IN THE SUPREME COURT OF THE STATE OF ALASKA

Kelly Tshibaka, Commissioner of the Department of Administration in her Official Capacity,	)	
Appellant,	)	
v.	)	
The Retired Public Employees of Alaska,	)	Supreme Court No. **S-17577**
Appellee.	)	

Trial Court Case No. **3AN-16-04537 CI**

APPEAL FROM THE SUPERIOR COURT
THIRD JUDICIAL DISTRICT AT ANCHORAGE
THE HONORABLE ERIC AARSETH

BRIEF OF APPELLANT STATE OF ALASKA, COMMISSIONER OF THE DEPARTMENT OF ADMINISTRATION

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AUTHORITIES PRINCIPALLY RELIED UPON

CONSTITUTIONAL PROVISIONS:

Alaska Const. art. XII, § 7

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.

ALASKA STATUTES:

AS 39.30.090

(a) The Department of Administration may obtain a policy or policies of group insurance covering state employees, persons entitled to coverage under AS 14.25.168, 14.25.480, AS 22.25.090, AS 39.35.535, 39.35.880, or former AS 39.37.145, employees of other participating governmental units, or persons entitled to coverage under AS 23.15.136, subject to the following conditions:

(1) a group insurance policy shall provide one or more of the following benefits: life insurance, accidental death and dismemberment insurance, weekly indemnity insurance, hospital expense insurance, surgical expense insurance, dental expense insurance, audiovisual insurance, or other medical care insurance;

(2) each eligible employee of the state, the spouse and the unmarried children chiefly dependent on the eligible employee for support, and each eligible employee of another participating governmental unit shall be covered by the group policy, unless exempt under regulations adopted by the commissioner of administration;

(3) a governmental unit may participate under a group policy if

(A) its governing body adopts a resolution authorizing participation and payment of required premiums;

(B) a certified copy of the resolution is filed with the Department of Administration; and

(C) the commissioner of administration approves the participation in writing;

(4) in procuring a policy of group health or group life insurance as provided under this section or excess loss insurance as provided in AS 39.30.091, the Department of Administration shall comply with the dual choice requirements of AS 21.86.310, and shall obtain the insurance policy from an insurer authorized to transact business in the state under AS 21.09, a hospital or medical service corporation authorized to transact business in this state under AS 21.87, or a health maintenance organization authorized to operate in this state under AS 21.86; an excess loss insurance policy may be obtained from a life or health insurer authorized to transact business in this state under AS 21.09 or from a hospital or medical service corporation authorized to transact business in this state under AS 21.87;

(5) the Department of Administration shall make available bid specifications for desired insurance benefits or for administration of benefit claims and payments to (A) all insurance carriers authorized to transact business in this state under AS 21.09 and all hospital or medical service corporations authorized to transact business under AS 21.87 who are qualified to provide the desired benefits; and (B) insurance carriers authorized to transact business in this state under AS 21.09, hospital or medical service corporations authorized to transact business under AS 21.87, and third-party administrators licensed to transact business in this state and qualified to provide administrative services; the specifications shall be made available at least once every five years; the lowest responsible bid submitted by an insurance carrier, hospital or medical service corporation, or third-party administrator with adequate servicing facilities shall govern selection of a carrier, hospital or medical service corporation, or third-party administrator under this section or the selection of an insurance carrier or a hospital or medical service corporation to provide excess loss insurance as provided in AS 39.30.091;

(6) if the aggregate of dividends payable under the group insurance policy exceeds the governmental unit's share of the premium, the excess shall be applied by the governmental unit for the sole benefit of the employees;

(7) a person receiving benefits under AS 14.25.110, AS 22.25, AS 39.35, or former AS 39.37 may continue the life insurance coverage that was in effect under this section at the time of termination of employment with the state or participating governmental unit;

(8) a person electing to have insurance under (7) of this subsection shall pay the cost of this insurance;

(9) for each permanent part-time employee electing coverage under this section, the state shall contribute one-half the state contribution rate for permanent full-time state employees, and the permanent part-time employee shall contribute the other one-half;

(10) a person receiving benefits under AS 14.25, AS 22.25, AS 39.35, or former AS 39.37 may obtain auditory, visual, and dental insurance for that person and eligible dependents under this section; the level of coverage for persons over 65 shall be the same as that available before reaching age 65 except that the benefits payable shall be supplemental to any benefits provided under the federal old age, survivors, and disability insurance program; a person electing to have insurance under this paragraph shall pay the cost of the insurance; the commissioner of administration shall adopt regulations implementing this paragraph;

(11) a person receiving benefits under AS 14.25, AS 22.25, AS 39.35, or former AS 39.37 may obtain long-term care insurance for that person and eligible dependents under this section; a person who elects insurance under this paragraph shall pay the cost of the insurance premium; the commissioner of administration shall adopt regulations to implement this paragraph;

(12) each licensee holding a current operating agreement for a vending facility under AS 23.15.010--23.15.210 shall be covered by the group policy that applies to governmental units other than the state.

(b) In this section,

(1) “eligible employee” means

(A) an employee who has served in permanent full-time or part-time employment with the same governmental unit for 30 days or more, except an emergency or temporary employee;

(B) an elected or appointed official of a governmental unit, effective upon taking the oath of office; and

(C) a contractual employee of the legislative branch of state government under AS 24.10.060(f) if the employee's personal services contract provides that the employee is entitled to coverage;

(2) “governmental unit” means the state, a municipality, school district, or other political subdivision of the state, and the North Pacific Fishery Management Council;

(3) “insurance”, “insurance carrier” and “insurance policy” include health care services, health care service contractors and contracts, and health maintenance organizations.

AS 39.35.001

The purpose of this chapter is to encourage qualified personnel to enter and remain in service with participating employers by establishing plans for the payment of retirement, disability, and death benefits to or on behalf of the members.

AS 39.35.095

The following provisions of this chapter apply only to members first hired before July 1, 2006: AS 39.35.095--39.35.680.

AS 39.35.115

(a) A defined benefit retirement plan for employees of the state, political subdivisions, and public organizations is created. The plan becomes effective January 1, 1961, at which time contributions by the employers and members begin.

(b) The retirement plan established by AS 39.35.095--39.35.680 is intended to qualify under 26 U.S.C. 401(a) and 414(d) (Internal Revenue Code) as a qualified retirement plan established and maintained by the state for its employees and for the employees of political subdivisions, public corporations, and public organizations of the state, and for

the employees of other employers whose participation is authorized by AS 39.35.095--39.35.680 and who participate in this plan.

(c) An amendment to AS 39.35.095--39.35.680 does not provide a person with a vested right to a benefit if the Internal Revenue Service determines that the amendment will result in disqualification of the plan under the Internal Revenue Code.

(d) The retirement plan established by AS 39.35.095--39.35.680 is a joint contributory plan.

(e) If, upon termination of the plan, all liabilities are satisfied, any excess assets shall be deposited in the general fund, subject to the approval of the termination by the Internal Revenue Service.

AS 39.35.120

(a) An employee of the state shall be included in this plan upon commencement of employment with the state, or on January 1, 1961, whichever is later. Unless an employee participates in a university retirement program under AS 14.40.661--14.40.799, an employee of a political subdivision or public organization that becomes an employer shall be included in the plan on the effective date of the employer's participation or the date of the employee's commencement of employment with the employer, whichever is later.

(b) Inclusion in the plan is a condition of employment for an employee except as otherwise provided for

(1) an elected official;

(2) Repealed by SLA 2005, ch. 50, § 10 eff. July 1, 2009.

(3) an employee of the university who participates in a university retirement program under AS 14.40.661--14.40.799.

AS 39.35.280

In addition to the contributions that the state is required to make under AS 39.35.255 as an employer, the state shall contribute to the plan each July 1 or, if funds are not available on July 1, as soon after July 1 as funds become available, an amount for the ensuing fiscal year that, when combined with the total employer contributions that the administrator estimates will be allocated under AS 39.35.255(c), is sufficient to pay the plan's past service liability at the contribution rate adopted by the board under AS 37.10.220 for that fiscal year.

AS 39.35.535

(a) Except as provided in (d) of this section, the following persons are entitled to major

medical insurance coverage under this section:

(1) for employees first hired before July 1, 1986,

(A) an employee who is receiving a monthly benefit from the plan and who has elected coverage;

(B) the spouse and dependent children of the employee described in (A) of this paragraph;

(C) the surviving spouse of a deceased employee who is receiving a monthly benefit from the plan and who has elected coverage;

(D) the dependent children of a deceased employee who are dependent on the surviving spouse described in (C) of this paragraph;

(2) for members first hired on or after July 1, 1986,

(A) an employee who is receiving a monthly benefit from the plan and who has elected coverage for the employee;

(B) the spouse of the employee described in (A) of this paragraph if the employee elected coverage for the spouse;

(C) the dependent children of the employee described in (A) of this paragraph if the employee elected coverage for the dependent children;

(D) the surviving spouse of a deceased employee who is receiving a monthly benefit from the plan and who has elected coverage;

(E) the dependent children of a deceased employee who are dependent on the surviving spouse described in (D) of this paragraph if the surviving spouse has elected coverage for the dependent children

(b) Except as provided in (d) of this section, after an election of coverage under this section, major medical insurance coverage takes effect on the same date that benefits begin, and stops when the member or survivor is no longer eligible to receive a monthly benefit. The coverage for persons age 65 or older is the same coverage available for a person under 65 years of age. The benefits payable to persons age 65 or older supplement any benefits provided under the federal old age, survivors and disability insurance program. The medical premium and optional insurance premiums owed by a member or survivor shall be deducted from the benefit owed to the member or survivor before payment of the benefit.

(c) A benefit recipient may elect major medical insurance coverage in accordance with regulations and under the following conditions:

(1) a person, other than a disabled member or a disabled member who is appointed to normal retirement, must pay an amount equal to the full monthly group premium for retiree major medical insurance coverage if the person is

(A) younger than 60 years of age and has less than

(i) 25 years of credited service as a peace officer under AS 39.35.360 and 39.35.370; or

(ii) 30 years of credited service under AS 39.35.360 and 39.35.370 that is not service as a peace officer; or

(B) of any age and has less than 10 years of credited service;

(2) a person is not required to make premium payments for retiree major medical coverage if the person

(A) is a disabled member;

(B) is a disabled member who is appointed to normal retirement;

(C) is 60 years of age or older and has at least 10 years of credited service; or

(D) has at least

(i) 25 years of credited service as a peace officer under AS 39.35.360 and 39.35.370; or

(ii) 30 years of credited service under AS 39.35.360 and 39.35.370 not as a peace officer.

(d) Receipt under a qualified domestic relations order of a monthly benefit from the plan does not entitle a person or the person's spouse or child to insurance coverage under (a) of this section. However, a member's former spouse who receives a monthly benefit under a qualified domestic relations order is entitled to receive major medical insurance coverage if the former spouse

(1) elects the coverage within 60 days after the first monthly benefit paid under the order is mailed first class or otherwise delivered; and

(2) pays the premium established by the administrator for the coverage.

(e) The administrator shall inform members who have requested appointment to retirement that the health insurance coverage available to retired members may be different from the health insurance coverage provided to employees. The administrator shall also notify those members of time limits for selecting optional health insurance coverage and whether the election is irrevocable. A member who has requested appointment to retirement shall indicate in writing on a form provided by the administrator that the member has received the information required by this subsection and whether the member has chosen to receive optional health insurance coverage.

(f) On and after July 1, 2007, benefits under this section shall be provided in part by the Alaska retiree health care trust established under AS 39.30.097(a).

AS 39.35.700.

The provisions of AS 39.35.700--39.35.990 apply only to members first hired on or after July 1, 2006, to members who are employed by employers that do not participate in the defined benefit retirement plan established under AS 39.35.095--39.35.680, to former

members as defined in AS 39.35.680, or to members who transfer into the defined contribution retirement plan under AS 39.35.940.

AS 39.35.720

An employee who becomes a member on or after July 1, 2006, shall participate in the plan set out in AS 39.35.700--39.35.990.

AS 39.35.750

(a) An employer shall contribute to each member's individual account an amount equal to five percent of the member's compensation from July 1 to the following June 30.

(b) An employer shall also contribute an amount equal to a percentage, as adopted by the board, of each member's compensation from July 1 to the following June 30 to pay for retiree major medical insurance. This contribution shall be paid into the Alaska retiree health care trust established by the commissioner of administration under AS 39.30.097(b) and shall be accounted for in accordance with regulations established by the commissioner

(c) Notwithstanding (b) of this section, the employer contribution for retiree major medical insurance for fiscal year 2007 shall be 1.75 percent of each member's compensation from July 1 to the following June 30.

(d) An employer shall also make contributions to the health reimbursement arrangement plan under AS 39.30.370

(e) An employer shall make annual contributions to a trust account in the plan, applied as a percentage of each member's compensation from July 1 to the following June 30, in an amount determined by the board to be actuarially required to fully fund the cost of providing occupational disability and occupational death benefits under AS 39.35.700--39.35.990 and retirement benefits elected by disabled peace officers and firefighters under AS 39.35.890(h)(2). The contribution required under this subsection for peace officers and firefighters and the contribution required under this subsection for other employees shall be separately calculated based on the actuarially calculated costs for each group of employees.

AS 39.35.880

(a) The medical benefits available to eligible persons are access to the retiree major medical insurance plan and to the health reimbursement arrangement under AS 39.30.300. Access to the retiree major medical insurance plan means that an eligible person may not be denied insurance coverage except for failure to pay the required premium.

(b) Retiree major medical insurance plan coverage elected by an eligible member under this section covers the eligible member, the spouse of the eligible member, and the dependent children of the eligible member.

(c) Retiree major medical insurance plan coverage elected by a surviving spouse of an eligible member under this section covers the surviving spouse and the dependent children of the eligible member who are dependent on the surviving spouse.

(d) Major medical insurance coverage takes effect on the first day of the month following the date of the administrator's approval of the election and stops when the person who elects coverage dies or fails to make a required premium payment.

(e) The coverage for persons 65 years of age or older is the same as that available for persons under 65 years of age. The benefits payable to those persons 65 years of age or older supplement any benefits provided under the federal old age, survivors and disability insurance program.

(f) The medical and optional insurance premiums owed by the person who elects coverage may be deducted from the health reimbursement arrangement. If the amount of the health reimbursement arrangement becomes insufficient to pay the premiums, the person who elects coverage under (a) of this section shall pay the premiums directly.

(g) The cost of premiums for retiree major medical insurance coverage for an eligible member or surviving spouse who is

(1) not eligible for Medicare is an amount equal to the full monthly group premiums for retiree major medical insurance coverage;

(2) eligible for Medicare is the following percentage of the premium amounts established for retirees who are eligible for Medicare:

(A) 30 percent if the member had 10 or more, but less than 15, years of service;

(B) 25 percent if the member had 15 or more, but less than 20, years of service;

(C) 20 percent if the member had 20 or more, but less than 25, years of service;

(D) 15 percent if the member had 25 or more, but less than 30, years of service;

(E) 10 percent if the member had 30 or more years of service.

(h) The eligibility for retiree major medical insurance coverage for an alternate payee under a qualified domestic relations order shall be determined based on the eligibility of the member to elect coverage. The alternate payee shall pay the full monthly premium for retiree major medical insurance coverage.

(i) A person who is entitled to retiree major medical insurance coverage shall

(1) be informed by the administrator in writing

(A) that the health insurance coverage available to retired members may be different from the health insurance coverage provided to employees;

(B) of time limits for selecting optional health insurance coverage and whether the election is irrevocable; and

(2) indicate in writing on a form provided by the administrator that the person has received the information required by this subsection and whether the person has chosen to receive optional health insurance coverage.

(j) The monthly group premiums for retiree major medical insurance coverage are established by the administrator in accordance with AS 39.30.095. Nothing in AS 39.35.700--39.35.990 guarantees a person who elects coverage under (a) of this section a monthly group premium rate for retiree major medical insurance coverage other than the premium in effect for the month in which the premium is due for coverage for that month.

(k) In this section, “health reimbursement arrangement” means the plan established in AS 39.30.300.

ALASKA ADMINISTRATIVE CODES:

2 AAC 39.280

When necessary to maintain the financial integrity of the plan, the administrator may change the premiums and the terms of coverage.

JURISDICTIONAL STATEMENT

The superior court entered final judgment on August 8, 2019 disposing of all claims by all parties in this case. [Exc. 181] This Court has jurisdiction over this appeal pursuant to AS 22.05.010(b) and Alaska Rule of Appellate Procedure 202(a).

PARTIES

Kelly Tshibaka, in her official capacity as administrator of the Public Employees' Retirement System of Alaska ("PERS"), is the appellant.[1] [Exc. 2, 181] The Retired Public Employees of Alaska, Inc.—a nonprofit corporation—is the appellee. [Exc. 1]

ISSUES PRESENTED

1. Article XII, section 7 of the Alaska Constitution protects public employees' deferred compensation from being diminished. Dental-visual-audio ("DVA") coverage for PERS members differs from major medical coverage because it is not deferred compensation given in exchange for State service. Rather, retirees must enter a new contract for this coverage at retirement, and they must fund it entirely through premium payments—with no State contribution. Is DVA coverage a constitutionally protected "accrued benefit" of State employment?

2. In 2014, the State adopted a new dental plan, saving $10 million by steering providers and members into the network, improving coverage on some services, reducing coverage on others, and imposing explicit frequency limitations. The actuarial value of the plan increased by three percent; members' premiums decreased by ten percent. Did

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[1] *See* AS 39.35.003 (providing that the Commissioner of Administration is the administrator of PERS).

the superior court err by disregarding the premium savings and improved actuarial value of the plan to conclude that the 2014 changes effected an unconstitutional diminishment?

3. The superior court awarded RPEA the relief it requested, determining that dental coverage was diminished and ordering the State to provide retirees "the option of returning to the 2013 plan." Final judgment entered, and the State implemented the decision. The court then awarded new relief—ordering that the old plan be the default and that the State now conduct a retrospective claims review with an eye toward more future relief that RPEA did not request. Was this award of post-judgment remedies error?

INTRODUCTION

Article XII, section 7 of the Alaska Constitution protects accrued benefits earned during State employment against diminishment or impairment. PERS members are statutorily entitled to major medical coverage in retirement, primarily at State expense. Members who retire before their entitlement to State-paid coverage kicks in can choose to pay their own premiums, but eventually, all retirees who meet the length of service requirements receive coverage, with the State paying between seventy and one hundred percent of the premium.

In *Duncan v. Retired Public Employees of Alaska, Inc.*, the Alaska Supreme Court held that Article XII, section 7 protects major medical coverage from diminishment because it is deferred compensation—consideration for years of service.[2] Here, the Court must decide whether the State's optional dental-visual-audio ("DVA") coverage—a plan

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

that is one hundred percent retiree funded—is an "accrued benefit" of State employment, and thus afforded constitutional protection. But DVA coverage is unlike major medical coverage in critical ways. Because the State pays for no part of retirees' DVA coverage, is not part of the deferred compensation the State owes them for their service. Retirees elect this coverage under a separate contract at the time of retirement, and the consideration they give for it is their own premium payments, not past work. This Court should therefore hold that the diminishment clause does not apply.

If any constitutional protection attaches to DVA coverage, it protects only what the State offers new employees by statute—the opportunity to purchase a dental plan when they retire—and only if the State has exercised its discretionary authority to offer such a plan to current employees. PERS members are promised nothing more than that.

If this Court concludes that the diminishment clause protects the benefits themselves, it must consider how the diminishment analysis articulated in *Duncan* differs from a one hundred percent retiree funded plan. *Duncan* emphasized that the accrued benefit in the medical insurance context was the coverage, not the State-paid premiums. In the dental benefits context, premiums must be part of the analysis because retirees, not the State, bear the cost. Protecting the details of coverage without regard to the expense—as the superior court did—traps retirees in an upward spiral of premiums to pay for outdated coverage, ultimately dooming the plan to fail. And even if the superior court were correct to apply the diminishment clause to retiree-funded benefits without regard to premiums, the court erred by finding a diminishment in the absence of the objective, quantitative comparison between plans that *Duncan* requires.

Finally, the superior court gave RPEA everything it asked for in this case, ruling from the bench on applicability of the diminishment clause and then signing RPEA's proposed decision after trial without alteration. The State complied exactly with "Option 2" of that order by rapidly restoring the more expensive "Legacy Plan" as an option for retirees. But while this appeal was already pending and open enrollment began, the superior court awarded new injunctive relief to RPEA, requiring the old plan to be the default. Months later, the superior court went even farther, this time ordering the State to perform a massive multi-year retrospective claims review, for the purpose of awarding undefined additional relief to non-party retirees at some later date. The superior court exceeded its authority by awarding new forms of relief after final judgment.

STATEMENT OF THE CASE

I. Factual and statutory background.

A. The State has provided, and largely funded, major medical coverage for PERS retirees since 1975.

The Alaska Legislature created the Alaska Public Employees Retirement System ("PERS") in 1961 "to encourage qualified personnel to enter and remain in service" to the State "by establishing plans for the payment of retirement, disability, and death benefits" for its members.[3] Membership in PERS is "a condition of employment" for most State employees.[4] Title 39, Chapter 35 of the Alaska Statutes, titled "Public

[3] AS 39.35.001. The Teachers' Retirement System ("TRS"), established in 1955, has the same purpose. The issues in this appeal apply equally to TRS and PERS.

[4] AS 39.35.120 (making membership in the Public Employees Defined Benefit Retirement Plan mandatory for most employees hired before July 1, 2006); AS 39.35.720

Employees Retirement System of Alaska," defines PERS benefits.

Retirees and employees who entered State service before July 1, 2006 are members of the PERS defined benefit retirement plan.[5] A defined benefit plan, otherwise known as a traditional pension plan, "defines the benefit first, and then the plan administrator attempts to set the current contribution rates to pay for those future benefits."[6] Alaska's defined benefit plan members are divided into Tiers I, II, and III depending on when they came into State service, with the value of pension benefits decreasing each time PERS was amended.[7] Article 7 of Chapter 35 lists the benefits included in the defined benefit retirement plan,[8] which include the pension benefit[9] plus nonoccupational and occupational disability and death benefits.[10]

In 1975, the Alaska Legislature added major medical coverage as a mandatory PERS benefit. The legislation stated that "[e]ach person who is entitled to receive a monthly benefit from the retirement system *shall be provided* with major medical

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(mandating membership in the defined contribution retirement plan for most employees hired on or after July 1, 2006).

5 AS 39.35.095 (stating that AS 39.35.095 through AS 39.35.680 "apply only to members first hired before July 1, 2006"); AS 39.35.115 (creating a "defined benefit retirement plan" effective January 1, 1961).

6 *Moro v. State*, 351 P.3d 1, 9 (Or. 2015) (describing 26 U.S.C. § 414(j)); *Koster v. City of Davenport, Iowa*, 183 F.3d 762, 765 (8th Cir. 1999) (describing the difference between defined benefit and defined contribution retirement plans).

7 [*See* Exc. 23 (describing pension and medical benefits for Tiers I-III)]; *Duncan*, 71 P.3d at 885 (describing 1986 amendment to PERS lowering benefit amounts and increasing retirement age, creating Tier II).

8 AS 39.35.001 (listing retirement, disability, and death benefits).

9 AS 39.35.370.

10 AS 39.35.400; AS 39.35.410; 39.35.420; 39.35.430.

insurance coverage."[11] Medical coverage for defined benefit plan members is codified in Article 7 of the PERS statute at AS 39.35.535. The July 1, 1975 booklet published by the Division of Retirement and Benefits ("DRB") to describe the new health care program promised that "[t]he entire cost of this Medical Program for Retired Employees and their eligible family members will be paid by the Public Employees Retirement or Teachers' Retirement Systems." [R. 249] The 1980 handbook similarly promised: "Comprehensive major medical insurance is provided . . . . There is no cost to you for this insurance."[12]

The defined benefit plan closed to new members July 1, 2006, and employees and retirees who began State service on or after that date belong instead to the PERS defined contribution plan known as Tier IV.[13] Article 10 of the PERS statute describes Tier IV benefits. These include the defined contribution retirement plan that replaced the traditional pension[14] plus occupational disability and death benefits.[15] A defined contribution plan pays no pension, but is instead simply an investment account to which the employee and the employer contribute to fund the employee's retirement.[16]

Medical benefits for Tier IV members also appear in article 10, at AS 39.35.880.

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[11] *Duncan*, 71 P.3d at 885 n.4 (quoting Ch. 200, §§ 1-2, SLA 1975 (emphasis added)).

[12] *Id.* at n.24.

[13] *See* AS 39.35.700.

[14] AS 39.35.710.

[15] AS 39.35.890; AS 39.35.892.

[16] *See* AS 39.35.710; *Koster*, 183 F.3d at 765 ("'[A] defined contribution' plan entitles the member to the amount in his individual account at the time of his retirement, which equals the contributions made to the account plus or minus the investment's market fluctuations.").

"The medical benefits available to eligible persons [in Tier IV] are access to the retiree major medical insurance plan and to the health reimbursement arrangement under AS 39.30.300."[17] "Access" means "an eligible person may not be denied insurance coverage except for failure to pay the required premium."[18]

PERS employers must contribute funds to pay for major medical insurance for all retirees.[19] And although the State's contribution to premiums decreases with each new tier, *all* retirees who meet the statutory service requirements are promised access to the medical insurance benefit, with the State covering at least a significant portion of premiums by age 65. Tier I retirees vest in PERS benefits after five years, after which they are eligible for 100 percent State-paid medical premiums beginning at age 50.[20] Tier II retirees' premiums are paid 100 percent by age 60, and Tier III employees over age 60 receive full premium payments if they completed at least ten years of service.[21]

Most Tier IV retirees are not guaranteed "[a]ccess to the retiree major medical

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[17] AS 39.35.880(a).

[18] *Id.*

[19] Ch. 200, §§ 1-2, SLA 1975 [Exc. 85]; AS 39.35.280 (mandating that a portion of the funds contributed to PERS by employers of Tier I, II, and III employees go to the Alaska retiree health care trust to pay for the major medical insurance provided for retirees by AS 39.35.535); AS 39.35.750 (mandating contribution by employers of Tier IV employees into the same trust "to pay for retiree major medical insurance").

[20] [Exc. 23-24 (explaining that Tier I retirees receive "[s]ystem paid medical premiums at either early or normal retirement," *i.e.* age 50 or even younger if specific years-of-service requirements are met)].

[21] [Exc. 23 (explaining that Tier II retirees receive "[s]ystem paid medical premiums" at age 60 "or at any age with 30 years of service" and Tier III employees' premiums are the same, with the added requirement of 10 years of service before premiums kick in at age 60)]. [*See also* Tr. 36-37]

insurance plan," until they reach Medicare eligibility.[22] The subset of Tier IV retirees able to access the system earlier because of their lengthy service must pay their premiums until they reach Medicare age. The State then pays between 70 and 90 percent of the premium, depending on the employee's years of service.[23]

B. Unlike the State's mandatory medical coverage, dental coverage is part of an optional suite of retiree-funded plans that PERS members may elect—and independently fund—at the time of retirement.

In 1979—four years after the State began providing mandatory major medical coverage to retirees—the Alaska Legislature extended DVA coverage as an optional supplement to medical coverage for PERS members.[24] The 1979 session law appears outside the PERS statute, in Chapter 30 of Title 39 rather than Chapter 35.

Alaska Statute 39.30.090(a) originally codified 1955 territorial legislation authorizing—but not mandating—the creation of group insurance plans for employees.[25] The first part of AS 39.30.090(a) authorizes the State, in permissive rather than mandatory language, to create various supplemental insurance policies: the State "*may* obtain a policy or policies of group insurance covering state employees" and others.[26] Optional policies include DVA coverage, optional life insurance, and others.[27] Unlike medical coverage, the legislature has never required the State to offer any of the categories of optional coverage

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22 AS 39.35.880(a).

23 AS 39.35.880(g).

24 Ch. 55, § 1, SLA 1979. [Exc. 110]

25 Ch. 151, § 2, SLA 1955. [Exc. 131]

26 AS 39.30.090(a) (emphasis added).

27 *Id.*

in AS 39.30.090(a). And unlike medical coverage, the State pays nothing towards this optional insurance. The Legislature was explicit about this: subsection (a)(10) of the statute says that retirees receiving medical coverage "*may* obtain auditory, visual, and dental insurance" if the member electing coverage "pay[s] the cost of the insurance."[28]

As with the major medical program, DRB published booklets to describe the DVA coverage being offered to PERS members. The 1979 booklet explained that a "supplementary [DVA] plan [was] now available to those individuals receiving [PERS] benefits." [Exc. 112] According to the 1979 booklet, "[p]articipation in this plan is voluntary and, should [a member] elect this coverage, the premium will be deducted from [the member's] monthly benefit warrant." [*Id.*] From 1979 through 2011, DRB's handbooks reinforced the voluntary nature of this coverage. The 2000, 2003, and 2013 handbooks all stated that the State "is pleased to be able to offer this voluntary [DVA] Plan." [Exc. 38, 54; R. 1027; Tr. 50-51] "If coverage is elected, the premiums are paid by deductions from your retirement check." [Exc. 38, 54; R. 1027]

DRB's implementing regulation explicitly allows for the State to "change the premiums and terms of coverage" when "necessary to maintain the financial integrity of the plan."[29] And DRB's handbook notified members that the optional DVA benefits "may change from time to time," advising members to consult the most updated version of the handbook before deciding whether to continue coverage. [Exc. 38, 54; R. 1027]

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[28] AS 39.30.090(a)(10) (emphasis added). [*See also* Tr. 38-39]

[29] 2 AAC 39.280.

C. The State revised the optional retiree dental plan in 2014, updating coverage and reducing premiums for retirees.

By 2012, steep increases in the costs associated with dental coverage raised concerns about the health and integrity of the DVA plan. [Tr. 606, 779-81] The State determines premium levels based on the costs incurred by the plan, the cost of administration, and the need to keep a reserve. [Tr. 78, 608-09, 620.] So in 2000, a retiree electing individual DVA coverage paid $41 a month. In 2001 that same retiree would pay $48 and in 2005, $54. [Exc. 154] By 2009, the rate increased to $70. [*Id.*] These increases were "due principally to the rising cost of health care." [Exc. 160] DRB worried that if increases continued, fewer retirees would elect to buy the increasingly expensive coverage—with no corresponding increase in plan value to the retiree—exacerbating the problem and pushing the plan into an "actuarial death spiral" if membership became insufficient to spread the risk and finance care. [Tr. 78-79, 607-08, 1091-93]

The State, as part of its process of identifying and hiring a new third-party administrator ("TPA"),[30] undertook an effort to revise the plans. DRB sought to salvage the plan by eliminating unnecessary treatments, focusing on coverage of evidence-based care to meet or exceed industry standards while still controlling costs. [*See* Tr. 522, 779, 784-89, 798-800, 1062-63, 1212]

Effective January 1, 2014, the Department of Administration adopted new dental

[30] The State contracts with a private company, called the third-party administrator or TPA, to administer benefit plans. [Tr. 31-32, 40] The TPA is principally responsible for the day-to-day claims-handling process and must administer the plan in accordance with its terms. [Tr. 32, 45, 47, 776]

plan language for the optional DVA plan. [Exc. 71; Tr. 853-54] The Plan adopted in 2014 has gone by various names in this litigation, including the "Moda plan," [R. 300] the "AlaskaCare plan," [Exc. 4], "the 2014 Plan," [Exc. 161; R. 962] and, by the end of the superior court litigation, "the Standard Plan." [Exc. 186] The State will use "2014 Plan" or "Standard Plan" on appeal, the latter of which is the name now being used by DRB to differentiate from the "Legacy Plan," which operated from 2003 through 2013 and has now been restored as an option for retirees as a result of this case. [*See, e.g.*, Exc. 186] The Legacy Plan is also known as the 2013 Plan. [Exc. 161]

The key features of the two plans are the same.[31] Under both plans, retirees can elect to cover themselves alone or may add spouses and children. [Exc. 154, 186; Tr. 38] Both plans require retirees to pay one hundred percent of the premiums. [Exc. 145, 183; Tr. 38-39] Both plans classify services as preventative (covered at 100 percent), restorative (covered at 80 percent after the fifty dollar deductible is paid), or prosthetic (covered at 50 percent after the deductible). [Exc. 183; Tr. 113-15] Both plans have a $2,000 per beneficiary annual cap on payments for services. [Exc. 183; Tr. 79, 113, 1095]

The Standard Plan also made changes. First, it strengthened the "steerage" component of its network, incentivizing the use of in-network dentists by reducing

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[31] After final judgment in this case, DRB created a document for retirees summarizing the Standard Plan and the Legacy Plan. [Exc. 186-89]. Testimony and exhibits admitted at trial describe the changes, and citations are provided both to evidence admitted at trial and the straightforward post-judgment summary created by DRB. Note that this document was prepared before the superior court's order requiring the Legacy Plan to be the default, so it informs retirees that they do not need to do anything to keep their Standard Plan coverage. [Exc. 184] That later changed. [Exc. 191-92]

payments to out-of-network providers, resulting in lower out-of-pocket charges for retirees who chose in-network dentists. [Exc. 168, 183; Tr. 119-22, 218, 622-27, 693-94, 1043, 1257] Patients' selection of in-network dentists incentivizes dentists to join the network. [*see* Tr. 238-39, 296-97, 624, 1043] Overall, the steerage feature saved the plan approximately $10 million from 2013 to 2014. [Tr. 664, 751]

The Standard Plan also added explicit frequency limitations on some services and moved other services between coverage levels. Some of these changes added coverage that did not previously exist under the Legacy Plan, while other changes reduced coverage. For example, in Class I: preventative services, the Standard Plan added frequency limitations of twice per year for exams, x-rays, cleanings, topical fluoride treatments, and sealants, with more frequent treatments allowed in some circumstances where dentally necessary. [Exc. 164-65, 187; Tr. 127-40] The Legacy Plan had no explicit frequency limitation on those services, but did have a limitation that *all* services be "necessary for diagnosis or treatment of dental condition as determined by the claims administrator." [Exc. 186; Tr. 72, 75, 136, 200] The new plan added coverage every five years for adult sealants, which had not been previously covered, and moved periodontal maintenance Class II into Class I for 100 percent coverage. [Exc. 165, 187; Tr. 142]

The Standard Plan also increased coverage for some Class II Restorative services and decreased coverage for others. Optional inlays and crown buildups moved from Class III: Prosthetic Services to Class II: Restorative Services. [R. 1040, 1081; Exc. 187; Tr. 1155] Brush biopsy, periodontal scaling/root planning, full-mouth debridement and root canal retreatments all have frequency limitations. [Exc. 166-67, 187; Tr. 156, 161] For

example, the Standard Plan made explicit that a second root canal on the same tooth by the same dentist would not be covered within 24 months because the "[i]nitial service should include retreatment within this timeframe if necessary." [Exc. 187; R. 1082, Tr. 154]

Additional coverage modifications were made in Class III: Prosthetic Services. The Standard Plan added porcelain restoration coverage for visible teeth—a benefit not available under the Legacy Plan. [Exc. 188; R. 1038, 1083] Frequency limitations of once in seven years were added for crowns, onlays, bridges, and dentures. [Exc. 167, 188-89] Denture adjustment, repair, and reline, moved from Class II to Class III services, and other Class III services added frequency requirements. [Exc. 168, 189] The Standard Plan expanded dental plan coverage for implants. [Exc. 189, 1048, 1083]

When the Standard Plan was implemented in 2014, retirees' DVA premiums were *reduced* by ten percent.[32] The primary driver of this reduction was cost savings from the steerage feature of the Standard Plan network. [Tr. 693-94, 751]

II. Procedural history.

A. The Superior Court granted summary judgment to RPEA, concluding that the diminishment clause applies to the retiree-funded DVA plan.

RPEA filed its Complaint for Declaratory and Injunctive Relief January 29, 2016. [Exc. 1] The Complaint identified one cause of action, "Violation of the Alaska Constitution Article XII, § 7," alleging that retiree dental insurance is "an accrued and

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32 The exact changes were $70 to $63 for Retiree Only, $139 to $125 for retiree and spouse, $125 to $113 for retiree and children, and $198 to $178 for retiree and family. [Exc. 154]

vested benefit" and that the State's 2014 plan amendments "diminished and impaired the accrued benefits of state employees who were hired before January 1, 2014." [Exc. 6-7] RPEA requested: (1) declaratory judgment that the 2014 changes effected an unconstitutional diminishment, and (2) "permanent injunctive relief prohibiting the defendant from continuing to use the [Standard] plan for employees who were hired by the state before January 1, 2014," requiring the State to "either reinstate the [Legacy Plan] or adopt a plan that offers comparable advantages." [Exc. 7-8] No other relief was requested.

Early in the case, the parties cross-moved for partial summary judgment on the central legal dispute: whether the diminishment clause applies to optional, retiree-funded DVA benefits. [R. 294-306; 222-42; R. 202-19; 189-200] After extensive briefing and oral argument, the superior court ruled from the bench, granting RPEA's motion for partial summary judgment and denying the State's cross-motion. [Exc. 142-43]

Citing *Duncan* in its cursory ruling, the court said "the employees' rights to benefits under the retirement [system] vest on employment in the system . . . rather than at the time when the employee becomes eligible to receive those benefits." [Exc. 142] The court compared DVA coverage to "an option to purchase, an option to lease, an option to explore," noting that "options have value." [Exc. 143] In the court's view, *Duncan* held that "accrued benefits" is a term so broad, it has "no limitation." [Exc. 143] The court decided that the very existence of a DVA plan when "an employee starts their employment" is what "defines the terms of that option to purchase in the future." [Exc. 143] And the superior court signed RPEA's proposed order "find[ing] as a matter of law

that retiree dental-vision-audio insurance benefits offered to public employees when they are hired are an accrued benefit within the meaning of [the diminishment clause], and accordingly they may not be diminished or impaired." [Exc. 133]

The State moved for reconsideration, noting that "the scope of the right the [Superior] Court believes is protected is unclear," and asking the court to clarify that "the only term offered to an employee at the time of employment is the option to purchase DVA coverage during retirement if the Department obtains such a policy." [R. 109-10] Without explaining whether anything more than "the option to purchase DVA coverage" is protected, the court denied the motion. The court said only that "[a]lthough retirees self-fund their DVA coverage, the option to buy the insurance is still part of the benefit they are offered at the time of employment." [Exc. 145]

B. After a six-day trial, the superior court adopted RPEA's view that the Standard Plan diminished an accrued benefit.

The parties then conducted discovery and prepared for a trial to "determine whether or not the 2014 plan diminishes retirees' benefits compared to the 2013 plan." [Exc. 162] Trial took place April 9-12 and July 30-31, 2018, with testimony from fact witnesses and experts on the retiree dental benefits plan before and after the changes.

The State unsuccessfully sought to exclude the testimony of RPEA's expert, human resources professional Todd Allen, on the grounds that his opinion did not meet *Duncan*'s requirement for quantitative evidence to establish whether medical plan changes do or do not create equivalency across the entire group of plan members. [R. 26-30] At trial, Mr. Allen presented a list of his perception of the plan changes and opined as

to each whether it was an enhancement, a diminishment, or neither. [Exc. 148-53] Mr. Allen testified that his "overall opinion" based on that list "look[ing] at the frequencies, the introduction of frequency limitations, as well as the service level limitations, as well as age limitations," "was that the changes had a diminishing impact on the plans from 2013 to 2014." [Tr. 356, 402]

Richard Ward, a credentialed actuary specializing in employee benefits plans, testified for the State about the actuarial value of the two plans. [Tr. 641, 644-655] Mr. Ward's firm serves as the "benefits consultants and actuaries for Alaska Care," including the retiree dental plan. [Tr. 642] The firm provides the actuarial services the State uses to determine premium levels for all of its benefit plans. [Tr. 620-21, 642] Mr. Ward served as an expert through a separate contract between his employer and the State, but was not paid anything for his work on this case beyond his normal compensation. [Tr. 643]

Mr. Ward explained that the "actuarial value" of a plan is "the average share of medical spending that is paid by the plan as opposed to being paid out of pocket by the consumer." [Tr. 678] Actuarial value measures the value of the coverage itself, independent of premiums. [Tr. 663, 678] In other words, "for every hundred dollars of expenses that could be paid by either the member or the plan, if 70 percent are paid by the plan, then the actuarial value is 70 percent on average." [Tr. 648] Mr. Ward testified that based on those calculations, "from an actuarial value perspective, the benefits were improved from 2013 to 2014 in aggregate" by 2.4 percent in the first year and 3.3 percent by 2016. [Tr. 652; Exc. 155]

After trial, the parties submitted written closing arguments and proposed findings of fact and conclusions of law. [R. 424-596] On April 17, 2019, the superior court entered RPEA's proposed decision without alteration. [Exc. 159-80] In its order, the superior court reaffirmed its conclusion that "the retiree dental plan is covered by the guarantee against diminishment of benefits in Alaska Constitution Article XII, Section 7." [Exc. 162] Crediting the testimony of RPEA's expert witness Todd Allen and dismissing that of Richard Ward, the court listed the benefits that it perceived as having been diminished and those that it perceived as having been enhanced by the 2014 plan amendments. The court concluded that "overall the enhancements are not equivalent to the diminishments" [Exc. 171] and that therefore, "the 2014 plan diminishes and impairs the benefits available to retirees . . . ." [Exc. 175]

The court stated that it had "not simply counted the number of entries on each list," but had "considered the magnitude of each change, the number of members affected by the changes, the fact that two of the enhancements are themselves a mix of an enhancement (improvement of the class of coverage) and a diminishment (frequency limits were imposed), and the fact that the only unequivocal enhancement (coverage for athletic mouthguards) is of limited utility to a largely retired population." [Exc. 171] The court's diminishment analysis rested heavily on its conclusion that because of third-party administrator practices not objected to by the State, the 2013 plan provided broader coverage than the 2013 plan booklet's explicit provisions said. [Exc. 158, 163-67, 177]

Regarding the network steerage changes, the court found that the "loss of freedom to choose one's dental provider without financial penalty" amounted to a diminishment

because "members value freedom of choice" and "burdening this choice with a financial penalty impairs the benefits previously granted." [Exc. 171] The court deemed the dramatic reduction in retiree costs irrelevant. In the court's view, "*Duncan* held that the Alaska Constitution protects retirees' benefits," no matter how much they cost, and therefore, premium amounts are always irrelevant "regardless of who pays." [Exc. 175-76] The court ignored evidence that the actuarial value of the plan increased, concluding as a matter of law that under *Duncan*, no quantitative analysis of plan changes was required and that a layperson's qualitative analysis was legally sufficient. [Exc. 177]

The superior court then entered the order drafted by RPEA, which "declare[d] that the 2014 changes to the retiree dental plan [were] unconstitutional" and "enjoin[ed] the State from continuing to offer the 2014 retiree dental plan as the only dental plan available to retirees." [Exc. 179] Three remedial options were provided from which the State could select: "(1) return to the 2013 retiree dental plan; (2) provide individual retirees the option of returning to the 2013 plan or continuing with the 2014 plan; or (3) negotiate a new alternative plan that RPEA accepts as comparable and not diminishing retirees' benefits." [Exc. 179] The court's April 17 order had an effective date of May 1, 2019, with "motions for additional/alternate relief" due May 17, 2019. [Exc. 158] RPEA filed no motion for additional relief before the deadline, or indeed, before Final Judgment was entered.

C. After the State began to implement the court's decision and final judgment was entered, the court awarded RPEA new relief.

The superior court's April 17 order "gave the State 13 days to implement a new

dental plan for retirees," a plan covering 55,000 people and processing $33 million in claims annually. [R. 413] The State selected and rapidly implemented the court's Option 2—recreating the 2013 Plan as a "Legacy Plan" and giving retirees the "option of returning to" that plan "or continuing with the 2014 plan." [R. 964] This was a significant undertaking, as DRB carried out a massive amount of work to re-implement the Legacy Plan in preparation for the fall 2019 open enrollment period. [R. 416, 962-66] Faced with the impossibility of defining the coverage of the 2013 Plan within the Court's 13-day time frame—much less performing the actuarial analysis necessary to set premium rates, designing and implementing an open enrollment system, and programming a new claims adjudication system—the State moved for a temporary stay of the superior court's order until January 1, 2020. [R. 418]

The court entered final judgment in favor of RPEA on August 15, 2019. [Exc. 181] The Final Judgment stated that the court would "continue to exercise jurisdiction of this case to ensure the State complies with the Court's Order." [*Id.*] The court denied the State's motion to stay implementation but acknowledged "that the state [was] proceeding in a timely fashion and in good faith. The original deadline stated in the Court's order was unrealistic." [R. 986] The next day, the State filed a status report providing a comprehensive timeline of its implementation of the Court's order. [R. 692] The State filed a Notice of Appeal on September 13, 2019.

On September 17, 2019, RPEA filed a "Motion to Enforce Court Order and for Related Relief." [R. 2173] RPEA now asked the Court to change Option 2, which had directed the State to offer retirees the option of returning to the Legacy Plan, and

demanded that the Legacy Plan be made the default option during open enrollment. [R. 2179] RPEA also asked the court, among other things, to order "a retrospective review of claims denied under the 2014 Plan that would have been granted had the 2013 Plan remained in effect," explaining its possible intention to seek "court order[ed] reimbursement to members" on unpaid claims at some point in the future. [R. 2179-80][33]

On October 7, 2019, the superior court awarded RPEA its full reasonable attorneys' fees as a prevailing constitutional litigant, plus Civil Rule 79 costs and "other reasonable costs" in the amount of $51,758.75. [Exc. 190]

As open enrollment for the two-plan system was beginning in November, the court "prohibited [the State] from establishing the unconstitutional 2014 plan as the default plan" for 2020, now requiring the State to move all plan members automatically to the Legacy Plan instead and make the Standard Plan the option. [Exc. 191-92] The Court also directed the state to begin a retrospective claims review. [Exc. 192]

The State moved for reconsideration and clarification, arguing that the court did not have authority to order additional post-judgment remedies, nor discovery in anticipation of further remedies, outside the scope of the Complaint. [R. 2220] And the

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[33] This latter request originated not with RPEA, but with the superior court judge's suggestion at a status hearing nearly four months after the final decision that perhaps claims that had not been paid under the 2014 Plan (that would have been covered under the higher-premium 2013 Plan) should be paid retroactively to non-party retirees.[August 8, 2019 Status Hearing Tr. 12] ("[M]y first concern . . . is capturing the numbers of denied services that the retired folks requested . . . from 2014 until present and ongoing . . . so that we could retroactively reimburse them or whatever needs to happen, okay?") RPEA picked up this suggestion and requested, in essence, discovery aimed at this newly contemplated form of relief. [R. 2179-80]

State noted that the court had not provided any dates to clarify the scope of the newly ordered claims review. [R. 2226] The superior court denied reconsideration on December 12, 2019, and invited RPEA to respond regarding "the terms of what claim analysis is due, and to whom claims analysis is due." [Exc. 208-13] The court also denied the State's motion for a stay pending appeal of the order to switch the default plan. [Exc. 214]

RPEA accepted the superior court's invitation to request a retrospective claims analysis "for all the years that the 2014 plan was in effect," 2014 through 2019. [R. 2210] The purpose of this five-year review shifted; RPEA now wished "to consider what other remedy," besides the declaratory and injunctive relief it had requested and received, "may be appropriate." [R. 2211-12] In February 2020, the State filed another status report describing its rapid and complete implementation of the Court's April 2019 Order. [Exc. 215-20] The superior court then denied the last piece of the State's November motion and ordered that the retrospective claims analysis should begin as of the filing of the Complaint in this case in early 2016. [Exc. 223]

Once again, the State moved for a stay, explaining that this analysis would cost over $1 million dollars and that no source of funds existed to pay for this effort, other than the plan assets—*i.e.*, retiree premiums. RPEA did not oppose the motion to stay the retrospective claims review, and the superior court therefore granted the motion and allowed this appeal to proceed without additional complication.[34]

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[34] The superior court's post-judgment awards of relief necessitated two motions from the State to supplement the record and add new points on appeal. This final round of

STANDARDS OF REVIEW

This court reviews grants and denials of motions for summary judgment de novo, and summary judgment "is proper if there are no material facts in dispute and the moving party is entitled to judgment as a matter of law."[35] "The proper interpretation of a constitutional provision is a question of law to which this [C]ourt applies its independent judgment."[36]

The question of whether particular changes to a retiree benefit plan effectuated a diminishment should be treated as a mixed question of law and fact.[37] Legal aspects of that question, such as whether the superior court followed the appropriate method of comparative analysis under this Court's cases, should receive de novo review.[38] "In a mixed question of law and fact," this Court "review[s] the legal question separately, applying [its] independent judgment to adopt the legal rule that is most persuasive in light of precedent, reason, and policy."[39] Factual findings made within the correct legal

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motion practice does not appear in the appellate record as it transpired after the second addition of supplemental record material relevant to the superior court's February 19, 2020 order.

[35] *Duncan v. Retired Public Employees of Alaska, Inc.*, 71 P.3d 883, 886 (Alaska 2003).

[36] *Id.* (quoting *Hickel v. Cowper*, 874 P.2d 922, 926 (Alaska 1994)).

[37] *See, e.g.*, *Resurrection Bay Auto Parts, Inc. v. Alder*, 338 P.3d 305, 307 (Alaska 2014) ("Whether an employee falls within an employee exemption from overtime pay is a mixed question of law and fact.).

[38] *See, e.g.*, *Duncan*, 71 P.3d at 892 (describing the types of "reliable evidence" relevant to making a comparative analysis of plans, using a group approach); *Resurrection Bay Auto Parts*, 338 P.3d at 307 (explaining that the application of the law to established facts receives de novo review).

[39] *Fred Meyer of Alaska, Inc. v. Bailey*, 100 P.3d 881, 884 (Alaska 2004).

framework should be overturned only if they are clearly erroneous, meaning that "after a review of the record as a whole," the Court is "left with a definite and firm conviction that a mistake has been made."[40]

ARGUMENT

I. The diminishment clause does not apply to the retiree dental plan because that plan is not an "accrued benefit" of the State retirement system.

The diminishment clause of the Alaska Constitution provides:

> Membership in employee retirement systems of the State or its political subdivisions shall constitute a contractual relationship. Accrued benefits of these systems shall not be diminished or impaired.[41]

This provision protects deferred compensation for State service. But optional dental benefits—unlike major medical coverage—are not provided to employees as deferred compensation for work. They are not benefits the State is required to, or promises to, ever provide. Rather, dental coverage can be purchased by retirees through a separate contractual relationship entered well after an employee enters the PERS system—namely, at the time of retirement. Retirees receive this coverage not as compensation for their years of service, but in exchange for premiums they agree to pay when and if they enroll.

Diminishment clause protection cannot and should not reasonably extend to benefits that the state is not obligated to provide, and that a retiree elects to purchase and pay for after State service ends. And if the diminishment clause reaches anything at all in

[40] *Id.* at 883-84.

[41] Alaska Const. art. XII, § 7.

the universe of optional benefits funded by retiree premiums, it protects a more circumscribed benefit. At most, it protects the narrow promise made at the time of employment—*access* to a reasonable State-managed DVA plan—*if* the State has exercised its discretion to create one. The State has honored that limited obligation here by providing a high quality, reasonably priced plan.

A. The diminishment clause protects "deferred compensation," meaning valuable consideration given to retirees by the State in exchange for employees' labor.

Interpretation of a constitutional provision begins with its plain language.[42] "Unless the context suggests otherwise, words are to be given their natural, obvious[,] and ordinary meaning."[43] The diminishment clause, by its terms, protects the "accrued benefits" employees receive as part of their "contractual relationship" with the State.[44]

The definition of a "benefit" is "profit or gain," especially "the consideration that moves to the promisee" in a contractual relationship.[45] And a benefit "accrues" when it "come[s] into existence as an enforceable claim or right."[46] An "accrued benefit" is, therefore, "profit or gain" to which a retiree has "an enforceable claim" that flows as

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42 *West v. State, Bd. of Game*, 248 P.3d 689, 695 (Alaska 2010) (explaining that this Court "interpret[s] Alaska's constitution according to reason, practicality, and common sense, taking into account the plain meaning and purpose of the law as well as the intent of the drafters." (internal quotation marks omitted)).

43 *Hammond v. Hoffbeck*, 627 P.2d 1052, 1056 n.7 (Alaska 1981) (quoting *County of Apache v. Southwest Lumber Mills, Inc.*, 376 P.2d 854, 856 (Ariz. 1962)).

44 Alaska Const. Art. XII, § 7.

45 Black's Law Dictionary 178 (9th ed. 2004).

46 *Id.* at 23.

"consideration" from the employment relationship.[47]

That definition is consistent with four decades of this Court's precedent, beginning in 1981 when *Hammond v. Hoffbeck* recognized that "benefits under PERS are *in the nature of deferred compensation*." [48] "Deferred compensation" means "[p]ayment for work performed, to be paid in the future or when some future event occurs."[49] And the closely related term "accrued compensation" describes "[r]emuneration that has been earned but not yet paid."[50] These definitions together make clear that the "accrued benefits" protected by the diminishment clause encompass the consideration the employee earns during her working years, which will be transferred during retirement as part of that employee's compensation for service.

In *Duncan*, this Court held that major medical insurance is protected by the diminishment clause because it is deferred compensation that is offered to the employee for the employee's public service.[51] The State argued that only the premium payments

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[47] *Id.*; *Hall v. Add-Ventures, Ltd.*, 695 P.2d 1081, 1087 n.9 (Alaska 1985) ("Formation of a contract requires an offer, encompassing all essential terms, an unequivocal acceptance by the offeree of all terms of the offer, consideration, and intent to be bound by the offer.").

[48] *Hammond*, 627 P.2d at 1057 (emphasis added).

[49] Black's Law Dictionary 322 (9th ed. 2004); *Livingston v. Metro. Util. Dist.*, 692 N.W.2d 475, 480 (Neb. 2005) ("Deferred compensation . . . is defined as compensation which is earned in exchange for services rendered.").

[50] *Id.* The phrase "accrued benefits" in the diminishment clause has also long been synonymous with "vested rights." *Id.* at 1055 (citing *Bidwell v. Scheele*, 355 P.2d 584, 586 (Alaska 1960)).

[51] *Duncan*, 71 P.3d at 887 ("[M]edical insurance is . . . part of an employee's benefit package and the whole package is an element of the consideration that the state contracts to tender in exchange for services rendered by the employee.").

themselves—not the coverage the premiums bought—were the “benefits” protected from diminishment.[52] But the court said that “medical insurance,” like the PERS death benefits at issue in *Hammond*, is “part of an employee’s benefit package and the whole package is an element of the consideration that the state contracts to tender *in exchange for services rendered* by the employee.”[53] Thus, whatever benefits “make up the retirement benefit package that becomes part of the contract of employment when the public employee is hired, including health insurance benefits,” are “accrued benefits” protected by the diminishment clause.[54]

Duncan thus reinforces the understanding that the diminishment clause does not protect everything that might loosely be called a “benefit,” but rather, only the specific package of retirement benefits the State promises to public employees as deferred compensation for service. Major medical insurance is thus protected by the diminishment clause not simply because it is a retirement benefit, but because it is deferred compensation.[55] The State offers to cover employees after a certain age during their retirement, in exchange for labor performed, and PERS members accept that offer by beginning employment and serving for the required period. The diminishment clause protects the value of this deferred compensation the employee earns.

This focus on bargained-for deferred compensation in the employment contract—

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52 *Id.* at 888-89.

53 *Id.* at 887 (emphasis added).

54 *Id.* at 888.

55 *Id.*

what the State promised employees would later receive during retirement in exchange for their service—appears across this Court's diminishment cases and in similar cases from other jurisdictions.[56] In *Sheffield v. Alaska Public Employees' Ass'n, Inc.*, this Court addressed state employees' early retirement benefits.[57] Prior to a 1986 amendment, the PERS Act provided that state employees with at least five years of service could choose early retirement, subject to an actuarial adjustment of the amount of PERS benefits they would have received at normal retirement.[58] The Court held that the diminishment clause prohibited changing the actuarial tables to reduce the amount employees would receive in early retirement compared to the tables in place at the time of their employment.[59] That decision protected the deferred compensation the State had initially promised employees in exchange for their service—calculation of pensions using a particular formula—from being diminished.[60]

The diminishment clause constitutionalizes the contractual principle of irrevocable

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[56] *E.g.*, *Hammond*, 627 P.2d at 1056 (stating that death benefits—which are essentially a life insurance policy—are an element of consideration offered to public employees in exchange for their services); *Sheffield v. Alaska Public Employees' Ass'n, Inc.*, 732 P.2d 1083, 1084 (Alaska 1987) (holding that article XII, section 7 protects how the monetary value of the benefits are calculated, prohibiting the State from using factors that would reduce the amount of early retirement benefits the employee would receive compared to payments calculated under the system in place at the time of his employment); *Livingston*, 692 N.W.2d at 480 (holding that coverage under a supplemental long-term disability policy was not protected by the Contracts Clause of the United States Constitution because it was not deferred compensation; rather, it "depended on the payment of premiums.").

[57] *Sheffield*, 732 P.2d at 1084.

[58] *Id.* (citing AS 39.35.370(a)–(c)).

[59] *Id.*

[60] *Id.* at 1089.

offers in unilateral contracts. As the Oregon Supreme Court explained in construing a similar state constitutional provision,[61] "[a]n offer for a unilateral contract invites the other party to accept with performance—that is, by actually *doing* the performance that the offering party seeks."[62] A binding unilateral contract forms when the accepting party has fully performed its obligation under the contract.[63] An offer of State employment is a unilateral contract; it invites employees to accept the promised salary and benefits—including retirement benefits—through performance of job duties over time.[64]

Traditionally, an offeror could withdraw an offer for a unilateral contract at any time until the offeree has completed performance.[65] But to prevent injustice that results when an offer is withdrawn while the other party is performing her end of the bargain, many contracts have "an implied term" preventing the employer from "revoking the employee's opportunity to vest those benefits."[66] "[A]n offer is impliedly irrevocable if the invited form of acceptance takes time to complete and the accepting party is attempting to complete the acceptance."[67]

This common law concept of contracts is the animating principle underlying the

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[61] *Moro v. State*, 351 P.3d 1, 18, 20 (Or. 2015) (explaining that in Oregon, PERS benefits are "contractual" and receive constitutional protection under the state and federal Contracts Clauses).

[62] *Id.* (emphasis in original) (citing *Corbin on Contracts* § 1.23).

[63] *Id.*

[64] *Id.*

[65] *Id.* at 35 & n.32 (citing Lord, 1 *Williston on Contracts* § 5:13 at 987).

[66] *Id.* at 35.

[67] *Id.*

diminishment clause. Whatever the State offers to give employees during retirement as part of their compensation cannot be diminished in value while the employee is performing his or her end of the deal.[68] The text of the diminishment clause and this Court's cases confirm that "accrued benefits" means deferred compensation: retirement benefits offered at the time of hiring, earned through labor as public employees, and provided by the State during retirement.

B. Dental benefits—unlike major medical insurance—are only provided to retirees who opt in, in exchange for retirees' own premium payments, not as deferred compensation for state service.

The employment benefit package the constitution protects from diminishment is not undefined or without limitation, and with good reason. Its terms are set forth in statutes, regulations, and DRB practices.[69] Unlike major medical insurance and the other benefits the court has protected through the diminishment clause, DVA benefits are *not* part of the contract of employment when a public employee is hired.

In the major medical insurance context, this Court made clear in *Duncan* that the protected benefit is *the coverage* promised by statute. The Court highlighted that beginning in 1975, employees were repeatedly promised "that [medical] benefits would be *provided and paid for by the state* during their retirement."[70] The PERS statute

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68 *Duncan*, 71 P.3d at 887.

69 *McMullen v. Bell*, 128 P.3d 186, 190–91 (Alaska 2006) ("An employee's vested benefits arise by statute, from the regulations implementing those statutes, and from the division's practices.").

70 *Duncan*, 71 P.3d at 885. *Duncan* was decided in a pre-Tier IV world. In Tier IV, the promise is less financially generous. But even Tier IV retirees are promised major medical coverage supplemental to Medicaid, with the State covering a majority of the

promises employees that if they meet statutory service eligibility requirements (satisfying the employment contract), they will receive major medical insurance, regardless of cost.[71]

DVA coverage has always been different. Where the 1975 legislation mandated that PERS members were entitled to State-paid major medical coverage in retirement, the 1979 legislation instead provided that a retiree "may" elect DVA coverage and pay for it.[72] Alaska Statute 39.30.090(a) promises no contribution toward retiree dental coverage. Unlike major medical coverage, members do not earn the coverage by working, they buy it by paying premiums. This Court has never extended the diminishment clause so far as to protect anything retirees did not earn through their service.

The rationale underlying the diminishment clause suggests no reason to do so now. Article XII, section 7 demands that the State honor promises it makes to its

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cost—at least 70 percent. AS 39.35.880(g)(2). Given Tier IV retirees' obligations to contribute a significant percentage of premiums, it is far from clear that *Duncan*'s premium analysis applies exactly the same way to these retirees. A decrease in premiums would be a considerable benefit to a Tier IV retiree, just as decreased dental premiums benefit retirees who buy dental coverage. The intersection of Tier IV and major medical insurance under the diminishment clause remains an open question.

[71] [Exc. 85 (amending AS 39.35.535 in 1975 to provide that retirees "shall be provided with major medical insurance coverage)]; [Exc. 91 ("The entire cost of this Medical Program for Retired Employees and their eligible family members will be paid by the Public Employees Retirement or Teachers' Retirement Systems.")]; AS 39.35.535(a) & (c)(2) (describing, for Tier III retirees, the requirements to be "entitled to major medical coverage" and the age and service requirements for retirees who are "not required to make premium payments for retiree major medical coverage); AS 39.35.880 (promising access to "retiree major medical insurance" for Tier IV employees, with the State paying 70 to 90 percent of premium costs after meeting certain requirements).

[72] [Exc. 110 (Ch. 55, § 1, SLA 1979)]. *See Moro*, 351 P.3d at 25 ("[N]ot all remunerative provisions are terms of the PERS offer. Instead, a remunerative provision will be a term of the offer only if it is mandatory, rather than optional or discretionary.").

employees, guaranteeing retirees the benefit of the bargain they struck when they were hired. No promise analogous to the State's guarantee of major medical insurance coverage has ever been made about dental insurance, or any of the other supplemental benefits available for retirees to purchase.[73] These benefits do not "accrue," to use the constitution's language, unless and until a retiree enters a new and different contract with the State to buy coverage during retirement.

Other courts have reached this exact conclusion regarding supplemental plans that plan members purchase at their own expense. In *Livingston v. Metropolitan Utilities District*, the Nebraska Supreme Court held that the Metropolitan Utilities District ("MUD") had the right to modify the long-term disability ("LTD") policy it offered as optional coverage to its employees.[74] Similar to the Alaska Supreme Court's diminishment clause jurisprudence, "Nebraska has long recognized that pensions are not gratuities."[75] The Nebraska Supreme Court had "held that a pension plan offered to officers of the Nebraska State Patrol . . . was 'deferred compensation, earned in exchange

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[73] AS 39.30.090(a)(10) ("[A] person who elects insurance under this paragraph shall pay the cost of the insurance premium."); [Exc. 110, 112]

[74] *Livingston v. Metro. Util. Dist.*, 692 N.W.2d 475, 477, 479 (2005).

[75] *Id.* at 480. Similar to the protection afforded by Alaska's diminishment clause, Nebraska and Oregon recognize that state retirement systems create contracts between the state and its employees who are members of the system. These contracts are protected by the contracts clause of the U.S. Constitution and, in Oregon, the state constitution as well. *Haplin v. Nebraska State Patrolmen's Retirement Sys.*, 20 N.W.2d 910, 915 (Neb. 2000) ("Since the plaintiffs' pension rights are contractual in nature, it must next be determined whether state action has impaired those obligations, and, if so, whether the impairment is forbidden by the Constitution."); *Moro*, 351 P.3d at 18–19 (analyzing the issue under Oregon's contract clause, which the court has interpreted as being consistent with the federal contract clause).

for services rendered [and created] in the employees reasonable expectations entitled to legal protection.'"[76] Like RPEA here, Livingston argued "that at the time he was offered and accepted employment with MUD, he was promised that he would have the option to obtain lifetime LTD coverage."[77]

The Nebraska Supreme Court disagreed and held that optional coverage under the LTD plan is not a pension protected by the Contracts Clause.[78] Deferred compensation is "compensation which is earned in exchange for services rendered."[79] But—like Alaska's DVA coverage—enrollment in the "LTD plan was purely voluntary[,] and the accrual of coverage under this policy was not contingent upon the rendering of services, but instead depended upon the payment of premiums and the occurrence of an injury."[80] Similarly here, because the State does not provide optional DVA coverage in exchange for public servants' work, it is not "an accrued benefit" of public employment and therefore falls entirely outside the protection of the diminishment clause.

C. If the diminishment clause applies here, it protects—at most—the opportunity to purchase a dental plan if one has been created by the State, not the details of coverage.

If the Court disagrees and concludes that DVA coverage is somehow subject to the diminishment clause, the discretionary and inchoate nature of the statute offering retirees

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76 *Livingston*, 692 N.W.2d at 480 (quoting *Haplin v. Nebraska State Patrolmen's Retirement Sys.*, 20 N.W.2d 910 (Neb. 2000)).

77 *Id*. at 479.

78 *Id.*

79 *Id.*

80 *Id.*

DVA coverage confirms that only access to buy dental coverage—not a fixed level of benefits at a particular cost—can be protected. In 1955, the territorial Legislature authorized the discretionary creation of "a policy or policies of group insurance" for public employees.[81] The modern version of that statute says that the Department of Administration "*may* obtain a policy or policies of group insurance" covering current employees, retirees, "*or*" any of several other groups.[82] The statute does not require the creation of any such policies.[83] A supplemental benefit plan, if the Department exercises its authority to create one, must include "one or more" of a discrete list including life insurance, dental insurance, and others, but need not include any particular coverage.[84] Under AS 39.30.090(a)(2), "eligible employee[s] of the state" plus spouses and dependents "*shall* be covered" by any such supplemental plan "unless exempt." But "a person receiving benefits under" PERS "*may* obtain auditory, visual, and dental insurance" and "*shall* pay the cost of the insurance."

This language contrasts sharply with the statutory mandate to provide "major medical insurance coverage" to retirees at State expense. At most, AS 39.30.090(a)

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[81] Ch. 151, § 2, SLA 1955. [Exc. 131]

[82] AS 39.30.090(a) (emphasis added).

[83] *See State, Dep't of Transp. and Pub. Facilities v. Sanders*, 944 P.2d 453, 457 (Alaska 1997) (holding that the use of "may" means officials maintained discretion); *Putnam v. State*, 930 P.2d 1290, 1292 (Alaska Ct. App. 1996) (stating that the use of the permissive "may" implies the existence of other alternatives); *see also Livingston*, 692 N.W.2d at 481 (concluding that the use of the "word 'may' in this statute implies that the MUD board of directors has discretion with regard to whether any LTD plan is implemented," and that use of the word "may" "gives the board the discretion to modify those terms of employment enumerated in the statute").

[84] AS 39.30.090(a).

promises the opportunity to participate in an undefined State-administered DVA plan, *if* the Department of Administration has exercised its discretionary authority to create one.

The superior court, recognizing the circumscribed nature of this purported promise, analogized it to "an option to purchase, an option to lease, an option to explore." [Exc. 143; Tr. 1313] But that analogy does not support the court's conclusion that specific *coverage* in any particular plan is protected. "An option contract is a promise which meets the requirements for the formation of a contract and limits the promisor's power to revoke the offer."[85] To create an enforceable option, the terms must be clear and fixed—an offer to transfer a particular thing for a particular price at some time in the future.[86] An "option to purchase," for example, is a contract "allowing [one party] to *buy property at a specified price* within a specified time, or within a reasonable time in the future, but without imposing an obligation to purchase."[87]

The legislature did not create an "option" for retirees to purchase anything specific. No access to any particular set of benefits is promised. Indeed, not even the existence of coverage—much less the scope or details—is guaranteed. The statute merely authorizes the State to create supplemental benefits and assures retirees that, if a dental

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[85] Restatement (Second) of Contracts, § 25 (1981).

[86] *E.g.*, *Myers v. Lovetinsky*, 189 N.W.2d 571, 576 (Iowa 1971) ("[S]pecific performance of an option cannot be obtained by the optionee . . . unless the terms of the option, including the price, are definite, or unless a means is provided for fixing the terms definitely."); *Brown's Shoe Fit Co. v. Olch*, 955 P.2d 357, 362-63 (Ct. App. Utah 1998) (refusing to enforce an "agreement to agree" because the terms were not sufficiently definite).

[87] Black's Law Dictionary 1204 (9th ed. 2004) (emphasis added).

and audiovisual plan is created, they will have access to coverage.[88]

PERS guarantees numerous types of specific deferred compensation in exchange for employee work. A unilateral contract requiring the State to provide those benefits thus arises at the time an employee enters State service. For supplemental plans, though, AS 39.30.090 creates only an agreement to agree in the future. No contract exists until a retiree expresses a desire to be covered *and* agrees to pay the cost. The opportunity to make that choice—with no detail about the scope of the benefits or what they will cost—is the most that can be found in AS 39.30.090(a), and is the most the diminishment clause protects. RPEA acknowledges that the State kept that promise here by offering a reasonable dental plan to retirees that meets or exceeds industry standards.[89]

In sum, this Court's precedent is clear that the diminishment clause protects deferred compensation offered in exchange for State service. As a fully retiree-funded plan offered during retirement in exchange for premium payments, optional DVA coverage does not fall within the protections of Article XII, section 7. At most, the "accrued benefit" is the opportunity to purchase coverage, not the coverage itself.

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[88] *See, e.g.*, *In re Unisys Corp. Retiree Medical Ben. ERISA Litigation*, 58 F.3d 896, 904 (3d Cir. 1995) ("An employer who promises lifetime medical benefits, while at the same time reserving the right to amend the plan under which those benefits were provided, has informed plan participants of the time period during which they will be eligible to receive benefits *provided* the plan continues to exist." (emphasis in original)).

[89] [R. 584] (accepting the validity of the State's dental coverage expert that the Standard Plan meets or exceeds industry standards).

II. Even if the diminishment clause applies to the coverage offered under the optional DVA plan, RPEA did not meet its burden to show that the Standard Plan adopted in 2014 diminished the benefit.

If this Court disagrees and concludes both that the diminishment clause applies to retiree-funded plans and that it protects something beyond the opportunity to access a reasonable plan, the Court must address the superior court's conclusion that the 2014 changes diminished coverage. RPEA bore the burden of proving that the changes "diminished or impaired" a constitutionally protected benefit.[90]

In deciding whether RPEA met its burden, the superior court incorrectly ignored the effect of a reduction in retiree-paid premiums on this analysis. But even if retiree premiums are excluded from the diminishment analysis, the superior court's subjective, qualitative comparison of plan changes was inadequate as a matter of law under *Duncan*. *Duncan* instructed the court to consider the value of the benefit to the recipients using "solid, statistical data drawn from actual experience—including accepted actuarial sources—rather than by unsupported hypothetical projections."[91] A quantitative analysis of the value of coverage was required.

RPEA provided no such analysis. The State's expert, by contrast, performed an actuarial comparison and concluded that the 2014 changes increased the value of the

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[90] *State, Dep't of Revenue v. Andrade*, 23 P.3d 58, 71 (Alaska 2001) ("A party raising a constitutional challenge to a statute bears the burden of demonstrating the constitutional violation."); *Retired Public Employees of Alaska, Inc. v. Mathiashowski*, No. 3AN-00-7540CI, 2006 WL 4634279 (Alaska Super. Ct. April 27, 2006) (explaining, in the *Duncan* case on remand, that "[t]he plaintiffs bear the overall burden of proof as to each of their causes of action.").

[91] *Duncan v. Retired Public Employees of Alaska, Inc.*, 71 P.3d 883, 892 (2003).

plan. Retirees—whose premium rates decreased—agree, and most prefer that plan.

A. When the benefit is retiree funded, premiums must play a part in a *Duncan*-style diminishment analysis of disadvantages and advantages.

Even if the diminishment clause applies to retiree-funded coverage, that coverage can change. This Court acknowledged in *Hammond* that "the fact that rights in PERS vest on employment does not preclude modifications in the system."[92] Changes that disadvantage employees "must be offset by comparable new advantages."[93] In the medical insurance context, *Duncan* recognized that coverage may evolve with medical practice.[94] Retirees do not have the right "'to receive exactly the same package of health benefits which were offered [at vesting,] but rather a right to a reasonable . . . benefit package, one which is in keeping with the mainstream of such packages.'"[95]

"Diminish" means to "make or become less," or to make something "seem less impressive or valuable."[96] Consistent with that definition, this Court and others have emphasized the *value* of the benefit to the recipient as the touchstone of diminishment analysis.[97] So in the medical insurance context, the value of the benefit is not premium

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[92] *Hammond v. Hoffbeck*, 627 P.2d 1052, 1057 (Alaska 1981).

[93] *Id.*

[94] *Duncan*, 71 P.3d at 891 (2003) (recognizing that "health insurance benefits must be allowed to change as health care evolves").

[95] *Id.* (quoting *Studier v. Mich. Pub. Sch. Employees Ret. Bd.*, File 00-92435-AZ, Circuit Court for Ingham Count, Michigan, pp. 17–18 (Order 2/21/01) (first alteration in original)).

[96] New Oxford American Dictionary, Oxford University Press (3d ed. 2010).

[97] *Duncan*, 71 P.3d at 890-91 (repeatedly discussing the "value" of medical benefits to retirees); *Hammond*, 627 P.2d at 1059 (holding that "the value of a benefit that is equivalent to a life insurance policy" had been improperly reduced). *See also Koster v. City of Davenport, Iowa*, 183 F.3d 762, 768 (8th Cir. 1999) (assuming without deciding

payments because the State, not retirees, pays those premiums. That was part of *Duncan*'s holding: the State's payment of premiums alone did not meet its obligation to retirees; the State promised coverage, not premiums, as compensation for service.[98]

But in this context, the retirees pay the full cost of the coverage, so premiums cannot rationally be ignored in any diminishment analysis. The trial court's conclusion that premiums have nothing to do with the value of a plan and play no part in the diminishment analysis misread *Duncan*, defying logic and common sense. RPEA has argued that the constitution requires the State to forever offer an "unusually generous plan" even if that "generosity"—which retirees must buy themselves—becomes cost prohibitive and retirees do not purchase it. [R. 585] When retirees foot the bill for coverage, premiums affect the value of plan membership.

RPEA's witnesses acknowledged this. Freda Miller, plan member and former benefits manager for the state, testified that premium increases could drive members out of the plan. [Tr. 68-69] Ms. Miller acknowledged that if premiums rose above a certain level, continuing to participate in the plan would make no rational sense given the $2,000 cap on benefits per beneficiary, and testified that she herself would at some point opt out if premiums rose too high. [Tr. 79] Once a member opts out, she cannot return. [Tr. 69]

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that statutory state pension benefit "create[d] a contract for purposes of the Contract Clause under the U.S. Constitution," and holding that the state's use of excess pension funds "d[id] not *diminish the value* of the members' benefits or compromise the soundness of the plan").

[98] *Duncan*, 71 P.3d at 892 ("[M]erely comparing old and new premium costs does not establish equivalency.").

Mr. Allen, RPEA's expert in human resources, similarly acknowledged the importance of cost, including premiums, to plan members. [Tr. 343, 533-36] He agreed that "it doesn't make sense to incur . . . a big increase in premium in order to provide [other] people with care that isn't medically or dentally necessary." [Tr. 533]

Cathye Smithwick, the State's dental coverage expert, gave detailed testimony about the disastrous effect on a plan when premiums rise too high. Voluntary plan participants can easily conclude that when premiums rise too much, they fare better financially by self-insuring—meaning dropping out of the plan. [Tr. 1091] Ordinarily healthier members opt out first, resulting in a smaller plan population that requires more care, which sends premiums up even more. That phenomenon is known as the "actuarial death spiral." [Tr. 1092-93]

This inescapable reality—that the cost of something affects its value to the purchaser—underscores why these optional retiree dental benefits should not fall under diminishment clause's protection at all. If the State promised every retiree a new car at retirement, a court could easily compare the value of cars given to retirees in 1990 versus the ones provided in 2020, by comparing features and prices. But if the State merely promised retirees the *opportunity to purchase* a car from the State upon retirement, with no details about features or price, a court would struggle to analyze changes to that opportunity as improvements or diminishments. How can one evaluate, for example, a change from offering a Cadillac to a Toyota Camry, at significantly lower cost? So long as a car—regardless of make or model—is offered at a fair market price, the State would be meeting its narrow promise to retirees without diminishment.

If the Court holds that the diminishment clause applies to optional DVA coverage and not just access to a reasonable plan, it should hold that the superior court erred in performing a diminishment analysis without accounting for reduced premiums. When plan members pay premiums themselves, a reduction in premium should be considered a valuable offset against diminishments. Here, the record establishes that any purported diminishment to coverage in 2014 was more than offset by the significant premium reduction; the plan paid a higher percentage of the costs of care while retirees paid less to participate. RPEA has never argued otherwise; it merely insists that this reality is irrelevant. [R. 571] Yet even RPEA's witnesses' testimony is clear that controlling premiums is instrumental to offering a plan and assuring its continuing vitality.

B. Even if the Court does not consider retiree premiums, RPEA did not meet the standard in *Duncan* to establish objectively that the 2014 plan amendment diminished the value of coverage.

Finally, even if the superior court was correct to perform a *Duncan*-type analysis that omitted premiums altogether, the court erred because it did not follow *Duncan*'s instruction to compare the value of coverage in an objective, quantitative way. To prove the 2014 changes diminished the value of the retirees' coverage, RPEA was required to present "reliable evidence," evaluating the value of the plan to the entire group and not any individual retiree.[99] This requires more than hypothetical projections or statements by witnesses that the terms of the plan have changed; this Court requires "solid, statistical

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[99] *Id.* at 892-93.

data drawn from actual experience—including accepted actuarial sources"[100] to compare the amended plan against the value of the accrued benefit. This Court also has recognized the importance of "keeping a pension system flexible to permit adjustments in accord with changing conditions and at the same time maintain the integrity of the system."[101]

RPEA's evidence fell far short of what this Court requires. Although Mr. Allen testified that his diminishment analysis took into account something beyond simple counting of purported diminishments versus purported enhancements, he identified no factor he had considered other than whether, in his view, each individual change enhanced or diminished coverage "based on age, frequency and service levels." [Tr. 357-59, 387, 402] He did not look at claims data to determine how higher or lower utilization of different services might affect an analysis of diminishment, despite acknowledging that "utilization is a key part of evaluating a plan." [Tr. 539] He explicitly disclaimed having considered "the numbers of people affected by the various changes." [Tr. 357; 387] He did nothing to consider how many retirees used any particular service. [Tr. 593]

Indeed Mr. Allen "did not attempt to place a value" on *any* of the changes he looked at. [Tr. 593] He only considered "how many age frequencies . . . or service limitations or . . . time frequencies were placed" in the 2014 Plan. [Tr. 594] He conceded that he had simply "counted the number of changes that involved frequency limits and

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[100] *Id.*

[101] *Id.* at 889 n. 26 (quoting *Hammond v. Hoffbeck*, 627 P.2d 1052, 1057 (Alaska 1981)); *see also id.* at 892 (stating that this guideline, applied in *Hammond*, also applies to reviewing changes to health insurance coverage).

age limits" and then "counted for enhancements" and "compared those numbers," making no attempt to value any of the changes. [Tr. 595] That simplistic counting endeavor was the entire basis of his opinion that the plan was diminished. [Tr. 595]

The court, relying heavily on Mr. Allen's opinion, signed RPEA's draft findings purporting to have considered something beyond the number of apparent diminishments and apparent enhancements. Specifically, the court said it considered the number of people affected by each change to the dental plan. [Exc. 171] But the evidence does not support the superior court's purported consideration of quantitative data. One RPEA witness, Sharon Farmer, testified that in 2014, the State's TPA denied 66 claims for a routine examination, 59 claims for a crown, 115 claims for a bridge, and 19 claims for dentures. [Tr. 962] Those numbers cannot support a finding that the plan was diminished using a group approach across more than 50,000 members.[102] In reality, the superior court—through RPEA's attorneys' draft opinion—did no more than Mr. Allen did. The trial court's diminishment analysis amounted to a subjective "gut feeling" comparison.

As a matter of law, this Court requires more. And appropriately so. *Duncan*'s guidance, to ensure disadvantages are met with offsetting advantages, contemplates a mathematical, objective approach—one the State can apply when responding to large-scale health trends, evolutions in health care, cost spikes, or when considering and implementing plan changes. RPEA's approach is unpredictable and amorphous. Should this Court approve it, the State will have no way to meaningfully evaluate potential

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[102] *See id.* at 892-93.

coverage changes going forward. The result would be what this Court rejected in *Duncan*, "a Pyrrhic victory, as [the retirees'] 'frozen' health benefits become more obsolescent with each passing year."[103]

By contrast, the State presented quantitative evidence in the form of "solid, statistical data," "including actuarial sources," through its expert Richard Ward. Mr. Ward confirmed that no single standard applies to actuarial valuation of medical plans. [Tr. 657.] He therefore relied on two main sources to determine his methodology: (1) the process used by the Affordable Care Act; and (2) the expert reports submitted to the superior court in *RPEA v. Mathiashowski*[104] after this Court remanded the matter in *Duncan*. [Tr. 658.] In those proceedings, Judge Mark Rindner found the State's actuaries to be credible.[105] They obtained the raw claims data to determine what benefits had been paid under the amended retiree major medical plan and then determined what benefits would have been paid, had the plan remained unchanged.[106] Based on that analysis, the State's experts concluded that the 1999-2000 changes to the major medical coverage did not constitute a diminishment.[107] The trial court adopted their findings and concluded that the 1999-2000 changes "were in balance a net benefit to retirees."[108]

Replicating those methods, Mr. Ward used raw claims data to calculate the

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103 *Id.* at 891 (internal quotation marks omitted).

104 *Retired Public Employees of Alaska, Inc. v. Mathiashowski*, No. 3AN-00-7540CI, 2006 WL 4634279 (Alaska Super. Ct. April 27, 2006).

105 *Id.* at ¶ 76.

106 *Id.* at ¶ 95.

107 *Id.* at ¶ 105.

108 *Id.* at ¶¶ 104 & 115.

actuarial value of the plan from 2014-2017. [Tr. 652-53] He concluded that the actuarial value rose from 69.7 to 72.1 percent in the first year after the amendments, and increased further to 73 percent by 2016. [Exc. 155][109] Small decreases in total plan payments for coverage in a number of service categories, like exams, x-rays, and fluoride were more than offset by large increases in coverage in other service categories of great significance to retirees—specifically implants and periodontal maintenance. [R. 2130]

Finding fault with numerous aspects of Mr. Ward's work, inexplicably including his "demeanor," the court rejected his opinion that the *value* of the plan to retirees increased in 2014. [Exc. 173-75] His mathematical analysis simply concluded that the plan paid a higher percentage of retiree dental care after the changes than it did before.

RPEA's (and the superior court's) most strenuous objection to Mr. Ward's analysis is that he excluded out-of-network claims, which the superior court speculated had skewed the value of the amended plan downward because post-amendment, the plan paid a lower percentage of out-of-network claims. [Exc. 174] But in excluding out-of-network claims, Mr. Ward followed the guidelines for valuing health care plans under the Affordable Health Care Act, as well as the superior court's decision in *Mathiaskowski*. [Tr. 659; 749-51.][110] And Mr. Ward did perform a trend analysis to confirm that addition

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[109] Mr. Ward calculated the actuarial value of the 2013 plan two ways. First, using Moda data, he made adjustments to determine what the plan would have paid in 2013 under the plan's coverage limitations, resulting in an actuarial value of 69.7 percent. [Exc. 155; Tr. 653] Second, he used HealthSmart's raw data to calculate the actuplan's 2013 actuarial value, resulting in an actuarial value of 66 percent. [*Id.*]

[110] In *Mathiaskowski,* the superior court did not consider changes to the plan that were neither a reduction nor an increase to benefits. *See* 2006 WL 4634279, at ¶ 70.

of out-of-network claims would not materially alter the actuarial values he calculated. [Tr. 660] In any event, the trial court's attacks on Mr. Ward are speculative red herrings; *RPEA* had the burden of proof, but provided no actuarial analysis itself. The record contains no evidence that Mr. Ward's valuation is wrong.

More fundamentally problematic, though, is the superior court's conclusion that loss of freedom to choose one's own dentist was itself a diminishment, however unquantifiable, a conclusion that weighed heavily in the court's "gut-feeling" analysis. This Court should reject the notion that steerage in a dental plan is itself a diminishment. Neither *Duncan* nor any other authority supports RPEA's view about network steerage. Retirees remain free under the Standard Plan to see the dentist of their choosing. [Exc. 183] But because of the steerage features of the plan, they are less able to shift the cost of that personal choice onto their fellow plan members who prefer to reap the cost savings of using in-network providers. [*See* Tr. 1112-13]

What is more, the added steerage incentives in the 2014 amendment saved retirees approximately $10 million in the first year, and that savings drove a significant reduction in premiums. [Tr. 664] Two-thirds of retirees surveyed said they were unwilling to pay higher premiums to ensure reimbursement at higher rates when seeing out-of-network providers. [Tr. 1053] Calling the alleged loss of freedom of choice a "diminishment," but ignoring the offsetting reduction in premiums, was error.

Mr. Ward's sound actuarial analysis of the comparative value of the plans is further underscored by the retirees' subsequent confirmed preference for the Standard Plan over the Legacy Plan. Of the retirees who participated in open enrollment in late

2020, 63.5 percent chose the Standard Plan. [Exc. 216-17] And after open enrollment closed, DRB received more than 400 contacts from retirees the superior court had ordered defaulted into the Legacy Plan, but preferred the Standard Plan. [Exc. 217]

Should the Court decide to treat this case exactly like *Duncan* even though retirees, not the State, pay dental premiums, the Court should hold that RPEA failed as a matter of law to meet its burden: it provided no objective, quantitative measure of the comparative value of the Standard and Legacy Plans.

III. Additional relief cannot be awarded after final judgment, especially where that relief was never requested in the Complaint.

RPEA received everything it asked for in its Complaint via the Court's December 8, 2016 award of partial summary judgment and April 17, 2019 order. Those remedies—declaratory judgment and injunctive relief—were incorporated into the August 8, 2019 Final Judgment, which disposed of all claims and ended the litigation.

But on September 17, 2019, after this appeal was filed, RPEA filed a "Motion to Enforce Court Order and for Related Remedies." [R. 2132] RPEA asked the Court for five new remedies, two of which are relevant here: (1) Prohibit the State from allowing the 2014 Plan to serve as the default plan during open enrollment, and (2) Require the State to conduct a retrospective review of claims denied under the 2014 Plan that would have been granted had the 2013 Plan remained in effect. [R. 2136] The first of these new remedies directly contradicts the court's instruction that the State could give retirees the "option" of returning to the 2013 Plan "or continuing in the 2014 Plan." [Exc. 179, 191, 214] And the second—effectively a discovery order—apparently anticipated yet more

future new remedies.[111]

This was error. RPEA had ample opportunity to seek additional remedies after trial and before entry of judgment, but did not do so. [Exc. 158] The superior court should have treated RPEA's motion for new "related relief" as what it was, a motion to amend the final judgment pursuant to Civil Rule 59(f). Such motions must be filed within 10 days; this motion came well beyond that. [Exc. 181; R. 2133] RPEA sought to avoid its untimeliness problem by insisting that it merely sought enforcement of the court's order. By the time of RPEA's post-judgment motion, the State was already far along in that process. The State completed implementation in February 2020, yet the superior court continued to award RPEA new relief. [Exc. 216] The new remedies RPEA sought were plainly inconsistent with both its Complaint and the superior court's decision.

This Court has held that new claims cannot be raised post-judgment regarding the details of implementation of a final decision. *State v. Alaska Civil Liberties Union*[112] explained that constitutional review of the individual details of the State's implementation plan would "hamper the primary goal of expeditious compliance and exceed the scope of the remedies sought in the original complaint." The same is true here. Even if the superior court's judgment stands, the post-judgment orders requiring the State

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[111] The court contemplated monetary relief to non-party retirees [Aug. 8 Status hearing, Tr. 12]; RPEA, recognizing the unavailability of that relief, offered that retirees might be compensated in other ways, including recapture of past denied claims through future premium reductions. But both the court and RPEA ignored that retirees in the Standard Plan from 2014 through 2019 were not paying premiums to support broader coverage.

[112] *State v. Alaska Civil Liberties Union*, 159 P.3d 513, 514-15 (Alaska 2006).

to move all retirees into the Legacy Plan as the default and to perform a massive and expensive retrospective claims review must both be reversed.

IV. The award of attorneys' fees and costs should be reversed.

If this Court reverses the judgment on any ground urged by the State, the State will become the prevailing party and the fee and cost award will be reversed as well. But even if RPEA prevails here, the Court should reverse the award of RPEA's non-Rule 79 costs: over $50,000 paid to Moda to analyze data, to expert witnesses for non-testifying work, and to a non-testifying actuarial expert. [Exc. 190; R. 734-36] The parties briefed this novel issue below, but the superior court simply signed RPEA's proposed order without explanation of the extraordinary cost award beyond declaring the costs "reasonable." [Exc. 191]

Alaska Statute 09.60.010(c)'s allowance of "full reasonable fees and costs" was intended to narrow—not to expand—the public interest litigant exception.[113] The statute "expressly overrule[d]" this Court's public interest litigation decisions "'insofar as they relate to the award of attorney fees . . . to or against public interest litigants in future civil actions,'" leaving in place full fee awards only in constitutional cases.[114] The legislature was concerned that the doctrine had "created an unbalanced set of incentives for parties

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[113] *See Alaska Conservation Found. v. Pebble Ltd. Partnership*, 350 P.3d 273, 280 (Alaska 2015) ("[T]he Alaska Legislature abrogated and replaced our public interest litigation exception to Rule 82 with a new statutory provision that encourages and protects parties bringing constitutional claims.").

[114] *Krone v. State, Dep't of Health and Social Servs.,* 222 P.3d 250, 254 (Alaska 2009) (quoting Chapter 86, § 1(b), SLA 2003).

litigating issues that [fell] under the public interest litigant exception,'" and that "'[t]his imbalance [had] led to increased litigation, arguments made with little merit, difficulties in compromising claims, and significant costs to the state and private citizens.'"[115]

This Court should read the statute to provide "full reasonable fees" and "costs," interpreting "costs" to mean Rule 79 costs, consistent with this Court's prior approach. Under this Court's earlier public interest litigant jurisprudence, costs beyond Rule 79 were never allowed. To the contrary, in *Hickel v. Southeast Conference*, this Court declined to find a public interest exception to Administrative Rule 7(c), which limits the amount of expert witness fees a prevailing party may recover under Rule 79.[116] Here, the superior court gave RPEA *all* of its expert witness fees, including fees that it paid to a non-testifying expert. This Court "has allowed an award of costs for experts' pre-trial preparation time *only* in (1) cases involving bad faith or reprehensible conduct, or (2) in divorce cases where awards of costs are not governed by Rule 7(c)."[117] Rule 7(c) means "'[a] party may not recover . . . costs associated with experts if they do not testify.'"[118] RPEA does contend that either scenario applies to this case.

Nothing in the history of AS 09.60.010 suggests that the Legislature intended to create extraordinary cost liability that did not exist under the judicially created public

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[115] *Id*. (quoting Chapter 86, § 1(b), SLA 2003).

[116] *Hickel v. Southeast Conference*, 868 P.2d 919, 931 (Alaska 1994); *see also* Administrative Rule 7(c) ("Recovery of costs for a witness called to testify as an expert is limited to the time when the expert is employed and testifying and shall not exceed $150.00 per hour, except as otherwise provided in these rules.").

[117] *Hickel*, 868 P.2d at 931.

[118] *Id.* (quoting *Atlantic Richfield Co. v. State*, 723 P.2d 1249, 1253 (Alaska 1986)).

interest litigant exception to Rule 82. Instead, the Legislature narrowed the scope of the public interest litigant exception to put the parties on "more equal footing."[119] This Court should reject an expansive reading of AS 09.60.010 and limit RPEA's recovery to the costs authorized under Rule 79 and Administrative Rule 7(c).

CONCLUSION

The State asks this Court to reverse, hold that retiree-funded benefits are not "accrued benefits" of public employment, and order judgment entered in its favor.

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[119] Ch. 86, § 1(a), SLA 2003.