554, 557 (Alaska 1993)

[29] 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))

[30] Here the duty to pay 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 member or beneficiary. [...] The interest paid under this subsection is at the rate established by

III. UNDISPUTED FACTS

The AlaskaCare Retiree Health Plan is a health insurance policy provided to retired public employees of Alaska who have earned vested retirement benefits.

The State and the RPEA agree that vested retirement benefits are valuable property rights.[31]

The terms of the AlaskaCare Plan are provided in a handbook called the "Retiree Insurance Information Booklet – May 2003."[32] Page 16 of that handbook states that when AlaskaCare Plan members reach age 65, the Plan benefits become "supplemental" to Medicare.

> You or your eligible dependent **must** elect Medicare Part A and B at age 65, regardless of any other coverage you have. If you or your eligible dependent is eligible for Medicare coverage (and most people are eligible at age 65), the benefits available under this plan become supplemental to your Medicare coverage.

Exhibit 1 at p. 2 (emphasis in original)

> 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 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))

[31] Amended complaint, ¶44, p. 13. Answer to amended complaint, ¶44, p. 9.

[32] See Exhibit 2 at p. 4, n. 6, citing In Re *D.T.*, OAH No. 10-0577-PER (2011), page 2.

AS 39.35.006 provides the OAH with the jurisdiction and final authority within the executive branch to hear and decide appeals of decisions made by the Plan administrator concerning Plan terms and benefits before the matter may be appealed to the Superior Court.

> **AS 39.35.006 Appeals.** An employer, member, annuitant, or beneficiary may appeal a decision made by the administrator to the office of administrative hearings established under AS 44.64. An aggrieved party may appeal a final decision to the superior court.

On April 13, 2016, the OAH ruled that the terms of the AlaskaCare Plan did not support the Plan administrator's decision to require Plan members who had paid their annual Medicare deductible to pay a second deductible as a condition of receiving AlaskaCare Plan benefits that are supplemental to Medicare.[33]

The DRB, as the designated administrator of the Plan, had the right under AS 39.35.006 and by court rule[34] to appeal that decision to the Superior Court within 30 days. The last sentence of the OAH opinion gave the DRB clear notice of the 30-day deadline for appealing the decision to the Superior Court:

> Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision. [Exhibit 2, p. 7]

The DRB chose not to appeal the OAH decision. It did not notify Plan members of the OAH decision and continued requiring them to pay the second deductible.[35] Then, 42 days after the OAH decision, the DRB issued "AlaskaCare Retiree Health Plan Amendment No. 2016-2." See Exhibit 4.

The document purports to amend the Plan by "**Replac[ing] in whole the Effect of Medicare section found on page 16.**" Id. at p. 1 (emphasis in original)

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[33] In Re C. P., OAH No. 15-0283-PER (copy of opinion attached as Exhibit 2)

[34] Alaska Appellate Rule 602(a)(2)

[35] Affidavit of RPEA President Sharon Hoffbeck, Exhibit 3, p. 2 at ¶ 4.

It also purports to amend the parts of the Plan dealing with "Coordination of Benefits" by "**Replac[ing] in whole the Coordination of Benefits section under General Provisions found on pages 101-105.**" Id. at p. 2. (emphasis in original) The sections the amendment purportedly "replaced" appear in pp. 2-7 of Exhibit 1.

The amendment states that it was effective the day it was signed, May 25, 2016.[36] The distribution list on the first page of the document indicates that it was not distributed to Plan members.[37]

Based on information and belief, at no time since the OAH decision In re C.P., OAH No. 15-0283-PER (April 16, 2016) has the DRB ever stopped requiring Plan members to pay a second deductible as a condition of receiving Plan benefits that were supplemental to Medicare.[38]

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[36] Exhibit 4 at pp. 1 and 5.

[37] Id. at p. 1.

[38] Affidavit of RPEA President Sharon Hoffbeck, Exhibit 3, at p.2, ¶ 5.

IV. ARGUMENT

The DRB's conduct following the OAH decision supports the conclusion that the DRB determined the decision was well-founded and unlikely to be reversed on appeal. As a result, instead of appealing, the DRB decided to issue an "amendment" as grounds it could point to as its "authority" for continuing to require Plan members to pay a second deductible in spite of the OAH decision.

Requiring Plan members to pay a second deductible after the OAH ruling ignored the ruling and was a diminishment and impairment of Plan benefits that violated the command, the promise and the guarantee of Art. XII, §7 of the Alaska Constitution.

The DRB's amendment was imposed with a complete disregard to the limitations and the requirements specified by the Alaska Supreme Court in Duncan. By unilaterally depriving retirees of vested contractual rights, it also violated the common law of contracts.

The intent of the amendment was not to keep the Plan from becoming obsolete. No comparable new benefit or advantage was added to the Plan to offset the diminishment/impairment, so the State did none of the studies or perform the analyses required by Duncan. It made no effort to obtain court approval before or after implementing its Plan amendment. It put the burden on retirees to file an action challenging its action. That is not the conduct of a fiduciary. It is instead conduct suggesting an agency that believes it has the freedom to do what it wants regardless of the constitution and regardless of the limitations, requirements and guidelines established by the Alaska Supreme Court.

The amendment was created and implemented without Plan members being given reasonable notice and opportunity to be heard **in court and in advance** of the implementation. The DRB completely ignored the role of the courts in vetting and approving changes to the Plan that was at the heart of the Duncan opinion. It did not even give Plan members notice of its intention to implement the change, the reason for the change, or any opportunity to respond or provide input to the DRB prior to

implementing the change. That conduct—those acts and omissions—deprived Plan members of property in violation of state and federal constitutional rights of Due Process.

The Alaska Constitution states that its terms shall be construed as being self-executing whenever possible.[39] It also requires all Alaska public officers to both affirm and subscribe that they will support and defend the Constitution of the United States and the Constitution of Alaska.[40] In a perfect world, there would be no need for the courts to review decisions made by the administrators of the AlaskaCare Plan or their proposed changes to the Plan. Unfortunately, this is not a perfect world.

When Aetna took over as the third-party administrator of the AlaskaCare Plan in 2014, the DRB began making substantive changes to the Plan without prior court review and approval and then leaving it to individual retirees or the RPEA to try figure out the all the negative effects of those changes and then, if necessary, challenge them in court. That is more than institutional hubris. It ignores the constitutional and contractual rights of the retired public employees who earned vested retirement benefits. It wrongfully shifts the State's burdens onto weaker parties who should not bear those burdens. It violates separations of powers by ignoring the limitations and requirements established by the Alaska Supreme Court in the Duncan case. The DRB's assumption of carte blanche authority to make any changes it wants to the Plan creates serious hardships for affected Plan members, major confusion and results in a tremendous waste of resources, requiring those changes to be examined after-the-fact and, when necessary, requiring equitable remedies to be developed and implemented that usually are, at best, only partially restitutionary and come years after the harm has occurred.

The DRB's conduct of summarily issuing a plan "amendment" instead of appealing a decision of the OAH is a clear example of the DRB's cavalier attitude and approach towards the Alaska Constitution; towards the Duncan decision and towards the people it should be serving with a fiduciary duty of good faith, loyalty, and candor to ensure they

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[39] Alaska Constitution, Art. XII, § 9.

[40] Alaska Constitution, Art. XII, § 5.

receive the retirement benefits that they earned and were promised in return for their public service.

The DRB is the Alaska state agency charged with the duty to administer the Plan. With that duty comes a heavy responsibility to ensure that the retired public employees of Alaska who earned vest retirement benefits actually receive those benefits. Given the power entrusted to the DRB and the relative vulnerability of Plan members, the DRB should be held to fiduciary standards of fulfilling its duties. Neither the RPEA nor the Alaska courts should have the primary responsibility for ensuring that the retirees receive the benefits they earned and were promised.

In this motion, the RPEA has provided the reasons why the DRB's "We can make whatever changes we want and if you don't like it, sue us" attitude and conduct is wrong as a matter of law. The DRB cannot be allowed to make whatever changes it wishes—under the guise of "modernizing" the Plan—without following the procedures required by law.

But the DRB conduct does more wrong than violate the law. It is also wrong on both moral and public policy grounds. Allowing the DRB to make changes and then leave it to the RPEA or individual retirees to challenge those changes in court can and does cause serious physical, emotional and financial suffering and hardship to Plan members during the time it takes for the cases to be prepared for filing, developed, presented and decided. It wrongly shifts burdens onto individual retirees or the RPEA to take action and is based on the apparent belief that individual retirees or the RPEA will always have the resources to mount and sustain such after-the-fact challenges that often last for years.

Placing the burden on retirees or the RPEA to try to determine and prove, after-the-fact, all the harmful effects experienced by Plan members as a result of changes summarily made by the DRB is a burden that is extremely difficult, if not impossible, to fulfill. State and federal laws protecting patient privacy seriously impair the ability of retirees and the RPEA to gain important information.

Much of the relevant information is buried deep in the records of the third-party Plan administrators ("TPAs"). Many Plan members trust what they are told by the TPAs

about what the Plan does and does not cover or else the simply accept what they are told because the idea of questioning the decision, much less appealing it, is too overwhelming to them. For these and other reasons, it is difficult to determine all the Plan members who have been negatively affected by the changes to the Plan. The DRB is certainly in the best position to know that information and has a fiduciary duty to disclose **in advance**, at least generally, what if knows or has reason to believe would be the effects of its proposed changes.

History shows that when the RPEA or other retirees bring such challenges, the cases are complicated, time-consuming and expensive. During the years it takes for the cases to make their way through the courts, some if not all Plan members are denied medical coverages that may determine whether or not they get the medical treatments prescribed by their doctors. Based on what the DRB has been doing in recent years by summarily making Plan changes, if and when the courts might eventually decide that the changes imposed by the DRB did result in an unconstitutional diminishment or impairment of retirement medical benefits, fashioning and implementing a restitution remedy is complicated, time-consuming and unlikely to result in full and fair remedy for many, if not most, affected Plan members.[41]

> **If the right to notice and a hearing is to serve its full purpose, then, it is clear that it must be granted at a time when the deprivation can still be prevented.** At a later hearing, an individual's possessions can be returned to him if they were unfairly or mistakenly taken in the first place. Damages may even be awarded to him for the wrongful deprivation. **But no later hearing and no damage award can undo the fact that the arbitrary taking that was subject to the right of procedural due process has already occurred. 'This Court has not . . . embraced the general proposition that a wrong may be done if it can be undone.'** Stanley v. Illinois, 405 U.S. 645, 647 (1972)

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[41] Some retirees may have died during the litigation. Others may not have any claims for restitution because they could not afford to pay for the medical treatments they needed and were denied while the DRB's Plan changes causing the denial of coverage were being litigated. These and similar reasons support the observation that **"once it becomes clear that the benefits are due, delaying payment is as good as not paying at all."** Henderson, R. C., "The Tort of Bad Faith in First-Party Insurance Transactions After Two Decades," 37 Ariz. L. Rev. 1153, 1159–60 (1995) (emphasis added)

Fuentes v. Shevin, 407 U.S. 67, 81–82 (1972) (emphasis added).

See State, Dept. of Natural Resources v. Greenpeace, Inc., 96 P.3d 1056, 1064 (Alaska 2004) ("The [U.S. Supreme] Court has emphasized that **the hearing must occur before the property interest is taken away**.") (emphasis added)

The Duncan opinion makes clear that proposed changes to the Plan that would result in the diminishment or impairment of any existing coverage should only be permitted to prevent the Plan from becoming obsolete, keeping it up-to-date with evolving medical science. Major changes in medical science do not happen frequently. When they do occur, they usually do not happen suddenly and are usually covered by the existing terms of the Plan.

In Duncan, the Court recognized that there might come a time when medical science might discover or develop a new and effective means of prevention, diagnosis, or treatment of a medical condition that is not covered according to the terms of the existing Plan and should be covered in accordance with the intent that retirees be provided with up-to-date major medical coverage.

In those unusual circumstances, the State should develop a comprehensive plan for proposing changes to the AlaskaCare Plan that preserves and protects the rights of retirees and fulfills the DRB's fiduciary duties; a plan that in good faith abides by the limitations, fulfills the requirements and follows the guidelines of the Duncan opinion; a plan that complies with all other applicable statutory and common law. It should also ensure that Plan members are fully and candidly informed of the reasons for and the substance and expected effect of the proposed changes and be given an opportunity to be heard in court before any change is made that reasonably can be expected to result in the diminishment or impairment of an existing Plan benefit.

To do this, the formulated plan should include at least the following five steps.

First, the DRB should specifically identify the new medical equipment, procedure, treatment, or medicine that has been discovered or developed that is important and

effective in the prevention, diagnosis, or treatment of a medical condition and explain why it is not covered under the terms of the existing Plan.

Second, the DRB should provide a complete and candid description of the existing coverages and benefits that would be diminished or impaired if the proposed changes were to be approved by the court and why the DRB believes those proposed changes would not result in a serious hardship to any Plan members or, if they would, how the DRB plans to prevent Plan members from experiencing those serious hardships.

Third, it should perform the kinds of equivalency analyses required by the Court in Duncan and show what those analyses revealed about how the proposed Plan changes would be "offset" by comparable new coverages and benefits that the DRB contends would provide Plan members with coverage for the new medical equipment, procedure, treatment, or medicine that is not provided by the existing Plan.

Fourth, it should provide the plan information described in the three steps above to all individuals who are, or are expected to become, members of the AlaskaCare Retiree Health Plan and give them a reasonable opportunity to provide feedback in order to allow the DRB to comply with the Duncan requirement that it ascertain in advance if any proposed change would result in a serious hardship to any Plan member.

Fifth, it should include the requirement that the DRB file an action in the Superior Court to request court approval of the proposed Plan amendments. At the start, the DRB should obtain court guidance and approval of the method, content and timing of the notice that the DRB must give to individuals potentially affected to ensure they have reasonable notice of the reasons for and effects of the proposed changes and have a reasonable opportunity to be heard in court.

DRB's performance of these five steps and obtaining court approval of the proposed changes **before** they are implemented are necessary to ensure that the DRB fulfills its fiduciary duties to Plan members and that the constitutional and contractual rights of Plan members are protected and preserved.

What the DRB has been doing violates the constitutional and contractual rights of Plan members; violates the requirements of Duncan, violates DRB's fiduciary duties to

Plan members and results in sudden denials of benefits that in many cases cause physical and emotion harm that as a practical matter is irreparable. It also places an oppressive burden on retirees, the RPEA and the court to try to 1) determine, after-the-fact, the various types of harm caused by changes to the Plan that the DRB unilaterally and suddenly imposes; 2) determine which Plan members suffered the harm, and then 3) determine and supervise restitutionary remedies that are complicated, difficult to administer, and all-too-often, provide too little, too late.

V. CONCLUSION AND RELIEF REQUESTED

Based on the undisputed facts and the legal authorities presented, the RPEA respectfully requests that the Court 1) hold that "AlaskaCare Retiree Health Plan Amendment 2016-2" is null and void; 2) enjoin the State from requiring Plan members who have paid their annual Medicare deductible to pay a second deductible amount as a condition they must fulfill before being entitled to receive any Plan coverages or benefits that are supplemental to Medicare; and 3) direct the State to determine the total amount of money each Plan member was charged since April 13, 2016 towards satisfying the second deductible required by the DRB as a condition of receiving a benefit provided by the Plan that is supplemental to Medicare and then reimburse the Plan member that amount of money, with interest, as restitution.

A proposed order, with proposed findings and conclusions of law, is attached.

DATED this 17th day of March 2020.

LAW OFFICES OF WM. GRANT CALLOW

WM. GRANT CALLOW, ABA No.: 7807062
Counsel to Plaintiff RPEA

Retired Public Employees of Alaska, Inc. v. State

Case No. 3AN-18-06722 CI

PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT
IN RE THE LEGALITY OF REQUIRING RETIREES TO PAY A SECOND DEDUCTIBLE AS A CONDITION OF RECEIVING MEDICAL BENEFITS THAT ARE SUPPLEMENTAL TO MEDICARE

EXHIBIT 1

Excerpts of Retiree Insurance Information Booklet – 2003

"Effect of Medicare" Section at p. 16 – exhibit page 2
"Coordination of Benefits" Section at pp. 101-105 – exhibit pp. 3-7

ALASKACARE

Retiree Health Plan

Retiree Insurance Information Booklet

May 2003

Effect of Medicare

You or your eligible dependent **must** elect Medicare Part A and B at age 65, regardless of any other coverage you have. If you or your eligible dependent is eligible for Medicare coverage (and most people are eligible at age 65), the benefits available under this plan become supplemental to your Medicare coverage. The claims administrator will assume you and/or your dependents have coverage under Medicare Part A when you or your dependent reach age 65. If you are not provided with Medicare Part A free of charge, you should submit a copy of your letter from Medicare stating that you are not eligible to the Division. **Everyone is eligible for Medicare Part B.**

If you do not enroll in Medicare coverage, the estimated amount Medicare would have paid will be deducted from your claim before processing by this plan. If you receive care outside the United States, Medicare does not cover your expenses; the retiree plan will take this into account. If you enter into a private contract with a provider that has opted out of Medicare, neither Medicare nor the retiree health plan will pay benefits for their services.

COVERED MEDICAL EXPENSES

Benefits are available for medically necessary services and supplies necessary to diagnose, care for, or treat a physical or medical condition.

To be medically necessary, the service or supply must be:

- 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;
- 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

GENERAL PROVISIONS

COORDINATION OF BENEFITS

The Plan protects you and your family to the extent of covered costs incurred. If you are entitled to benefits from other sources, such as employer or government sponsored health plans, the retiree health plan has the right to offset against or recover from those other plans or persons so that you do not duplicate recovery of covered medical expenses.

The retiree health plan coordinates benefits with other group health care plans to which you or your covered dependents belong. Other group plans are defined as benefit sources recognized for coordination of benefits and are listed below:

- Group or blanket disability insurance or health care programs issued by insurers, health care services contractors, and health maintenance organizations.
- Labor-management trustee, labor organization, employer organization, or employee benefit organization plans.
- Governmental programs, including Medicare.
- Plans or programs required or provided by any statute.
- Group student coverage provided or sponsored by a school or policy, whether it is subject to coordination or not.
- The State of Alaska Group Health Plans.

You may be covered both as a retiree and as a dependent of another covered person or you may have more than one health plan. If that occurs, you will receive benefits from both plans. However, the benefits received will be subject to the coordination of benefits provisions as indicated in this section.

Here's how benefits are coordinated when a claim is made:

- The primary plan pays benefits first, without regard to any other plan.

- When the retiree plan is secondary, the amount it will pay will be figured by subtracting the benefits payable by the other plan from 100% of expenses **covered** by the retiree plan on that claim. The plan pays the difference between the amount the other plan paid and 100% of expenses the retiree plan would cover.

- Neither plan pays more than it would without coordination of benefits. Benefits payable under another plan include the benefits that would have been payable whether or not a claim was actually submitted to the plan.

- Services which are limited to a maximum number of services in a year are not increased by having other coverage. For example, if you have two plans that each cover a single vision exam each year, the plans coordinate to cover up to 100% of a single vision exam; they do not pay for two vision exams in a year.

Example

This example assumes that the retiree has services so the retiree plan pays first.

	Retiree Health Plan	Employee Health Plan
Covered Expenses	$ 1,000	$ 1,000
Less Retiree Deductible	- 150	- 250
	= 850	= 750
Plan Coinsurance	x 80%	x 80%
Plan Payment without coordination	= 680	= 600
Plan Payment with coordination	= 680	= 320

Determining Order of Payment

A plan without coordination provisions is always the primary plan. If all plans have a coordination provision:

- A retiree plan is secondary to Medicare except if Medicare is provided before age 65 due to end stage Renal disease. Then the retiree plan remains primary for 30 months after Medicare was effective.

- Any active plan, whether it covers you as the retiree or a dependent, is primary to Medicare.

- The plan covering the retiree directly, rather than as a dependent, is the primary plan.

- A plan covering the person as a retired employee is secondary to a plan that covers that person as an active employee.

- If a child is covered under both parents' plans, the plan of the parent whose birthday falls earlier in the year (not the oldest) is the primary plan. If both parents have the same birthday, the plan that has covered a parent longer is the primary plan.

Following are exceptions to this birthday rule:

- If the other plan does not have this birthday rule, the other plan's rule is used to decide which plan is primary.

- If you are separated or divorced, the plans pay in the following order:

  — First, the plan of the parent whom the court has established as financially responsible for the child's health care (The claims administrator must be informed of the court decree. However, even though you are divorced and required to pay for medical coverage, your dependents are not automatically eligible for this plan. See the sections on *Eligibility* on pages 6-7 and *Continued Health Coverage* on pages 95-99.

  — Second, the plan of the parent with custody of the child.

  — Third, the plan of the spouse of the parent with custody of the child.

  — Fourth, the plan of the parent who does not have custody of the child.

If none of the above rules apply, the plan that has covered the patient longer is primary.

It is your responsibility to report the existence of and the benefits payable to you under any plan and to file for those benefits in the interests of computing services or benefits due under this Plan.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered is considered a covered service and a benefit paid. The reasonable cash value of any services that any service organization provides is considered an expense incurred by you or your covered dependent, and the liability under this Plan is reduced accordingly.

REIMBURSEMENT PROVISION

If you or a dependent suffers a loss or injury caused by the act or omission of a third party, medical benefits for the loss or injury will be paid only if the person suffering the loss or injury, or the legally authorized representative, agrees in writing:

- To pay the retiree health plan up to the amount of the benefits received under the plan if damages are collected from the third party or their representative. Damages may be collected by action at law, settlement, or otherwise.

- To provide the claims administrator a lien for the amount of the benefit paid or to be paid. This lien may be filed with the third party, his or her agent, or a court which has jurisdiction in the matter.

ACCESS TO RECORDS

All members of the Plan consent to and authorize all providers to examine and copy any portions of the hospital or medical records requested by the Plan when processing a claim, precertification, or claim appeal. Members are the retiree and eligible dependents covered by the Plan.

Retired Public Employees of Alaska, Inc. v. State

Case No. 3AN-18-06722 CI

PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT
IN RE THE LEGALITY OF REQUIRING RETIREES TO PAY A SECOND DEDUCTIBLE AS A CONDITION OF RECEIVING MEDICAL BENEFITS THAT ARE SUPPLEMENTAL TO MEDICARE

EXHIBIT 2

Final Decision – In Re C. P., OAH No. 15-0283-PER (April 13, 2016)
(7 pages)

BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS

In the Matter of	)	
	)	
C P	)	OAH No. 15-0283-PER
	)	Agency No. PERS 2015-0122

FINAL DECISION

I. INTRODUCTION

C P is a beneficiary of the AlaskaCare Retiree Health Plan ("Plan") medical insurance as a spouse of a Tier 1 retiree. He brought this appeal to contest the determination of the Division of Retirement and Benefits ("DRB" or "Division") to require an annual deductible under the Plan in addition to the annual deductible that Mr. P was required to pay pursuant to his membership in the Medicare Program, part B. After engaging in investigation and discovery, the parties stipulated that the case "may be resolved on dispositive motion practice," without the need for a hearing.[1] They then submitted cross-motions for summary adjudication.

A proposed decision was issued on January 11, 2016; it concluded that the language of the Plan is ambiguous as to whether DRB can require retirees to pay both deductibles sequentially, and therefore it must be construed to meet the insured's reasonable expectation that the deductibles may be satisfied concurrently. DRB submitted a Proposal for Action (PFA), urging that the proposed decision be rejected, and raising certain arguments that were not articulated in its summary adjudication brief, including that the proposed decision will cause "far reaching and potentially devastating results on the resources necessary to sustain the Plan and its coverage,"[2] and that Mr. P's "interpretation [of the Plan] does not reflect the reasonable expectations of an insured member."[3] Because these arguments had not been previously raised, the case was remanded to the ALJ, and Mr. P was given an opportunity to respond to DRB's new arguments. Mr. P filed a short responsive brief on March 8, 2016. DRB requested leave to file a reply to Mr. P's responsive brief, but leave was denied in an order dated March 23, 2016. As further discussed below, DRB's arguments in its PFA are not persuasive. The discussions in DRB's PFA and Mr. P's response, however, have resulted in slight revisions to the decision, to clarify the manner in which DRB should credit a retiree's assessed Medicare deductible towards the Plan deductible.

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1 June 11, 2015 Stipulation for Filing Dispositive Motions.
2 DRB's PFA at 6-7.
3 DRB's PFA at 10-11.

EXHIBIT 2

Mr. P's motion for summary adjudication is granted,[4] and DRB's failure to apply the amount of the assessed Medicare deductible to Mr. P's deductible under the Plan is reversed. DRB shall compensate Mr. P in the amount of $44.60, the amount of damages the parties have stipulated to be recoverable by Mr. P under this Decision.

II. BACKGROUND AND FACTS

The terms and conditions of coverage and benefits under the Plan are set out in the Retiree Insurance Information Booklet ("Booklet").[5] Because "there is no other document setting out the contractual obligations of the Plan, this .... Booklet is the insurance contract for Plan members."[6] The Plan requires an annual deductible of $150, and it provides that Plan benefits "become supplemental" to Medicare benefits for persons who are 65 years or older and thus eligible for Medicare.[7] Aetna is the entity that administers the Plan for DRB.

The Plan contains a Coordination of Benefits ("COB") provision[8] authorizing a "right to offset" against benefits paid by Medicare and other sources, designed to protect against retirees duplicating their recovery of medical benefits. Key pertinent provisions of the COB are quoted below:

- The primary plan pays benefits first, without regard to any other plan.
- When the retiree plan is secondary, the amount it will pay will be figured by subtracting the benefits payable by the other plan from 100% of expenses **covered** by the retiree plan on that claim. The plan pays the difference between the amount the other plan paid and 100% of expenses the retiree plan would cover.[9]

Mr. P became a beneficiary of the Retiree Medical Benefits Plan in January 2012, and until March 2014 the Plan was his sole source of medical benefits coverage.[10] During that period his only annual deductible was the $150 deductible required under the Plan. When he turned 65 in March 2014, he enrolled in Medicare Parts A and B. At that time, per the terms of the Plan, Medicare provided his primary health coverage and the Plan's coverage became "supplemental" to Medicare.

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4 Mr. P's motion was granted by order dated December 31, 2015, but the record was kept open to resolve a factual dispute regarding the amount of his damages. The parties subsequently resolved the dispute by stipulating to the amount of damages. *See* 1/6/16 Stipulation Regarding Damages Amount.

5 *In re D.M.*, OAH No. 08-0153-PER (2008), page 2.

6 *In re D.T.*, OAH No. 10-0577-PER (2011), page 2.

7 Agency Record ("AR") 42.

8 AR 43-47.

9 AR 44 (emphasis in original).

10 The factual recitations in this Decision are derived from the parties' respective briefs on summary adjudication, and unless otherwise indicated the facts discussed herein were not disputed.

EXHIBIT 2

In April 2014, Mr. P was required to pay the Medicare $147 annual deductible, in connection with receiving two sets of medical services that were deemed "covered services" under the Plan. Medicare assessed the charges from the first set of services as follows: $24.33 to deductible and $5.26 paid to the provider. Charges from the second set were assessed: $122.67 to deductible and $91.34 paid to the provider, leaving $25.17 unpaid. At this time AETNA assessed the full amount of the charge for the first services, $29.59, towards the Plan deductible ($5.26 more than was assessed by Medicare towards its deductible).

Subsequently, in connection with Mr. P receiving other medical services, Aetna charged him additional deductibles in October 2014 ($69.80) and November 2014 ($29.89 and $20.72) totaling $120.41, which when added to the $29.59 previously assessed by Aetna equals the total of the $150 Plan deductible. It should be noted that there appears to have been an "overlap" between the two charged deductibles of $24.33, which is that portion of the $29.59 charge for the first April 2014 medical services that was charged to both the Medicare & the Plan deductibles.

Mr. P asserted in his briefing that this sequence of charges resulted in him being charged a total deductible of $272.67 by Medicare and Aetna (on behalf of the Plan), or $125.67 in excess of the Medicare deductible.[11] In its brief, DRB disputed the amount of out-of-pocket expense actually paid by Mr. P, asserting that in fact he was only required to pay a total of $44.60 for his 2014 medical expenses.[12] The parties have subsequently stipulated that $44.60 is the correct amount.[13]

III. DISCUSSION

A. The Plan's Provisions Regarding Deductibles

Mr. P argues that assessing him for both the Medicare and the Plan deductibles violates the Plan provisions which allow only a single annual deductible to be charged to members. To evaluate his argument, we start with two basic premises. First, because there is no document other than the Booklet that sets out the contractual obligations of the Plan to its members, the Booklet constitutes the insurance contract for Plan members. Second, under Alaska law, interpretation of insurance contracts is governed by the premise that they "are considered contracts of adhesion that must be construed to provide the coverage 'a layperson would have

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11 P's Motion for Summary Adjudication ("Motion") at 5.

12 DRB's Opposition & Cross-Motion for Summary Adjudication ("Opp.") at 3, fn. 4.

13 1/6/16 Stipulation Regarding Damages Amount.

EXHIBIT 2

reasonably expected from a lay interpretation of the policy terms.'"[14] Insurance "coverage provisions are interpreted broadly, while exclusions are viewed narrowly."[15] The doctrine of interpretation in favor of an insured's reasonable expectations "is not dependent on there being any ambiguity in the contract language."[16] However, if the contract language is ambiguous and susceptible to more than one interpretation, "the interpretation that favors the insured is followed."[17]

As already noted above, the terms of the Plan require that the Plan's coverage is "supplemental" or "secondary" to Medicare after a retiree reaches 65 years of age. The COB, which is an integral part of the insurance contract, accomplishes the coordination between the Plan and Medicare by noting that Medicare first pays benefits without regard to the Plan.[18] The amount the Plan will then pay is calculated "by subtracting the benefits payable by the other plan from 100% of expenses **covered** by the [Plan] on that claim."[19] As stated in the COB, the Plan "pays the difference between the amount the other plan paid and 100% of expenses the [Plan] would cover."[20]

Mr. P contends that this language clearly defines what the Plan will pay when it is supplemental to Medicare – the Plan's payment is calculated by simply subtracting the benefits payable by Medicare "from 100% of expenses covered" by the Plan. He points out that the Booklet provides for a single, annual deductible, and it does not mention or refer to an additional deductible that must be paid when Medicare becomes the member's primary coverage. Nor can any such mention be found in relevant statutes or regulations. He concludes, therefore, that in the absence of an explicit, unambiguous Plan provision for two deductibles, only a single annual deductible can be charged to a member. He further argues that the net result of DRB's practice of requiring two separate deductibles is that a retiree member is penalized upon reaching age 65, as occurred in this case where Mr. P's effective, total annual deductible increased from $150 to $272.67. Such a result, he argues, is contrary to the provision that the Plan is intended to

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[14] *In re D.T.*, OAH No. 10-0577-PER (2011), at 2, *quoting Whispering Creek Condominium Owner Association v. Alaska National Insurance Company*, 774 P.2d 176, 177–178 (Alaska 1989).
[15] *Id.*
[16] *In re D.T.*, OAH No. 10-0577-PER, *citing Bering Strait School District v. RLI Insurance Company*, 373 P.2d 1292, 1295 (Alaska 1994).
[17] *Id.*
[18] AR 44.
[19] *Id.* (emphasis in original).
[20] *Id.*

EXHIBIT 2

"supplement" Medicare, because the concept of supplementation does not encompass increasing a member's out-of-pocket costs.

DRB argues in response that "[a] retiree cannot satisfy the Plan's deductible by satisfying the Medicare ... deductible... ."[21] But this argument is presented as a conclusion without any persuasive analysis, and without tying it to the actual Plan provisions set forth in the Booklet. Instead, it is supported only by an affidavit of a DRB manager[22] and by reference to documents that are extrinsic to the Booklet and thus are not part of the Plan itself.[23]

DRB's argument begs the question of how to properly interpret the Plan, because it fails to address the actual language of the Plan. The language of the COB states that the Plan's payment on a claim is calculated "by subtracting the benefits payable by the other plan from 100% of expenses **covered** by the [Plan] on that claim."[24] The failure to mention the assessment of the Plan deductible in that context, when contrasted with other Plan language generally requiring assessment of the Plan's deductible against members, results in the Plan being, at best, ambiguous as to whether both deductibles can be assessed against a retiree member or, stated differently, whether the expenses left unreimbursed by Medicare can be deemed ineligible to satisfy the Plan deductible. We must construe the Plan, as a contract of adhesion, in favor of the insured's reasonable expectations, that he or she not be charged a higher total of deductibles as a result of having reached age 65. Construing the Plan in this manner, a retiree can satisfy virtually all of the Plan deductible by satisfying the Medicare deductible. The expenses that Medicare did not pay are expenses borne by Mr. P, and there is no discernible reason not to treat them as the first $147 of member-borne expenses needed to satisfy the Plan's $150 deductible. Aetna, therefore, must credit Mr. P for the $147 Medicare deductible in its assessment of the Plan's $150 deductible.

As mentioned above, DRB raised an issue of fact regarding the damages Mr. P can claim in terms of the amount of out-of-pocket expenses he has incurred. Mr. P argued in his Motion that he is entitled to recover the $125.67 additional deductible assessed by Aetna and DRB.[25]

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21 DRB's Opp. at 5.

22 Affidavit of Michele Michaud, Chief Health Official for DRB (Ms. Michaud essentially offers an unsupported opinion as to the proper interpretation of the Plan: "a retiree who is eligible for medical services covered under both the Plan and Medicare must satisfy the Plan's annual $150 deductible").

23 *See, e.g.*, guidelines of Nat'l Assn. of Insur. Commissioners, excerpted in exh. 3 to DRB's Opp.

24 AR 44 (emphasis in original).

25 P's Motion at 9.

EXHIBIT 2

DRB countered that Mr. P "only paid a total of $44.60 out-of-pocket for his 2014 claims."[26] Mr. P then responded in a reply brief that he should be entitled to recover both the $125.67 and the $44.60 in out-of-pocket expense.[27] The parties have now resolved this factual dispute by stipulating that $44.60 is the correct amount of damages.

B. DRB's Proposal for Action

DRB's PFA primarily reiterates arguments that it raised in its motion for summary adjudication. These arguments are no more persuasive than when they were first presented and do not compel a rejection of the proposed decision. As previously mentioned, the PFA also asserts two arguments not previously raised in DRB's summary adjudication filings: (1) the proposed decision will cause "far reaching and potentially devastating results on the resources necessary to sustain the Plan and its coverage;"[28] and (2) Mr. P's "interpretation [of the Plan] does not reflect the reasonable expectations of an insured member."[29]

As an initial matter, DRB should have raised these arguments before issuance of the proposed decision. By stipulating that the matter could be decided on summary adjudication briefs, and then omitting any substantive discussion of these issues in its brief, DRB waived the opportunity to raise them. Nonetheless, these issues merit a brief discussion.

First, DRB has failed to set forth any admissible facts regarding its allegation as to the alleged impacts on Plan resources that will result from this decision. In any event, Mr. P's appeal is focused on the proper interpretation of Plan language and whether DRB's practices comport with that interpretation. Impacts on Plan resources that may or may not flow from this decision are policy matters that should have no bearing, one way or the other, on the proper interpretation and implementation of the Plan as written.

Second, DRB argues that Mr. P's expectation of paying only one deductible is unreasonable, contending that "[a] member receiving the benefit of coverage from two health care plans can reasonably expect to pay separate, independent deductibles pursuant to the independent terms of those two ... plans."[30] But this conclusory statement is presented without any factual support, and it ignores the language of the Plan itself. As discussed above, the Plan plainly states that it "becomes supplemental to ... Medicare coverage," and it then pays the

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26 DRB Opp. at 3, fn. 4.
27 P's 7/17/15 Reply at 3.
28 DRB's PFA at 6-7.
29 DRB's PFA at 10-11.
30 DRB's PFA at 10.

EXHIBIT 2

difference between the amount [Medicare] paid and 100% of expenses the [Plan] would cover." These statements are made without any mention of the member being required to pay the Plan deductible in addition to the Medicare deductible; stated differently, the Plan makes no mention of the expenses left unreimbursed by Medicare being ineligible to satisfy the Plan deductible. Given this language of the Plan, Mr. P's expectation of paying only one concurrent deductible is objectively reasonable, especially in the absence of **any** evidence to the contrary.[31]

IV. CONCLUSION

Mr. P's motion for summary adjudication is granted, and DRB's failure to apply the amount of the assessed Medicare deductible to Mr. P's deductible under the Plan is reversed. DRB shall compensate Mr. P in the amount of $44.60, representing his out-of-pocket expenses incurred due to having both deductibles assessed against him sequentially.

This Decision is issued under the authority of AS 39.35.006. The undersigned, in accordance with AS 44.64.060, adopts this Decision as the final administrative determination in this matter.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 13th day of April, 2016.

Signed
Andrew M. Lebo
Administrative Law Judge

[This document has been modified to conform to the technical standards for publication.]

[31] DRB also contends in its PFA that Mr. P failed to "provide any support for his assertion that his coverage, as coordinated under the Plan, resulted in an increase in his overall retiree medical costs." DRB's PFA at 10-11. This contention is not accurate; DRB has **stipulated** that Mr. P incurred $44.60 in out-of-pocket expenses as damages in this case.

EXHIBIT 2

Retired Public Employees of Alaska, Inc. v. State

Case No. 3AN-18-06722 CI

PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT
IN RE THE LEGALITY OF REQUIRING RETIREES TO PAY
A SECOND DEDUCTIBLE AS A CONDITION OF RECEIVING MEDICAL BENEFITS
THAT ARE SUPPLEMENTAL TO MEDICARE

EXHIBIT 3

Affidavit of RPEA President Sharon Hoffbeck
(3 pages)

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Attorney for Plaintiff

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**

AFFIDAVIT OF SHARON HOFFBECK
IN SUPPORT OF PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT IN RE THE LEGALITY OF REQUIRING RETIREES TO PAY A SECOND DEDUCTIBLE AS A CONDITION OF RECEIVING MEDICAL BENEFITS THAT ARE SUPPLEMENTAL TO MEDICARE

STATE OF ALASKA)
) ss
THIRD JUDICIAL DISTRICT)

I, Sharon Hoffbeck, under oath or affirmation, state the following:

1. The statements I am making in this affidavit are based on my personal knowledge and are true and correct to the best of my knowledge.

2. The RPEA is a voluntary membership organization whose mission is to help ensure that the retired public employees of Alaska receive the vested, constitutionally protected retirement benefits they earned and were promised to them in return for their public service are provided to them. RPEA also works to ensure that those vested benefits are not diminished or impaired in contravention of Art. XII, § 7 of the Alaska Constitution.

3. For approximately four (4) years I have served as president of the Retired Public Employees of Alaska ("RPEA"). I have been an active member of the organization for many more years. During that time, I have met and spoken with scores of retired public employees of Alaska who are covered by the AlaskaCare Retiree Health Plan and who have sought information and guidance concerning appeals of denials of claims for benefits.

4. To the best of my knowledge and belief, the Alaska Division of Retirement and Benefits ("DRB") has made no effort to notify any members of the AlaskaCare Retiree Health Plan ("Plan") of the fact, substance or import of the decision of the Alaska Office of Administrative Hearings ("OAH") in In Re C. P., OAH No. 15-0283-PER (April 13, 2016).

5. Based on my knowledge and belief, at no time since the OAH issued its decision In Re C. P. has the State ever ceased requiring Plan members who have paid their annual Medicare deductible to pay a second deductible as a condition of receiving any coverage or benefits provided by the Plan that is supplemental to Medicare.

DATED this 11th day of March 2020.

Sharon Hoffbeck

Sharon Hoffbeck

Subscribed before me on oath or affirmation this 11th day of March 2020.

SANDRA R. THOMPSON
Notary Public
State of Alaska
My Commission Expires Sep 27, 2021

Sandra R. Thompson
Notary Public of Alaska
My commission expires: 9-27-2021

Retired Public Employees of Alaska, Inc. v. State

Case No. 3AN-18-06722 CI

PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT
IN RE THE LEGALITY OF REQUIRING RETIREES TO PAY A SECOND DEDUCTIBLE AS A CONDITION OF RECEIVING MEDICAL BENEFITS THAT ARE SUPPLEMENTAL TO MEDICARE

EXHIBIT 4

AlaskaCare Retiree Health Plan Amendment No. 2016-2 (May 25, 2016)
(5 pages)

State of Alaska Department of Administration Division of Retirement and Benefits	**AlaskaCare Retiree Health Plan Amendment**	**Number:** 2016-2
		Effective Date: May 25, 2016
	Amends:	**Review Date:**
	Amends: (1) Effect of Medicare (2) Coordination of Benefits	**Distribution:** Deputy Commissioner Chief Health Official Vendor Manager Appeals Supervisor Communications Supervisor Legal Counsel TPA File

The State of Alaska provides, by means of self-insurance, health benefits covering individuals entitled to coverage under AS 14.25, AS 22.25, AS 39.35 or former AS 39.37, and their dependents. Such benefits are set forth in the ***Retiree Insurance Information Booklet*** (the "Plan"). Under authority of AS 39.30.090-098, the Commissioner of Administration hereby amends the Plan as follows:

Section 1: Amended Provisions

1. Effect of Medicare

Replaced in whole the Effect of Medicare section found on page 16.

You or your eligible dependent **must** elect Medicare Part A and B at age 65, regardless of any other coverage you have. If you or your eligible dependent are eligible for Medicare coverage (and most people are eligible at age 65), the benefits available under this Plan become supplemental to your Medicare coverage. The claims administrator will assume you and/or your dependents have coverage under Medicare Part A when you or your dependent reach age 65. If you are not provided with Medicare Part A free of charge, you should submit a copy of your letter from Medicare stating that you are not eligible to the Division. **Everyone is eligible for Medicare Part B.**

If you do not enroll in Medicare coverage, the estimated amount Medicare would have paid will be deducted from your claim before processing by this Plan. Relevant deductibles, coinsurance amounts and out-of-pocket limits continue to apply to both Medicare and the Plan. If you receive care outside the United States, Medicare does not cover your expenses; the Retiree Health Plan will take this into account. If you enter into a private contract with a provider that has opted out of Medicare, neither Medicare nor the Retiree Health Plan will pay benefits for their services.

2. Coordination of Benefits

Replaced in whole the Coordination of Benefits section under General Provisions found on pages 101-105.

The Plan protects you and your family to the extent of covered costs incurred. If you are entitled to benefits from other sources, such as employer or government sponsored health plans, the Retiree Health Plan has the right to offset against or recover from those other plans or persons so that you do not duplicate recovery of covered medical expenses.

The Retiree Health Plan coordinates benefits with other group health care plans to which you or your covered dependents belong. Other group plans are defined as benefit sources recognized for coordination of benefits and some examples are listed below; this list is non-exclusive:

- Group or blanket disability insurance or health care programs issued by insurers, health care services contractors, and health maintenance organizations.
- Labor-management trustee, labor organization, employer organization, or employee benefit organization plans.
- Governmental programs, including Medicare.
- Plans or programs required or provided by any statute.
- Group student coverage provided or sponsored by a school or policy, whether it is subject to coordination or not.
- The State of Alaska Group Health Plans.

You may be covered both as a retiree and as a dependent of another covered person or you may have more than one health plan. If that occurs, you will receive benefits from both plans. However, the benefits received will be subject to the coordination of benefits provisions as indicated in this section.

Here's how benefits are coordinated when a claim is made:

- The primary plan pays benefits first, without regard to any other plan.

- When the Retiree Health Plan is secondary, the amount it will pay will be figured by subtracting the benefits payable by the other plan from 100% of expenses **covered** by the retiree plan on that claim. The plan pays the difference between the amount the other plan paid and 100% of expenses the Retiree Health Plan would cover.
- In addition, when the retiree plan is the secondary plan, charges shall be applied to satisfy the retiree plan deductible in the order received by the claims administrator. Two or more charges received at the same time will be applied starting with the largest first.
- Neither plan pays more than it would without coordination of benefits. Benefits payable under another plan include the benefits that would have been payable whether or not a claim was actually submitted to that plan.
- Services which are limited to a maximum number of services in a year are not increased by having other coverage. For example, if you have two plans that each cover a single vision exam each year, the plans coordinate to cover up to 100% of a single vision exam; they do not pay for two vision exams in a year.

Example

This example assumes that the retiree has Medicare so Medicare pays first.

	Medicare	Retiree Health Plan
Covered Expenses	$ 1,000.00	$ 1,000.00
Less Retiree Deductible[1]	- 166.00	- 150.00
	= 834.00	= 850.00
Plan Coinsurance	x 80%	x 80%
Plan Payment without coordination	= 667.20	= 680.00
Plan Payment with coordination	= 667.20	= 332.80

Determining Order of Payment

A plan without coordination provisions is always the primary plan. If all plans have a coordination provision:

- The Retiree Health Plan is secondary to Medicare except if Medicare is provided before age 65 due to end stage Renal disease. Then the Retiree Health Plan

[1] Medicare deductible amount is governed by, and may change based on, federal statutes and regulations.

remains primary for 30 months after Medicare was effective. Relevant deductibles, coinsurance and out-of-pocket limits continue to apply to both Medicare and the Plan.

- Any active plan, whether it covers you as the retiree or a dependent, is primary to Medicare.
- A plan covering the retiree directly, rather than as a dependent, is the primary plan.
- A plan covering the person as a retired employee is secondary to a plan that covers that person as an active employee.
- If a child is covered under both parents' plans, the plan of the parent whose birthday falls earlier in the year (not the oldest) is the primary plan. If both parents have the same birthday, the plan that has covered a parent longer is the primary plan.

Following are exceptions to this birthday rule:

- If the other plan does not have this birthday rule, the other plan's rule is used to decide which plan is primary.

- If you are separated or divorced, the plans pay in the following order:

  — First, the plan of the parent whom the court has established as financially responsible for the child's health care (The claims administrator must be informed of the court decree. However, even though you are divorced and required to pay for medical coverage, your dependents are not automatically eligible for this plan. See the sections on *Eligibility* on pages 6-7 and *Continued Health Coverage* on pages 95-99.
  — Second, the plan of the parent with custody of the child.
  — Third, the plan of the spouse of the parent with custody of the child.
  — Fourth, the plan of the parent who does not have custody of the child.

If none of the above rules apply, the plan that has covered the patient longer is primary.

It is your responsibility to report the existence of and the benefits payable to you under any plan and to file for those benefits in the interests of computing services or benefits due under this Plan.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered is considered a covered service and a

benefit paid. The reasonable cash value of any services that any service organization provides is considered an expense incurred by you or your covered dependent, and the liability under this Plan is reduced accordingly.

Section 2: Conflict

In the event of a conflict between the language contained in this Amendment and previously adopted language contained in the Retiree Health Plan, the provisions of this Amendment shall control.

Section 3: Effective Date.

This amendment is effective for claims submitted for payment with dates of service on or after May 25, 2016.

Adopted this 25th day of May, 2016.

By: _____
John Boucher, Deputy Commissioner

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-18-06722 CI

[Proposed]

FINDINGS CONCLUSIONS AND ORDER GRANTING PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT

RE: "ALASKACARE RETIREE HEALTH PLAN AMENDMENT 2016-2"

Description of Motion and Relief Sought This Court has before it Plaintiff's motion for partial summary judgment asking the Court to hold and adjudge that a document titled "AlaskaCare Retiree Health Plan Amendment 2016-2," promulgated by the Alaska Division of Retirement and Benefits ("DRB") on May 25, 2016, is null and void as an amendment to the AlaskaCare Retiree Health Plan ("Plan").

The Plaintiff also asks the Court to enjoin the Defendant from its practice of requiring Plan members who have satisfied their annual Medicare deductible to pay a second deductible as a condition of receiving any coverage or benefit provided by the Plan that is supplemental to Medicare.

Finally, the Plaintiff asks the Court to order the Defendant to pay restitution to each Plan member who, since April 13, 2016, satisfied the annual Medicare deductible and was then required to pay a second annual deductible as a condition of receiving any coverage or benefit provided by the Plan that is supplemental to Medicare. The amount of the restitution sought is the amount any Plan member paid since April 13, 2016 towards satisfying the second deductible, plus interest.

Findings of Fact

1. The AlaskaCare Retiree Health Plan is a health insurance policy provided to retired public employees of Alaska who have earned vested retirement benefits.

2. The State and the RPEA agree that vested retirement benefits are valuable property rights.[1]

3. The terms of the AlaskaCare Plan are provided in a handbook called the "Retiree Insurance Information Booklet – May 2003." Page 16 of that handbook states that when AlaskaCare Plan members reach age 65, the Plan benefits become "supplemental" to Medicare.

4. On April 13, 2016 the OAH ruled In the Matter of C.P., OAH No. 15-0283-PER that the terms of the Plan did not require Plan members who had paid their annual Medicare deductible to pay a second deductible as a condition of receiving a Plan benefit that is supplemental to Medicare and therefore reversed a decision of the Plan

[1] Amended complaint, ¶44, p. 13. Answer to amended complaint, ¶44, p. 9.

administrator (the DRB) that required a Plan member who had paid the annual Medicare deductible to pay a second deductible before receiving those supplemental benefits.

5. The Plan administrator had the right to appeal that OAH decision to the Superior Court under AS 39.35.006 and Alaska Appellate Rule 602(a)(2). That right had to be exercised within 30 days of the OAH decision under Alaska Appellate Rule 602(a)(2).

6. The DRB did not appeal the OAH decision and did not notify Plan members of the decision.

7. In spite of the OAH decision, the DRB continued requiring Plan members who had paid their annual Medicare deductible to pay a second annual deductible as a condition of receiving any Plan benefit that was supplemental to Medicare.

8. On May 25, 2016, forty-two days after the OAH decision, the DRB issued a document titled "AlaskaCare Retiree Health Plan Amendment 2016-2" ("Amendment 2016-2") that purported to amend the Plan by removing and replacing "in whole" two separate sections of the Plan titled, respectively, "Effect of Medicare" and "Coordination of Benefits" that appear in the Retiree Insurance Information Booklet - May 2003 ("Plan handbook"). See Exhibits 1 and 4 in support of Plaintiff's motion.

9. Amendment 2016-2 provided that it was effective immediately. The distribution list on the face of the document indicates that it was not distributed to Plan members.

10. Plan members were given no advance notice of the reasons for, the contents of, or the expected effects of Amendment 2016-6. They were given no opportunity to be heard by the DRB before it was promulgated.

11. Amendment 2016-2 was created and promulgated without Plan members being given any notice or opportunity to be heard in court and without any effort by the DRB to abide by the limitations and fulfill the requirements for amending the terms of the Plan as established by the Alaska Supreme Court in Duncan v. Retired Public Employees of Alaska, Inc., 71 P.3d 882 (Alaska 2003) and have the amendment reviewed and approved by the court.

12. The DRB has since relied on Amendment 2016-6 as providing it with authority to require Plan members who have paid their annual Medicare deductible to pay a second deductible as a condition of receiving any benefit provided by the Plan that i supplemental to Medicare.

13. The DRB continues to this day to require Plan members who have paid their annual Medicare deductible to pay a second annual deductible as a condition of receiving any Plan benefit that was supplemental to Medicare.

CONCLUSIONS OF LAW

1. The decision of the OAH in the opinion In the Matter of C.P., OAH No. 15-0283-PER that the terms of the Plan did not require Plan members who had paid their annual Medicare deductible to pay a second deductible as a condition of receiving a Plan benefit that is supplemental to Medicare became the final decision on the issue when it was not appealed by the Plan administrator.

2. The purpose and intent of Amendment 2016-6 was to avoid complying with the OAH ruling by summarily creating a document that purported to amend the Plan to give the DRB the authority to require Plan members who had paid their annual Medicare deductible to pay a second deductible as a condition of receiving any Plan benefit that was supplemental to Medicare.

3. Based on the OAH ruling, requiring Plan members to pay the second deductible constituted a diminishment and impairment of a vested retirement benefit in violation of Art. 1, §7 of the Alaska Constitution.

4. Based on the OAH ruling, requiring Plan members to pay the second deductible deprived them a property without notice and opportunity to be heard required by Due Process required by the constitutions of Alaska and the United States.

5. Monies paid by Plan members after the date of the OAH ruling In the Matter of C.P., OAH No. 15-0283-PER (April 16, 2016) constituted an unlawful taking without just compensation in violation of the Takings Clauses of the constitutions of Alaska and the United States.

Based on the foregoing Findings of Fact and Conclusions of Law,

IT IS ORDERED: The motion is **GRANTED:**

1. The "AlaskaCare Retiree Health Plan Amendment 2016-6" is found, declared and adjudged to be null and void.

2. The State is enjoined from requiring Plan members who have paid their annual Medicare deductible to pay a second deductible amount as a condition they must fulfill to before being entitled to receive any Plan coverages or benefits that are supplemental to Medicare.

3. The State is directed to determine the total amount of money each Plan member was charged since April 13, 2016 towards satisfying the second deductible required by the DRB as a condition of receiving a benefit provided by the Plan that is supplemental to Medicare and then reimburse the Plan member that amount of money, with interest, as restitution.

DONE this ____ day of _____ 2020.

_____
Eric A. Aarseth
Judge of the Superior Court

Certificate of Service

By my signature below, I certify that on this 17th day of March 2020, I caused a true and complete copy of the foregoing Motion for Partial Summary Judgment re: the AlaskaCare Retiree Health Plan Amendment 2016-2, with the attached supporting exhibits 1-4, to be served upon Kevin McKenzie Dilg and Jeff Pickett, Assistant Attorneys General of the State of Alaska by email and by U.S mail, first class postage pre-paid and addressed to their respective addresses of record in Juneau and Anchorage.

Wm. Grant Callow