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

THE RETIRED PUBLIC EMPLOYEES OF ALASKA, INC., Plaintiff, v. STATE OF ALASKA, DEPARTMENT OF ADMINISTRATION, DIVISION OF RETIREMENT AND BENEFITS, Defendant.	**Case No. 3AN-18-6722 CI**

MOTION FOR PARTIAL DECLARATORY JUDGMENT AND TO ESTABLISH LAW OF THE CASE RE: THE SCOPE OF FIDUCIARY DUTIES OWED TO THE BENEFICIARIES OF THE ALASKACARE RETIREE HEALTH CARE PLAN BY THE ALASKA DIVISION OF RETIREMENT AND BENEFITS

Synopsis of Motion The AlaskaCare Retiree Health Care Plan ("the Plan") provides major medical insurance to eligible retired public employees of Alaska and their covered dependents, collectively referred to here as the "Plan beneficiaries."

One claim asserted in this case by the Plaintiff Retired Public Employees of Alaska ("RPEA") is that the Alaska Division of Retirement and Benefits ("DRB"), the administrator of the Plan, has breached certain fiduciary duties it owes to the

beneficiaries of the Plan by actions that have resulted in the improper elimination, diminishment and impairment of medical insurance benefits provided by the Plan.[1]

The DRB denies that it owes any fiduciary duties to the Plan beneficiaries beyond "a fiduciary duty to ensure that the funds held under AS 39.30.097 are used exclusively for the benefit of plan participant beneficiaries, including for the payment of retiree health care benefits and appropriate administrative costs," contending that the "failure of the DRB to do so could, under some circumstances, be a breach of DRB's duties to retirees and their beneficiaries."[2]

This motion seeks to resolve the issue of the scope of the fiduciary duties that the DRB owes to Plan beneficiaries.

The Alaska Supreme Court has recognized that a "special fiduciary relationship" exists between insurers and their insureds.[3] That fiduciary relationship is based on the special nature of insurance contracts—the financial security and peace of mind that insurers promise to provide; the often-dire circumstances and needs of insureds as a result of events that trigger the duty of insurers to perform; and the vulnerability of insureds to harm when insurers fail to fulfill their contractual obligations. For these reasons, the Alaska Supreme Court has held that insurers owe their insureds additional duties that extend beyond the normal duties of good faith and fair dealing that are inherent in every type of contract. Those additional duties are fiduciary in nature and provide special protection to insureds, helping to ensure that insurers fulfill their contractual obligations to provide the promised protections to their insureds.

The RPEA contends that because the beneficiaries of the AlaskaCare Plan have substantially fewer protections than the protections provided to individuals covered by private insurance, the reasons for holding the DRB to the higher standards of a fiduciary are more numerous and compelling than in cases involving of private insurers.

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[1] See Plaintiff's Fourth Claim for Relief.

[2] See DRB's answer to Plaintiff's Fourth Claim for Relief.

[3] Lloyd's & Inst. of London Underwriting Companies v. Fulton, 2 P.3d 1199, 1209 (Alaska 2000)

The RPEA's argument finds support in analogous federal law. Under ERISA, the administrators of retirement plans established by private employers owe fiduciary duties to their plan beneficiaries. Those duties are established by statute and have been expanded by numerous decisions of the federal courts, including the United States Supreme Court.

The issue of the nature and scope of DRB's fiduciary duties to Plan beneficiaries is an issue of law that has not yet been addressed by the Alaska Supreme Court. A definitive ruling on this important issue will advance the resolution of this case by allowing for more focused discovery and simplifying the issues for trial. A definitive ruling is also likely to help avoid future litigation by clarifying the duties of the DRB and the rights and expectations of Plan beneficiaries.

Relief Requested

In this motion, the RPEA respectfully requests that the Court hold that the DRB has a "special fiduciary relationship" with the beneficiaries of the AlaskaCare Plan that gives rise to certain fiduciary duties that include:

1. The duty of good faith and fair dealing, which includes a duty not to do anything that will injure the right of the Plan beneficiaries to receive the benefits of the Plan in accord with the terms of the Plan;[4]

2. The duty of loyalty and disavowal of self-interest,[5] which embraces the duty to act solely in the best interests of Plan beneficiaries[6] to ensure that a) the claims of

[4] See Guin v. Ha, 591 P.2d 1281, 1291 (Alaska 1979); see gen. Restatement (Second) of Contracts § 205 (1979). This is a duty that parties to all contracts have to each other, fiduciaries and non-fiduciaries alike.

[5] Munn v. Thornton, 956 P.2d 1213, 1220 (Alaska1998), citing Wagner v. Key Bank of Alaska, 846 P.2d 112, 116 (Alaska 1993); see Metropolitan Life Ins. Co. v. Glenn, 554 U.S. 105, 111, 128 S.Ct. 2343, 2347–48 (2008).

[6] See Devlin v. Blue Cross and Blue Shield, 274 F.3d 76, 88 (2d Cir.2001), quoting Donovan v. Bierwirth, 680 F.2d 263, 271 (2d Cir.1982) (Friendly, J.).

beneficiaries get a full and fair review;[7] b) that their legitimate, covered claims for medical benefits are timely paid, and c) that no claims will be paid that are not legitimate or not covered by the Plan;[8]

3. The duty to deal honestly, fairly and candidly with Plan beneficiaries in all aspects of Plan administration, including in the course of appeals by Plan beneficiaries of the denials of claims;[9]

4. When a claim is denied, the duty to advise Plan beneficiaries—in a timely manner and in a way that is reasonably understandable to a layperson—of all the reasons why that claim has been denied, including references to specific Plan language relied upon by DRB or its third-party administrator in denying the claim;[10]

5. The duty to disclose to Plan beneficiaries all facts that materially affect their rights and interests and which might influence their action(s), including but not limited to timely informing them of issues of coverage or other benefits that have been appealed

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[7] Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 974 (9th Cir. 2006), citing 29 U.S.C. § 1133(2).

[8] See Gaither v. Aetna Life Ins. Co., 394 F.3d 792, 807–08 (10th Cir. 2004) (Under ERISA, the plan administrator as "a fiduciary has a duty to protect the plan's assets against spurious claims ....").

[9] See Varity Corp. v. Howe, 516 U.S. 489, 506, 116 S.Ct. 1065, 1075, (1996), citing Bogert & Bogert, Law of Trusts and Trustees § 543, at 218-19 (duty of loyalty requires trustee to deal fairly and honestly with beneficiaries); 2A Scott & Fratcher, Law of Trusts § 170, pp. 311-312 (same); Restatement (Second) of Trusts § 170 (same).

[10] See AS 21.36.125(a)(15) ("An insurer doing business in this state shall not fail to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim ...."). And see Fulton, 2 P.3d at 1204, quoting Sauer v. Home Indemnity Co., 841 P.2d 176, 182 (Alaska 1992).

ERISA requirements are more detailed. See 29 U.S.C. § 1133(1); 29 C.F.R. 2605.503-1(g); see also Booton v. Lockheed Medical Ben. Plan, 110 F.3d 1461, 1463 (9th Cir. 1997) and Abatie, 458 F.3d at 974. RPEA contends that informing beneficiaries of the specific reasons for the denial of the claim is required as a matter of fundamental fairness required by due process because it "assists interested parties in determining whether to seek judicial review." See Southeast Alaska Conservation Council, Inc. v. State, 665 P.2d 544, 549 (Alaska 1983). It also "facilitates judicial review by demonstrating those factors which were considered" and promotes "careful and reasoned administrative deliberation." Id.

to the OAH or higher that raise a legal issue whose resolution might affect the medical benefits of other Plan beneficiaries, and timely notifying Plan beneficiaries of the substance of any decision by an Alaska court or hearing officer that can reasonably be expected to affect their retirement benefits and other rights under the Plan;[11]

6. The duty to give Plan beneficiaries reasonable notice and opportunity to be heard concerning any proposed changes in Plan benefits or administration that the DRB has reason to believe may negatively affect any benefit(s) or other advantages provided by the Plan, including a complete and candid statement of all the reasons why the DRB wants to make the proposed changes and any new benefits/advantages that the DRB contends would offset the Plan benefits/advantages it proposes to eliminate or reduce along with a reasonable description of what the DRB has done to satisfy the conditions and requirements established by the Alaska Supreme Court in Duncan v. Retired Public Employees of Alaska, Inc., 71 P.3d 882 (Alaska 2003), including the evidence, methods and results of any "equivalency analyses" that were done;[12]

7. The duty to provide Plan beneficiaries with reasonable assistance they might need to ensure that their claims for benefits are correctly submitted.[13]

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[11] See discussion at p. 14 and supporting Alaska opinions cited at fns 37 and 38, infra. See also, Eddy v. Colonial Life Ins. Co. of America, 919 F.2d 747, 750, (D.C. Cir.1990) ("The duty [of the ERISA plan administrator] to disclose material information is the core of a fiduciary's responsibility. [...] This fundamental common-law duty informs many of the statutory requirements of ERISA itself.") Note, however, that the United States Supreme Court has reserved answering the question "whether ERISA fiduciaries have any fiduciary duty to disclose truthful information on their own initiative, or in response to employee inquiries." See Varity Corp., 516 U.S. at 506, 116 S.Ct. at 1075.

[12] Id. The DRB has admitted in its answer that retirement benefits are valuable property rights. Any elimination, diminishment or impairment of a valuable property right without first giving beneficiaries reasonable notice and opportunity to be heard violates the due process guarantees of the Alaska Constitution and the Constitution of the United States.

[13] On its website, the DRB assures Plan members that "the DRB team has comprehensive knowledge of the systems' administrative procedure to assist member participants with professional services and expertise."
http://doa.alaska.gov/drb/help/mission.html#.XEo-3FxKhPY

Overview of the Case

The RPEA represents retired public employees of Alaska, hired before July 1, 2006,[14] who earned vested retirement benefits under the defined benefit plan of the Alaska Public Employee Retirement System ("PERS") and the Alaska Teachers' Retirement System ("TRS"). Those vested retirement benefits include major medical insurance coverage provided by the AlaskaCare Retiree Health Care Plan ("the Plan").

The monies used to pay medical claims and the costs of Plan administration come from funds held in trust. The funds of the trust come from contributions made by employees while they are actively employed in government service, from contributions made by the employing government agency and from the income generated by trust investments. By law, the corpus and income from the assets of the trust may be used only for the exclusive benefit of the Plan members and their beneficiaries.[15]

The Alaska Department of Administration is responsible for administering the state's retirement systems.[16] The commissioner of the department is the administrator of the Plan[17] and has the power and duty to approve or disapprove claims for retirement benefits.[18] In practice, the responsibility for administering the Plan is delegated to the DRB. The DRB is responsible for ensuring that all legitimate claims for covered medical benefits are timely paid in accordance with the terms the Plan.

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[14] The defined benefit plan at issue here applies only to public employees who were hired before July 1, 2006 and who earned vested retirement benefits under that Plan. The Alaska legislature ended the defined benefit plan and, in its place, substituted a defined contribution retirement plan for public employees first hired after July 1, 2006. See AS 39.35.700 et seq.

[15] AS 39.35.011, titled "Exclusive benefit," provides: "The corpus or income of the assets held in trust as required by the plan may not be diverted to or used for other than the exclusive benefit of the members or their beneficiaries."

[16] AS 44.21.020(7) Duties of department.

[17] AS 39.35.003(a)

[18] AS 39.35.004(a)(3)

The medical benefits of the AlaskaCare Plan are not available to the Plan beneficiaries until they reach age 55. For Plan beneficiaries between the ages of 55 and 65, the Plan provides primary medical coverage.[19] When a Plan beneficiary turns 65, the Plan provides that Medicare becomes the primary provider of major medical coverage for the beneficiary.[20] As a result, Plan beneficiaries who are 65 and older cost the Plan relatively little because the coverage provided by the Plan is secondary to Medicare.

Because a new retirement system went into effect for the public employees of Alaska who were first hired after July 1, 2006, with each passing year the number of beneficiaries under the Plan at issue in this case declines significantly due to mortality.

The medical benefits provided by the Plan are valuable property rights that arise from a contractual relationship.[21]

Due process under both the Alaska and United States constitution requires that individuals be given reasonable notice and a meaningful opportunity to be heard before being deprived of a valuable property interest.[22]

Both Alaska common law and the Alaska Constitution provide even greater protection to the vested retirement benefits of Alaska's public employees than constitutional due process.

Article XII § 7 of the Alaska Constitution states that the vested retirement benefits earned by the public employees of Alaska "shall not be diminished or impaired."

Under Alaska common law, when a party acquires vested rights under a contract, the other party may not amend the terms of the contract unilaterally to deprive the first

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[19] AS 39.35.535(a) and AS 14.25.168(a).

[20] AS 39.35.535(b) and AS 14.25.168(b).

[21] Alaska Constitution, Art. XII §7

[22] Heitz v. State, Dept. of Health and Social Services, 215 P.3d 302, 305 (Alaska 2009); Aguchak v. Montgomery Ward Co., Inc., 520 P.2d 1352, 1356 (Alaska 1974) (quoting Mullane v. Central Hanover Bank and Trust Co., 339 U.S. 306, 314-15, 70 S.Ct. 652, 656-657 (1950).

party of its rights.[23] Also under Alaska common law, there is implied in every contract a covenant of good faith and fair dealing that imposes on each party a duty to refrain from conduct that harms the right of the other party to receive the benefits of the contract.[24]

Despite these constitutional and common law protections, the Alaska Supreme Court has ruled that the state may make changes in the vested retirement medical benefits offered for the limited purpose of adjusting to the evolving nature of health care.[25] To do that, however, the state must first perform an "equivalency analysis" and establish with "reliable evidence" that each medical insurance benefit/advantage it proposes to eliminate or reduce will be offset by a new medical insurance benefit/advantage of equivalent value that "relates generally" to the type of benefit/advantage the DRB seeks to eliminate or reduce.[26] The "reliable evidence" required includes "solid, statistical data drawn from actual experience—including accepted actuarial sources—rather than by unsupported hypothetical projections."[27]

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

[24] Guin v. Ha, 591 at 1291; see Restatement (Second) of Contracts § 205 (1979).

[25] In Duncan v. Retired Public Employees of Alaska, Inc., 71 P.3d 882 (Alaska 2003) the Court indicated that, subject to certain conditions and limitations, the state may be permitted to change medical benefits "as health care evolves." Id. at 891. The Court rejected the state's argument that changes should be allowed "based on the ever-increasing costs of health care" and "the potential to put severe strains on the systems, jeopardizing their ability to pay any benefits." Id. at 888. The Court's reasoning is consistent with the opinion of Judge Posner, writing for the 7th Circuit sitting en banc:

> [When employers fail to anticipate rising] health costs, they should not expect the courts to bail them out by undoing the contractually determined allocation of risk on the question. Courts do not sit to relieve contract parties of their improvident commitments, except within the limited dispensation conferred by the doctrine of impossibility, not here invoked.

Bidlack v. Wheelabrator Corp., 993 F.2d 603, 609 (7th Cir. 1993) (en banc). Judge Posner also cautioned that courts should not simply assume that providing the promised benefits would be too costly. Id.

[26] Duncan, 71 P.3d at 892.

[27] Id.

The DRB publishes a handbook entitled, "Retiree Insurance Information Booklet." The handbook is the Plan's medical insurance policy, setting forth the Plan's coverages and associated benefits as well as the coverage exclusions.

Insurance policies are construed based on how they would be "understood by reasonable laypersons and not according to the interpretation of sophisticated underwriters."[28] They "must be construed so as to provide the coverage which a layperson would have reasonably expected, given a lay interpretation of the policy language."[29] These rules of construction apply "even though painstaking study of the policy provisions would have negated those expectations."[30]

Coverage provisions are construed broadly in favor of insureds, whereas exclusions are interpreted narrowly against the insurer.[31] Ambiguities are resolved in favor of coverage.[32] Insurance "policy language is ambiguous when it is susceptible to two or more reasonable interpretations."[33]

Ambiguities do not need to be resolved by the courts. If a plan administrator determines there is an ambiguity in Plan coverage, the Plan administrator may resolve the ambiguity in favor of coverage by issuing a "benefit clarification" or by establishing a practice of paying the type of claim at issue.[34] Over the years, the DRB has issued

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[28] O'Neill Investigations, Inc. v. Illinois Emp. Ins. of Wausau, 636 P.2d 1170, 1175 (Alaska 1981) (citations and quotations omitted).

[29] Id.

[30] Bering Strait School Dist. v. RLI Ins. Co., 873 P.2d 1292, 1294–95 (Alaska 1994)

[31] Hahn v. Alaska Title Guaranty Co., 557 P.2d 143, 145 (Alaska 1976)

[32] Bering Strait School Dist. v. RLI Ins. Co., 873 P.2d 1292, 1295 (Alaska 1994)

[33] USAA v. Neary, 307 P.3d 907, 910 (Alaska 2013)

[34] See McMullen v. Bell, 128 P.3d 186, 190–91 (Alaska 2006) ("An employee's vested [pension] benefits arise by statute, from the regulations implementing those statutes, and from the [DRB's] practices.").

numerous benefit clarifications establishing that the Plan covers certain types of medical claims.

The DRB uses an outside contractor called a third-party administrator ("TPA") to process the medical claims of Plan beneficiaries. The TPA is given the authority and discretion to determine at the first stages of the claims process which medical claims are payable under the Plan and how much will be paid on each covered claim.

The DRB's current TPA is the Aetna Life Insurance Company ("Aetna"). Aetna was chosen to replace HealthSmart as the Plan's TPA following competitive bidding. Aetna took over control of medical claims processing under the Plan in January 2014. After doing so, Aetna—with the knowledge and approval of the DRB—began denying certain types of medical claims that the Plan had historically covered.

Aetna and DRB have justified these new denials by relying on Aetna's "clinical policy bulletins" ("CPBs"). Aetna's CPBs are technical, proprietary documents developed by Aetna for the purpose of determining what coverages are provided under Aetna's own commercial health care policies. Aetna's CPBs, when applied to the Plan, eliminate and restrict various coverages and benefits the Plan had previously provided.

Aetna's CPB's were developed without reference to the AlaskaCare Plan, without reference to Alaska's rules for construing the language of insurance policies, and without reference to the past practices of the DRB and its previous TPAs in providing medical benefits under the Plan.

Compared to the plain meaning of the language of the AlaskaCare Plan, the definitions and standards contained in Aetna's CPB's are complicated and confusing to the average layperson. They contain many limiting qualifiers and exceptions that eliminate or reduce certain coverages. In addition, Aetna can amend its CPBs at any time in ways that result in further reductions of coverage.

In essence, the DRB, working in concert with Aetna, has eliminated and reduced certain Plan coverages by redefining and reinterpreting the language of the AlaskaCare Plan using the technical definitions and standards of Aetna's CPBs.

ARGUMENT

The Fiduciary Relationship Between Insurers and Insureds in Alaska

In Alaska, contracts of every type are held to contain an implied covenant of good faith and fair dealing that neither party will do anything to injure the right of the other to receive the benefits of the agreement.[35]

Insurers are held to higher standards that just the duty of good faith and fair dealing when dealing with the claims of their insureds. Those additional duties are fiduciary in nature and arise from the "special fiduciary relationship" that exists between the insurer and the insured.[36]

A "fiduciary relationship exists when one imposes a special confidence in another, so that the latter, in equity and good conscience, is bound to act in good faith and with due regard to the interests of the one imposing the confidence."[37] "Fiduciary obligations generally come into play when one party's vulnerability is so substantial as to give rise to equitable concerns underlying the protection afforded by the law governing fiduciaries."[38]

Fiduciary duties require "[l]oyalty and the disavowal of self-interest,"[39] considered to be "the hallmarks of the fiduciary's role."[40] In addition, "[t]he duty of a fiduciary embraces the obligation to render a full and fair disclosure to the beneficiary of all facts

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[35] Guin v. Ha, 591 P.2d at 1291; see gen. Restatement (Second) of Contracts § 205 (1979).

[36] Fulton, 2 P.3d at 1209; and see O.K. Lumber Co. v. Providence Washington Ins. Co.,759 P.2d 523, 525 (Alaska 1988) (stating that a "fiduciary relationship [is] inherent in every insurance contract").

[37] Munn v. Thornton, 956 P.2d 1213, 1220 (Alaska 1998), quoting Paskvan v. Mesich, 455 P.2d 229, 232 (Alaska 1969).

[38] Thomas v. Archer, 384 P.3d 791, 797 n.25 (Alaska 2016), quoting in part City of Hope Nat'l Med. Ctr. v. Genentech, Inc., 181 P.3d 142, 152 (Cal. 2008).

[39] Id.

[40] Wagner v. Key Bank of Alaska, 846 P.2d 112, 116 (Alaska 1993)

which materially affect [the beneficiary's] rights and interests"[41] and "which might [...] influence [the beneficiary's] action."[42]

Courts and legislatures impose fiduciary duties where there is an imbalance of knowledge or other power between the parties, resulting in a vulnerability that justifies special protections being provided to weaker party, as in the case of the relationship between a doctor and patient[43] or a lawyer and a client.[44] Fiduciary duties are also imposed when the very nature of the relationship itself is based on a promise that one party will serve the best interests or welfare of another, such as in the relationship between agent and principal[45] or between a guardian or conservator and a ward.[46]

All these characteristics are present in the relationship between insurers and their insureds and explain the special level of trust and confidence that insureds must place in their insurers to protect them from harm and loss when a covered event occurs.

The Alaska Supreme Court has recognized that the adhesionary aspects of insurance contracts make insureds "particularly reliant on the insurer's good conduct"[47] and that an insurer has a "peculiar ability to take advantage of its insured's trust, and the typical insured's vulnerability to overreaching conduct."[48]

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[41] Carter v. Hoblit, 755 P.2d 1084, 1086 (Alaska 1988) ("The fiduciary has a duty to fully disclose information which might affect the other person's rights and influence his action.) Greater Area Inc. v. Bookman, 657 P.2d 828, 830 (Alaska 1982), quoting Neel v. Magana, Olney, Levy, Cathcart & Gelfand, 491 P.2d 421, 428-29 (Cal. 1971) (en banc).

[42] Carter, 755 P.2d at 1086.

[43] Pedersen v. Zielski, 822 P.2d 903, 909 (Alaska 1991)

[44] See e.g., Greater Area Inc. v. Bookman, 657 P.2d 828, 830 (Alaska 1982)

[45] See e.g., Lee Houston & Associates, Ltd. v. Racine, 806 P.2d 848, 853 (Alaska 1991)

[46] See AS 13.90.010(d)(3) and Rule 17(c), Alaska R. Civ. P.

[47] Id. at 1209.

[48] Id. at 1208, citing State Farm Fire & Cas. Co. v. Nicholson, 777 P.2d 1152, 1157 (Alaska 1989); see Thomas v. Archer, 384 P.3d 791, 797 n. 25 (Alaska 2016) ("Fiduciary obligations

The Court has also stated that "[Alaska] recognizes a strong public interest in fostering trust in insurers and in protecting consumers who choose to buy coverage."[49] By recognizing the "special fiduciary relationship" between insurers and their insureds and imposing certain types of fiduciary duties on insurers to help ensure that they fulfill their contractual obligations, the Court has fostered that public policy.

The Court has also recognized that an unreasonable "delay in paying the policy benefits cause[s] a harm that, for bad faith tort claim purposes, cannot be vitiated."[50] The Arizona Supreme Court made the same point in Rawlings v. Apodaca,[51] explaining:

> [T]he insured's object in buying the company's express covenant to pay claims is security from financial loss ... and protection against economic catastrophe in those situations in which he may be the victim. [citations omitted] In both cases, [the insured] seeks peace of mind from the fears that accompany such exposure. [...]
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> Although the insured is not without remedies if he disagrees with the insurer, the very invocation of those remedies detracts significantly from the protection or security which was the object of the transaction. [...]
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> [O]ne of the benefits that flow from the insurance contract is the insured's expectation that [the insurer] will not wrongfully deprive him of the very security for which he bargained or expose him to the catastrophe from which he sought protection.

Wrongful denials and unreasonable delays in the payment of claims for medical benefits can have especially severe consequences. They can result in insureds failing to seek necessary medical treatment or, if they do, being denied treatment for financial

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'generally come into play when one party's vulnerability is so substantial as to give rise to equitable concerns underlying the protection afforded by the law governing fiduciaries.' ") (citations of quoted language omitted).

[49] Fleegel v. Estate of Boyles, 61 P.3d 1267, 1280 (Alaska 2002); Clary Ins. Agency v. Doyle, 620 P.2d 194, 205 (Alaska 1980) (noting "the need to promote public confidence in the insurance industry").

[50] Government Employees Insurance Company v. Gonzalez, 403 P.3d 1153, 1162 (Alaska 2017)

[51] Rawlings v. Apodaca, 726 P.2d 565, 570–71 (Ariz. 1986)

reasons. That, in turn, can result in a worsening of health; extended physical pain and suffering; significant and sometimes severe emotional distress; and the loss of employment due to extended medical disability. The financial consequences can be very serious, including bankruptcy.

All these potential consequences validate and reinforce the observation of one authority on insurance bad faith that in many cases, "once it becomes clear that the benefits are due, delaying payment is as good as not paying at all."[52]

The importance of ensuring that persons handling claims for medical benefits perform their duties in accordance with fiduciary standards of fidelity is reinforced by the Alaska Supreme Court's discussion of the relevant factors for determining what the Court terms the "reprehensibility" of an insurer's bad faith conduct. The Court followed guidelines provided by the United States Supreme Court, which include

> whether [...] the harm caused was physical as opposed to economic; [whether] the tortious conduct evinced an indifference or a reckless disregard to health or safety of others; [whether] the target of the conduct had financial vulnerability; [whether] the conduct involved repeated actions or was an isolated incident; [and whether] the harm was the result of ... mere accident."

Government Employees Insurance Company v. Gonzalez, 403 P.3d 1153, 1164 (Alaska 2017), quoting State Farm Mut. Auto. Ins. Co. v. Campbell, 538 U.S. 408, 419, 123 S.Ct. 1513, 1521 (2003)

Wrongful denials and unreasonable delays in the payment of claims for medical benefits are particularly likely to raise a number of these indicia of "reprehensibility."

The Alaska legislature has also recognized the vulnerability of insureds who have experienced a loss or an event that triggers the need for insurers to fulfill their contractual duties to provide the coverages they have promised to provide. As a result, the legislature enacted a series of statutes in AS 21.36 that are intended to provide

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[52] Henderson, R. C., "The Tort of Bad Faith in First-Party Insurance Transactions After Two Decades," 37 Ariz. L. Rev. 1153, 1159–60 (1995)

special statutory protections to insureds by deterring wrongful denials or delays in paying covered claims.

Many of the additional duties imposed on insurers by statute are expressed in the negative; that is, by the list of specific types of conduct prohibited by the Alaska Unfair Claims Settlement Practices Act ("UCSPA")[63] Those prohibitions apply to the most important part of an insurers' obligation under the insurance contract; claims-handling. The duties implied by those prohibitions are consistent with the kinds of duties the common law imposes on fiduciaries. As shown below, those duties are also consistent with the fiduciary duties that ERISA imposes on the administrators of retirement plans established by private employers.

The vulnerability of insureds exists despite the insurance statutes and regulations of Alaska that are intended to protect insurance consumers.[64] The Alaska Unfair Claims Settlement Practices Act states that no private right of action arises if an insurer violates the act.[65] In addition, the Court has recognized that "the State has limited means with which to police the insurance industry" and that "the statutory remedies fail to compensate the insured for damages involved in the insurer's bad faith denial of coverage."[66]

For all these reasons, Court has determined that "public policy strongly favors rules providing 'needed incentive to insurers to honor their implied covenant [of good faith] to their insureds' "[67] Those "rules" are the special duties that insurers are held to owe their insureds because of the special fiduciary relationship.

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[63] AS 21.36.125

[64] See e.g., AS 21.36.125; 3 AAC 26.010 et seq.

[65] AS 21.36.125(b) ("The provisions of this section do not create or imply a private cause of action for a violation of this section.")

[66] Nicholson, 777 P.2d at 1157, citing White v. Unigard Mutual Insurance Co., 730 P.2d 1014, 1019 n.3 (Idaho 1986).

[67] Id. at 1209, quoting Nicholson, 777 P.2d at 1157 (brackets in original).

For the same reasons, the DRB should be held to owe fiduciary duties to the retired public employees of Alaska in fulfilling its mission as the administrator of the Plan. That conclusion is supported by analogy to the reasons why ERISA imposes fiduciary duties on the administrators of retirement plans established by private employers in their dealings with the beneficiaries of those plans.

Administrators of Private Retirement Plans Owe Fiduciary Duties to Their Plan Beneficiaries

Administrators of retirement plans established by private employers for their retired employees are analogous to the DRB as the administrator of the AlaskaCare Plan. The administrators of those private retirement plans are governed by ERISA.[58]

The policies underlying the protections provided by ERISA statutes and regulations, and case law governing the standards of conduct of administrators of private retirement plans, all provide guidance concerning the appropriate standards of conduct of the administrators of public employee retirement plans such as the AlaskaCare Plan.[59] In Duncan, the DRB urged the Court to look to ERISA for guidance on a number of issues.[60]

Congress recognized the vulnerability of beneficiaries of private retirement plans and the corresponding need to protect them by discouraging plan administrators from overreaching, taking advantage of the trust and reliance that beneficiaries have no choice but to place on plan administrators.[61] Therefore, by statute Congress expressly

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[58] Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq.

[59] in appropriate cases, the Alaska Supreme Court refers to federal law for guidance when deciding certain issues. See e.g., French v. Jadon, Inc., 911 P.2d 20, 28 and n8 (Alaska 1996); Dingeman v. Dingeman, 865 P.2d 94, 99 n.6 (Alaska 1993); Jeffcoat v. State, Dept. of Labor, 732 P.2d 1073, 1075 (Alaska 1987).

[60] Duncan, 71 P.3d at 887 and 894.

[61] See gen., John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank, 510 U.S. 86, 96, 114 S.Ct. 517, 524 (1993) ("To help fulfill ERISA's broadly protective purposes, Congress

provided that the trustees and administrators of private retirement plans under ERISA owe fiduciary duties to their plan beneficiaries.[62]

The United States Supreme Court has observed that prior to ERISA, the common law of trusts governed most retirement plans.[63] The Court determined that Congress relied on that common law when creating ERISA to establish the general fiduciary duties that administrators of ERISA plans owe to ERISA beneficiaries.[64] The Court went on to explain that "trust law does not tell the entire story," and that "ERISA's standards and procedural protections partly reflect a congressional determination that the common law of trusts did not offer completely satisfactory protection."[65]

Based on the legislative record of ERISA, the Court concluded that "rather than explicitly enumerating all of the powers and duties of trustees and other fiduciaries [under ERISA], Congress invoked the common law of trusts to define the general scope of their authority and responsibility."[66] It concluded that "Congress expect[ed] that the courts [would] interpret [the] prudent man rule (and the other fiduciary standards) bearing in mind the special nature and purpose of employee benefit plans."[67]

For these reasons, federal courts have expanded and refined the general fiduciary duties of ERISA plan administrators established by statute. In doing so, they have drawn on the common law of trusts, "bearing in mind the special nature and

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commodiously imposed fiduciary standards on persons whose actions affect the amount of benefits retirement plan participants will receive.").

[62] 29 U.S.C. § 1104; 29 U.S.C. § 1002(21)(A).

[63] Varity Corp. v. Howe, 516 U.S. 489, 496, 116 S.Ct. 1065, 1070 (1996)

[64] Id.

[65] Id. at 497, 116 S.Ct. at 1070.

[66] Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc., 472 U.S. 559, 570, 105 S.Ct. 2833, 2840 (1985) (emphasis added)

[67] Id. (interior quotations and citations omitted)

purpose of employee benefit plans" and the goal of ensuring that beneficiaries have "completely satisfactory protection."[68]

Like all fiduciaries, plan administrators under ERISA owe a duty of loyalty to the plan beneficiaries.[69] That duty of loyalty requires the fiduciary to deal fairly and honestly with plan beneficiaries.[70] "[A] benefits determination by a plan administrator is a fiduciary act, one in which the administrator owes a special duty of loyalty to the plan beneficiaries."[71] ERISA plan administrators have a fiduciary duty "to execute faithfully the terms of the plan and 'to see that those entitled to benefits receive them.'"[72]

Plan administrators under ERISA must "discharge [their] duties solely in the interests of the participants and beneficiaries [and] for the exclusive purpose of providing benefits to them" and act "with the care, skill, prudence and diligence under the circumstances then prevailing of the traditional prudent [person.]"[73]

In addition, under ERISA "the plan administrator has a fiduciary duty to the insured to conduct an investigation and to seek out the information necessary for a fair and accurate assessment of the claim."[74]

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[68] Id.

[69] Varity, 516 U.S. at 506, 116 S.Ct. at 1075, citing Central States, 472 U.S. at 569–70, 105 S.Ct. at 2840-41.

[70] Id., citing Bogert & Bogert, Law of Trusts and Trustees § 543 at 218-19; 2A Scott & Fratcher, Law of Trusts § 170, pp. 311-312 and Restatement (Second) of Trusts § 170.

[71] Glenn, 554 U.S. at 111, 128 S.Ct. at 2347–48 (2008)

[72] Hennen v. Metropolitan Life Insurance Company, 904 F.3d 532, 541 (7th Cir. 2018), quoting Gaither v. Aetna Life Ins. Co., 394 F.3d 792, 807–08 (10th Cir. 2004)

[73] Devlin v. Blue Cross and Blue Shield, 274 F.3d 76, 88 (2d Cir.2001) quoting Donovan v. Bierwirth, 680 F.2d 263, 271 (2d Cir. 1982) (Friendly, J.). And see Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 152–53 105 S.Ct. 3085, 3095–96, (1985) (Brennan, J. joined by White, Marshall, and Blackmun, J.J., concurring).

[74] Rasenack ex rel. Tribolet v. AIG Life Ins. Co., 585 F.3d 1311, 1324 (10th Cir. 2009)

All these fiduciary duties serve a principal purpose of ERISA, described by the U.S. Supreme Court as "making sure that when 'a worker has been promised a defined pension benefit upon retirement—and if [the worker] has fulfilled whatever conditions are required to obtain a vested benefit—[the worker] actually will receive it.'"[75]

Under the Law, the DRB Has Fiduciary Duties to the Beneficiaries of the AlaskaCare Plan

The reasons for imposing fiduciary duties on private insurers and the administrators of ERISA retirement plans, discussed above, also justify imposing the same or similar fiduciary duties on the administrators of public retirement plans.

There are additional and even more compelling reasons for holding the administrators of public retirement plans to the higher standards of fiduciaries in the performance of their duties handling medical insurance claims under the AlaskaCare Plan. Those additional reasons arise from the fact that beneficiaries of the Plan have fewer protections than private insureds or the beneficiaries of private retirement plans and therefore are more vulnerable to harm. Those reasons include the following:

1. People who buy private insurance have the option of switching health insurers if they are dissatisfied with the claims handling of the health insurer they initially chose. Plan beneficiaries do not have that option. By their service as public employees, Plan beneficiaries have earned and fully paid for the vested Plan benefits. They cannot simply switch insurers if they are dissatisfied with claims handling. They are, essentially, captive insureds. They can only hope and trust if they have a medical problem, DRB will act promptly and in good faith to fulfill the state's obligation to pay all legitimate, covered claims in accordance with the terms the Plan so they can get the medical treatment and care that they need.

2. The DRB, as administrator of the AlaskaCare Plan, is exempt from regulation by the Alaska Division of Insurance, including the provisions of the Alaska Unfair Claim

[75] Central States, 472 U.S. at 569–70, 105 S.Ct. at 2840, quoting Nachman Corp. v. Pension Ben. Guaranty Corp., 100 S.Ct. 1723, 1733, 446 U.S. 359, 375 (1980).

Settlement Practices Act and other statutes in Title 21 and associated regulations that are intended to discourage bad faith conduct by private insurers doing business in this state.[76] Essentially, DRB is unregulated.

3. The DRB, as a state agency, is also exempt from punitive damages.[77] For private insurers, the potential liability for substantial punitive damages helps deter bad faith conduct. As explained by the Alaska Supreme Court, for private insurers, the prospect of being required to pay only normal contract damages as a consequence for failing to properly pay a covered claim is insufficient to deter wrongful denials of claims.[78] Quoting with approval the Texas Supreme Court, the Court pointed out that if insureds were prohibited from bringing a bad faith action in tort, "insurers could arbitrarily deny coverage and delay payment of a claim with no more penalty than interest on the amount owed."[79]

4. The administrators of public retirement plans are not subject to the ERISA statutes, regulations and federal court rulings that protect the beneficiaries of private-employer retirement plans by imposing fiduciary duties on the administrators of the private employer plans. The statutes and regulations that govern the DRB lack any of the protections for Plan beneficiaries that ERISA provides to the beneficiaries of private retirement plans.

5. Although the state statutes and regulations lack the protections for Plan beneficiaries that ERISA provides, the Alaska Supreme Court has ruled that the medical insurance benefits provided to retired public employees are vested contractual

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[76] AS 21.03.021(b)

[77] AS 09.50.280

[78] Nicholson, 777 P.2d at 1156, quoting Arnold v. National County Mut. Fire Ins. Co., 725 S.W.2d 165, 167 (Tex. 1987). See Government Employees Insurance Company v. Gonzalez, 403 P.3d 1153, 1162 n. 9 (Alaska 2017) (quoting itself and the 9th Circuit: "[A]n insurance company should not be allowed to buy immunity from a bad faith tort claim merely by belatedly paying all sums due under the contract" and "[a] defendant cannot buy full immunity from punitive damages by paying the likely amount of compensatory damages before judgment.")

[79] Id.

obligations that are constitutionally protected under Article XII, Section 7 of the Alaska Constitution.[80] As a consequence, DRB owes a higher standard of loyalty and trust to Plan beneficiaries as a fiduciary of the retiree health plan trust under these Constitutional protections.

6. There is a natural level of trust that Plan beneficiaries have in their government and the expectation that they will be treated honestly and fairly that exceeds the confidence that insureds have in private insurance companies.

Just as there is "a strong public interest in fostering trust in insurers,"[81] there is a public interest in promoting trust in government generally.[82]

The policy of encouraging such trust is particularly important in light of the underlying the purpose of Alaska's PERS and TRS; that is, "to encourage qualified personnel to enter and remain in [public] service."[83] If the public does not have confidence that the DRB will act with the fidelity of a fiduciary to fulfill the state's contractual obligation to provide the promised benefits, then the policy of encouraging qualified individuals to enter and remain in public service is undermined.

It is reasonable to assume that many retired public employees of Alaska who spent all or a substantial portion of their working lives in government service believe in good faith that the government they served will fulfill its promise to provide them with the vested retirement benefits they earned. Furthermore, most Plan beneficiaries are likely to view the DRB as lacking the kind of profit motive that tempts private insurers to deny covered claims and as not having any personal animus to deny legitimate medical benefits that are covered by the Plan. It also reasonable for Plan beneficiaries to trust

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[80] Duncan, 71 P.3d at 888.

[81] Fleegel v. Estate of Boyles, 61 P.3d 1267, 1280 (Alaska 2002); Clary Ins. Agency v. Doyle, 620 P.2d 194, 205 (Alaska 1980) (noting "the need to promote public confidence in the insurance industry").

[82] See gen. In re 2011 Redistricting Cases, 274 P.3d 466, 468 (Alaska 2012) (re: general policy of promoting "trust in government").

[83] AS 39.35.001

that the DRB will ensure that the TPAs it hires to handle claims will not wrongfully deny or unreasonably delay payment of all legitimate medical claims covered by the Plan.

Furthermore, like all members of the public, Plan beneficiaries have been subjected to years of advertising by the insurance industry, professing that the primary mission of insurers is to protect their insureds from serious financial harm and, in matters of health insurance, ensure that they promptly receive the medical care and treatment they need.[84] The DRB offers similar assurances to Plan beneficiaries on its website, stating that it seeks "to ensure excellent, accurate and timely service to its member community."[85] It touts its "organizational excellence" which it claims to achieve "by focusing on the customer to deliver exceptional services using effective and efficient processes."[86]

For all these reasons, Plan beneficiaries are naturally inclined to trust DRB's decisions concerning their medical claims and simply accept denials of claims without question. That trust, and the public policy of promoting that trust, provide further reasons for imposing special fiduciary duties on the DRB in the services it provides to the beneficiaries of the AlaskaCare Plan.

7. The fact that the Plan permits parties to appeal denials of claims is inadequate protection. Most AlaskaCare Plan beneficiaries are laypersons. They are unfamiliar with the intricacies of insurance policies, the meanings of certain technical insurance terms and the often-tangled array of coverages, exceptions, conditions, exclusions and

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[84] All insurers market themselves with promises to provide security, protection from financial disaster and peace of mind. People buy insurance trusting that the insurer will fulfill its promise to act "Like a Good Neighbor" who will protect them with its "Good Hands" and who will leave the policyholder exclaiming, "Aetna, I'm Glad I Met Ya." See Nicholson, 777 P.2d at 1155, n.6 (Alaska 1989) and Rawlings, 726 P.2d at 571, n.3.

[85] See http://doa.alaska.gov/drb/help/mission.html#.XEo-3FxKhPY

[86] Id.

amendments. Most Plan beneficiaries are older retired persons[87] who face declining health conditions. Most lack expertise in medical matters, including a lack of understanding of medical terminology, the technical coding that physicians use when they submit medical insurance claims forms, and how those codes are used by claims administrators in deciding whether to approve or disapprove medical claims. As a result, Plan beneficiaries are particularly vulnerable to being "fooled by [the] statement of reasons"[88] why a claim is being denied; confused by "medical mumbo-jumbo"[89] or by the technical language used by insurers. Plan beneficiaries should not be required to seek the advice of lawyers or physicians to understand their rights and the reasons why a claim in being denied.

The required appeal procedure of the AlaskaCare Plan is a multi-level process that can be daunting to the average layperson. It requires Plan beneficiaries to gather, review and comprehend medical records that are often difficult to obtain, difficult to read and difficult to understand. It also requires them to obtain and review the Plan provisions; to identify the specific coverage issue(s); and then to write and file the

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[87] DRB has published statistical information showing that as of 2017, average age of the 47,330 retirees then alive who were covered under PERS and TRS was between 69 and 70 years. See http://doa.alaska.gov/drb/pdf/pers/Alaska_rpt063017-PERS%20DB%20Report_FINAL.pdf and http://doa.alaska.gov/drb/pdf/trs/Alaska_rpt063017-TRS%20DB%20Report_FINAL.pdf. As this population continues to age, it faces the increasing medical challenges of aging, making many of them more susceptible to confusion about health care coverages, about why claims have been denied and about what options are available to file and pursue an appeal of the denial of any claim by Aetna. Furthermore, as this population continues to age, they face the increasing medical challenges of aging that make many more susceptible to confusion about health care coverages, about why their claims have been denied and about the existence of options for appealing such denials and how to pursue an appeal the denial of a claim by Aetna.

[88] Salomaa v. Honda Long Term Disability Plan, 642 F.3d 666, 680 (9th Cir. 2011) (ERISA case)

[89] Id. And see Guess, 598 P.2d at 904 ("[I]nsurers who seek to impose upon words of common speech an esoteric significance intelligible only to their craft, must bear the burden of any resulting confusion," quoting Judge Learned Hand in Gaunt v. John Hancock Mutual Life Insurance Co., 160 F.2d 599, 602 (2d Cir. 1947).

appeal, all within certain specified time limits and all at a time when some Plan beneficiaries are facing serious, on-going medical issues.

Sometimes claims administrators ask beneficiaries to get more information from their doctors, a request that requires further work for both insureds and their doctors, especially when doctors are asked to review a patient's record and write a narrative explanation. That requires substantial additional work for the doctor, work that is not paid for by insurance. As a result, some doctors may not do it, and those who do are discouraged from accepting patients who have AlaskaCare coverage. If the requested information is not provided, the denial of the claim stands. These factors make it imperative that any request by a claims administrator for the Plan beneficiary to gather and provide additional information be made in good faith, only if necessary, and with a reasonable explanation. Imposing fiduciary duties on the DRB and its TPA will help ensure those goals are met and that "trial denials" of claims and spurious requests for additional information do not occur.

The process of appealing denials of claims can take substantial time, during which medical bills are not being paid and possibly being sent to collections. While this is occurring, needed additional medical treatment may not be sought or, if it is, might not be provided without the assurance of payment from an insurer.

For these reasons, the availability of an administrative appeals process does not provide beneficiaries with sufficient protection to ensure that the legitimate, covered medical claims of Plan beneficiaries will be fully and timely paid.[90]

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[90] Furthermore, because of recent changes imposed by DRB concerning administrative appeals, beneficiaries are now being told by DRB that they may not appeal the denial of medical claims to the Alaska Office of Administrative Hearings ("OAH") unless DRB grants them permission to do so. This edict is contrary to AS 39.35.006, is contrary DRB's past practice of forwarding such appeals to the OAH, and is contrary to DRB's own published appeal guidelines that it mailed to the Plan beneficiaries. Those guidelines assured Plan beneficiaries that DRB would forward their appeal files, along with any additional documentation they submitted in support of their appeal, to the OAH within 15 calendar days of receiving the notice of a beneficiary's desire to take such an appeal.

An appeal to the OAH is the first opportunity Plan beneficiaries have for the denial of their medical claims to be independently reviewed by a disinterested and impartial tribunal. DRB's

Although a court decision requiring DRB to comply with fiduciary standards is no certain cure-all, it would at least clearly establish that the DRB and its third-party administrators have a duty serve the best interests of Plan beneficiaries with undivided loyalty and good faith, promptly paying all legitimate medical claims covered by the Plan and candidly informing Plan beneficiaries of all facts that materially affect their rights and interests and which might influence their action(s).

Holding the DRB to the standards of a fiduciary will also help the DRB resist efforts from outside the division to engage in trial methods of whittling down medical benefits in gradual ways, each affecting relatively few Plan beneficiaries so as to not generate a loud protest or support a class action. Such conduct is not permitted of a fiduciary.

As described above, the few beneficiaries who might have the confidence and courage to question a denial of a medical claim face a number of daunting challenges that discourage them from appealing denials of claims even at the lowest levels.[91] Those challenges increase greatly when the next level of appeal is to the Superior Court, where formal appellate rules are applicable. Hiring a lawyer is usually financially prohibitive because of mounting medical bills or because the cost of doing so could easily exceed the amount at issue. Finding a lawyer to handle such appeals on a pro bono basis is, at best, a challenge that is difficult to overcome.

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new claim of power, when exercised to prevent beneficiaries from appealing to the OAH, denies them that review. It forces beneficiaries to choose between abandoning their appeal or undertaking the much more expensive, complicated and time-consuming process of appealing to the superior court, an appeal that carries with it the associated risk of being assessed attorney fees if it is unsuccessful. For these reasons, preventing Plan beneficiaries from appealing to the OAH constitutes a diminishment and impairment of Plan benefits; that is, the denial of appeal rights and advantages that historically have been provided by the Plan and that are authorized by statute.

[91] Some obstacles that discourage appeals of denial of claims include 1) the challenge of trying to decipher medical records, diagnostic codes and so-called "Explanation of Benefit" forms that often "explain" denials of claims by use of technical jargon and numerical codes; 2) reading and understanding the terms of the Plan; and 3) challenging adjusters who hold themselves out to be insurance experts and represent themselves as people who are acting in the insured's best interests.

In sum, the reasons for holding the DRB to the standards of a fiduciary in fulfilling the state's obligation to provide the promised medical benefits to Plan beneficiaries are more numerous and compelling than the reasons for imposing such duties on private insurers and the administrators of ERISA plans. Holding the DRB to such fiduciary standards would help discourage it from taking any action that would, or might, diminish or impair any vested retirement medical benefit without first 1) showing good cause for the proposed change; 2) performing the analyses required by Duncan; 3) giving Plan beneficiaries reasonable notice and opportunity to be heard concerning the proposed changes, including a complete and candid statement of the reasons for the changes and a description of the proposed new benefits/advantages that the DRB contends would offset any benefits/advantages that would be eliminated or reduced; 4) meeting its burden of proving the changes satisfy the requirements of Duncan; and 5) giving notice to Plan beneficiaries that any of them who will suffer any serious hardship as a result of the plan changes may retain their existing coverage.

CONCLUSION

The RPEA supports any legitimate effort by the DRB to save the retirement trust money by cutting unnecessary Plan administrative costs and by being vigilant to ensure that only legitimate, covered medical claims are paid.

The key to RPEA's support for such efforts is that they are legitimate. Using artifice, such as altering the plain and established meanings of the words and phrases in the AlaskaCare Plan; such as summarily adopting so-called Plan "clarifying" amendments to avoid complying with judicial rulings; such as resorting to so-called "trial denials" of claims and making it more difficult for beneficiaries to appeal what they believe are wrongful denials of claims, are not legitimate efforts to reduce plan costs.

DRB's primary mission is to ensure that the eligible retired public employees of Alaska receive the vested retirement benefits they earned and have contractual and constitutionally guaranteed rights to receive. It should fulfill that mission and obligation by serving the best interests of Plan beneficiaries with good faith, loyalty, honesty,

fairness, candor, transparency and without guile or artifice. Granting this motion will help ensure that the DRB fulfills those goals.

For the foregoing reasons, the RPEA respectfully requests that this motion be granted.

DATED this 26th day of February 2019.

LAW OFFICES OF WM. GRANT CALLOW

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

Certificate of Service

By my signature below, I certify that on this 26th day of February 2019, I caused a true and complete copy of the foregoing motion to be served upon Kate Demarest Assistant Attorney General of the State of Alaska, counsel to Defendant, by email and hand-delivery and on Kevin McKenzie Dilg, Assistant Attorney General of the State of Alaska, counsel to Defendant, by email and U.S mail, first class postage pre-paid and addressed to their respective addresses of record.

Wm. Grant Callow