IN THE CIRCUIT COURT OF THE FIRST CIRCUIT

STATE OF HAWAI‘I

JAMES DANNENBERG, BILLY SOUTHWOOD, VALERIE YAMADA SOUTHWOOD, DUANE PREBLE, SARAH PREBLE, individually and on behalf of all others similarly situated, Plaintiffs, vs. STATE OF HAWAI‘I, COUNTY OF KAUAI, CITY AND COUNTY OF HONOLULU, COUNTY OF MAUI, COUNTY OF HAWAI‘I, HAWAI‘I EMPLOYER-UNION HEALTH BENEFITS TRUST FUND, BOARD OF TRUSTEES OF THE HAWAI‘I EMPLOYER-UNION HEALTH BENEFITS TRUST FUND, DOES 1-10, Defendants.	Civil No. 06-1-1141-06 JPC (Class Action) AMENDED AND FINAL FINDINGS OF FACT AND CONCLUSIONS OF LAW (PHASE 2) Trial Dates: May, June, July, August, September, and October, 2023 Closing arguments: December 11, 2023 Judge: Jeffrey P. Crabtree

AMENDED AND FINAL FINDINGS OF FACT AND CONCLUSIONS OF LAW (PHASE 2)

Table of Contents:

A. INTRODUCTION

1. The "Phase 1" bench trial for this case determined whether enforceable promises were made to class members regarding accruable retirement benefits. Phase 1 culminated with the court's Amended FOFCOL (Dkt. 2295, filed May 12, 2023).

2. "Phase 2" of the case was for the court to decide whether accrued retirement benefits were impermissibly diminished, and if so, damages. The bench trial for Phase 2 was held over 19 trial days in May, June, July, August, September, and October, 2023. The court received documentary exhibits, heard testimony, and carefully considered the oral arguments and written submissions of counsel. The vast majority of the evidence was not objected to. The court closely observed witnesses to evaluate their credibility and generally found all the witnesses credible. The main "dispute" between witnesses was between the expert witnesses, who had differing opinions about the best way to analyze the evidence. No expert's methodology was non-credible. In the end, this case came down to a) the applicable law; b) applying the law to the mostly undisputed facts, and c) applying the burden of proof.

3. The Phase 1 FOFCOL and these Phase 2 FOFCOL address the respective issues they resolve; however, they also overlap and complement one another and should be read together for a better understanding of the entire case.

4. After trial, the parties submitted proposed FOFCOL and responses to each other's FOFCOL. Closing arguments were held December 11, 2023. The court took the matter under advisement.

5. Further briefing occurred with Plaintiffs' motion (filed December 15, 2023) for reconsideration of the court's Phase 1 findings regarding life insurance benefits, including a related motion to allow a Reply brief, which the court granted along with allowing Defendants to file a response to the Reply brief.

6. These FOFCOL are not all-inclusive. Numerous exhibits and numerous proposed FOFCOL are not mentioned. The court cannot discuss each witness, each relevant exhibit, or each proposed finding, nor provide exact record cites to all or even much of the voluminous evidence, else these FOFCOL would be 150 pages without adding anything material to the final analysis. A trial judge is only required to make "brief, definite and pertinent findings, not elaborate findings nor negative findings of fact." *Doe v. Roe*, 5 Haw. App. 558, 565-66 (1985). Simply because a trial judge did not mention something "does not mean [s]he did not consider it." *Id*., s*ee*, *Jarrell v. Jarrell*, SDO (Haw.App. 1/18/13). The trial court must include enough facts as necessary to disclose to the appellate court the steps by which the trial judge reached his or her ultimate conclusion on factual issues. *See Upchurch v. State*, 51 Haw. 150, 155 (1969). "As to the adequacy of the trial court's findings, an appellate court will consider whether the findings are sufficiently comprehensive and pertinent to the issue to form a basis for the conclusion of law and whether they are supported by the evidence."

7. Each of the court's findings of fact was proven by a preponderance of the evidence, unless otherwise stated.

8. If findings of fact are deemed conclusions of law or conclusions of law are deemed findings of fact, they shall be so construed and given their full effect.

9. The court genuinely understands the importance of this case to the parties, to the retirees, and to the public. The importance of the case explains the parties' commendable thoroughness. In view of the court's long-known retirement date from the bench no later than January 31, 2024, the court prioritized finishing this case as its # 1 responsibility for at least the past 3-5 months. The court was able to conduct a thorough review.

10. This court wishes to make clear that in re-reading the *Dannenberg* opinion repeatedly for this case, and in coming to conclusions of law based on *Dannenberg*, this court relied solely on the final text of *Dannenberg*. Although the undersigned served as a Substitute Justice in *Dannenberg*, this court has not applied to this case -- and indeed cannot remember any specifics about -- any added knowledge gained in that role. (The court respectfully notes that the issue of the undersigned serving as a Substitute Justice in *Dannenberg* was fully reviewed and vetted and the record shows there was no violation by or objection to the undersigned serving as the trial judge after remand.)

B. CONCLUSIONS OF LAW

1. The opinion in *Dannenberg v. State, et al*, 139 Hawai'i 39 (2016) ("*Dannenberg*") firmly establishes much of the law this court must apply on the Phase 2 issue. The court first lists the relevant law for Phase 2 taken verbatim from *Dannenberg*. The court adds several related conclusions of law that flow from *Dannenberg,* or which this court adopts from other cases cited approvingly by *Dannenberg*.

2. What benefits are protected? *Dannenberg* explained, "[i]t is necessary to identify what health benefits are protected in order to answer the question of whether or not those benefits have been diminished or impaired in violation of [the Non-Impairment Clause]." *Dannenberg*, 139 Hawai'i at 50. (Taken from State Defendants' FOFCOL # 219 (Dkt. 2577), to which Plaintiffs had no objection (Dkt. 2587)).

3. Comparing benefits is required. "As noted above, in order to determine whether constitutionally protected benefits have been diminished or impaired, there must be a comparison between the accrued benefits an employee is entitled to and the benefits that the employee has received." *Dannenberg*, 139 Hawai'i at 52.

4. Flexibility is not only allowed, it is a goal. The language of the Non–Impairment Clause and the dual purpose of its framers was " . . . to protect government workers' accrued benefits, while providing future legislatures "with flexibility to make changes to the system so long as the changes neither diminished nor impaired a member's accrued benefits." *Dannenberg*, 139 Hawai'i at p. 56, citing *Everson*, 122 Hawai'i at 416. "Clearly, the Legislature's intent in replacing the Health Fund with the EUTF was to both fully protect retirees' accrued health benefits and deal with the spiraling costs associated with the Health Fund." *Id*.

5. The need for flexibility does not allow major deletions in types of coverages. "We agree with the *Duncan* court that this flexible standard should not be interpreted as approving major deletions in the *types of coverage* offered during an employee's term. Coverage of a particular disease or condition should not be deleted, even though other *coverage* might be improved, if the deletion would result in serious hardship to those who suffer from the disease or condition in question." *Dannenberg*, 139 Hawai'i at 57 (emphasis added).

6. Flexible and non-flexible factors. *Dannenberg* talks about what flexibility is and is not in the context of constitutionally protected benefits.

A. They are not an "exact package" of PEHF benefits, fixed and unchangeable. *Dannenberg*, 139 Hawai'i at 57.

B. "The EUTF is not free to change, to Appellants' disadvantage, the nature and/or core undertakings of the health benefits that were *promised* to retirees under the Health Fund." *Id.,* (emphasis added).

C. "The benefits provided should generally be in keeping with the mainstream of health insurance packages offered to active public employees in terms of scope and balance." *Dannenberg*, 139 Hawai'i at 57 citing *Duncan* (internal quotation marks omitted while leaving text intact).

D. "Appellants' accrued retirement health benefits constitute a *reasonable* health benefits package that Appellants could *reasonably* believe they were entitled to, based on the State's *promises* at the time of enrollment in the ERS, and based on *promises* of additional retirement health benefits made by the State and Counties, if any, during their course of employment. *Id*., citing *Everson*, 122 Hawai'i at 419 (emphasis added).

E. "Offsetting advantages and disadvantages must take into account how changes to health benefits impact retirees, as well as the government fisc. *Dannenberg*, 139 Hawai'i at 57, citing *Duncan*. The court concludes *Dannenberg* means that any part of the retirees plan that impacts retirees, including cost-sharing increases, or which impacts the government fisc, may be considered, but in and of themselves are generally not dispositive on the issue of impairment.

F. "[T]he "equivalent value" of accrued retirement health benefits must be viewed from the beneficiaries' viewpoint, and not simply in consideration of the cost to the State." *Id*.

G. "We agree with the *Duncan* court that this *flexible* standard should not be interpreted as approving major deletions in the types of coverage offered during an employee's term. Coverage of a particular disease or condition should not be deleted, even though other coverage might be improved, if the deletion would result in *serious hardship* to those who suffer from the disease or condition in question. Nor should barriers to timely delivery of an evolving standard of care be erected in the name of efficiency or cost-savings. *Id*., (emphasis added)

7. Comparison of active workers' benefits and retirees' benefits. "Although we have held that article XVI, section 2 protects accrued retirement health benefits, not *parity* of health benefits, a comparison to the health benefits offered to active employees is not irrelevant or wholly immaterial, as a measure of the *reasonableness* of any changes made to retirement health benefits over time." *Dannenberg*, 139 Hawai'i at 57-58 (emphasis on "reasonableness" added, and again, the limiting term "accrued" is not used as a measure of reasonableness).

8. In its Phase 1 Amended FOFCOL (Dkt. 2295, pp. 21-22, paragraph 21) this court ruled there was ". . . insufficient evidence to establish mutual assent that copays, deductibles, or other cost-sharing terms would either never increase in retirement or never increase above a particular rate or proportion to services charges." The court also found in Phase 1 (Dkt. 2295, p. 25, paragraph 5) that ". . . a worker's belief that he or she had accrued 'a health benefits plan with no major increases in co-pays' is too vague, standing alone, to enforce." (As discussed below, this finding in Phase 1 does not go nearly as far as Defendants argue.)

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9. Cost-sharing.

A. Defendants argue (see Dkt. 2577, paragraph 274): "The consequence of the Court's Phase 1 ruling on this point is that, without more, increases to cost sharing terms and out-of-pocket costs do not even qualify as "changes" to Plaintiffs' Accrued Benefits within the meaning of *Dannenberg*. Cost-sharing terms and out-of-pocket costs are not Accrued Benefits. As the Court noted in its Phase 1 FOF/COL, Plaintiff Dannenberg, Plaintiff Preble, and Plaintiffs' other witnesses all "understood that . . . cost-sharing could increase over time – as it had while they were active employees." FOF/COL at 12–13 at ¶¶ 15(A)–(B). Thus, contrary to Plaintiffs' position here, Plaintiffs' Accrued Benefits assume and include cost-sharing increases over time. That such increases have occurred and accompanied the Delivered Benefits both before and after June 30, 2003 does not constitute or evidence any diminishment or impairment of Plaintiffs' Accrued Benefits. Instead, it is entirely consistent with the scope of those Accrued Benefits as outlined by the Court in its Phase 1 ruling. Only if Plaintiffs' prove that their cost-sharing burden increased to such an extent that it represents a ***departure from*** the kind of modest, nominal increases that are assumed by their Accrued Benefits could this Court consider cost-sharing increases to be a "change" worthy of consideration under *Dannenberg*. Plaintiffs have not provided any evidence or proof to support such a contention here. (As discussed below, this finding in Phase 1 does not go nearly as far as Defendants argue.)

10. Cost-sharing increases are constitutionally protected, but not to the full extent argued by Plaintiffs.

A. The parties generally agree that putting the issue of cost-sharing methods on the side, and looking solely at the scope of retirees' accrued medical coverages, therapies, and

services for retirees – the coverages, therapies, and services were not reduced. The record is replete with evidence on this issue and the court will not list it all here.

B. Plaintiffs argue the non-diminishment of medical coverages, therapies, and services is not dispositive. Plaintiffs argue diminishment or impairment includes the increased cost-sharing burdens placed on retirees -- such as co-pays, maximums, and deductibles. A common example of this is the amounts charged to retirees when they go to the pharmacy to fill their prescriptions. Plaintiffs argue this cost-sharing was increased for retirees, and from the retirees' perspective (which is the perspective required by *Dannenberg*) their retirement benefits were thereby diminished in violation of Article XVI, Section 2 of the Hawai'i Constitution. Plaintiffs concede that "no retiree was promised that cost-sharing amounts would not change, but any such changes needed to be matched by related offsetting improvements." (Proposed FOFCOL 42.)

C. As quoted above, Defendants respond that reasonable cost-sharing is not a *per se* diminishment under Article XVI, Section 2 of the Hawai'i Constitution. As stated in their Response (Dkt. 2577, Exhibit A) to Plaintiffs' Proposed FOFCOL:

> Plaintiffs are not entitled to a specific cost-sharing rate or proportion of charges, while incremental increases in copays, deductibles, and other cost-sharing terms have *always* been part of the retiree benefit package, under both the PEHF and EUTF alike. *Again, the question for the Court is only whether any changes were unreasonable.*

(From State Defendants' Individual Responses . . . Dkt. 2577, Exhibit A, p. 12, response to Plaintiffs' para. 17.)(emphasis added). Defendants agree that "As explained throughout these Responses, and in State Defendants' Proposed Phase 2 FOF/COL, a change to cost-sharing terms is not a modification to Plaintiffs Accrued Benefits unless and until Plaintiffs prove it was *unreasonable*." (State Responses, Dkt. 2577, Exhibit A.)

D. Plaintiffs disagree, arguing that "reasonableness" is too squishy, and is a tort standard not applicable to contractual relationships, and is not rigorous enough for the constitutional requirements specific to retiree health benefits under Article XVI, Section 2. More specifically, Plaintiffs argue "[c]oncepts of what is fair or customary can inform the types of changes (e.g., the change from a major medical plan to a modern PPO plan), but they cannot validate adverse economic impacts that are unrelated to accompanying improvements in related benefits." *See*, Plaintiffs' Response to Defendants . . . (Dkt. 2587, paragraph 227).

E. *Dannenberg* says: "Finally, *unreasonable changes* to the retirement health benefits provided to Appellants by the Health Fund, *e.g.*, *disadvantages not offset by comparable advantages, may be considered a diminishment or impairment of their accrued retirement health benefits*; but it is for the trier-of-fact to determine, in the first instance, whether Appellants have demonstrated that particular changes *are unreasonable and constitute a diminishment or impairment of their accrued retirement health benefits*." *Dannenberg*, 139 Hawai'i at 58 (emphasis added). Again, note that the limiting term "accrued" is not used when describing "unreasonable changes to retirement health benefits."

F. *Duncan v. Retired Pub. Emps. of Alaska, Inc.*, 71 P.3d 882, 886 (Alaska 2003) was cited 21 times in the *Dannenberg* opinion. *Duncan* dealt with constitutionally protected health benefits in Alaska. *Dannenberg* noted:

> As this court observed in Kaho'ohanohano v. State, 114 Hawai'i 302, 347, 162 P.3d 696, 741 (2007), Alaska's constitution contains a provision that is "nearly identical in wording and substance" to article XVI, section 2 of the Hawai'i Constitution. Accordingly, the court in Kaho'ohanohano cited Alaska's case law as "instructive in interpreting our own clause."

Dannenberg, 139 Hawai'i at 52-53.

G. "As the Alaska Supreme Court noted in *Duncan v. Retire Public Employees of Alaska, Inc*., constitutionally protected "[h]ealth benefits must be allowed to change as health care evolves." "Health benefits can be modified so long as the modifications are reasonable, and *one condition of reasonableness is that disadvantageous changes must be offset by comparable new beneficial changes.*"" *Dannenberg*, 139 Hawai'i at 48 (emphasis added).

11. Based primarily on *Dannenberg* as highlighted above, along with the applicable FOFCOL from Phase 1, this court's conclusion of law is: an increase in cost-sharing on retirees, in and of itself, does not automatically and always prove a violation of the Non-Impairment Clause. However, cost-sharing is part of the constitutional analysis. Cost-sharing is also an integral part of the flexibility that *Dannenberg* recognizes is necessary in an area as complex as health care benefits for thousands of retirees.

12. The court's next and closely related conclusion of law is: cost-sharing increases in and of themselves can (but do not necessarily) result in an impermissible diminishment of accrued medical benefits under our constitution. The court's separate paragraph No. 21 at pp. 21-22 of the Phase 1 FOFCOL -- entitled "Cost-sharing issues"-- already found there were no specific promises as to cost-sharing issues. The entire paragraph is:

> 21. Cost-sharing issues. The court finds that co-insurance (i.e., cost-sharing based on a percentage of the cost of services) has been a part of retiree health benefits since the early days of PEHF. *See* Exh. SOH-1771R. It is clear that some services or prescriptions are completely free of cost-sharing measures, others are not. Plaintiffs' witnesses seemed to agree that at minimum, modest or incremental increases in co-pays were likely over time. **The court finds insufficient evidence to establish mutual assent that copays, deductibles, or other cost-sharing terms *would either never increase in retirement or never increase above a particular rate or proportion to service charges***.

(emphasis added). State Defendants seem to interpret the bolded language in two, inconsistent, ways. First, State Defendants argue:

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> "Plaintiffs are not entitled to a specific cost-sharing rate or proportion of charges, while incremental increases in copays, deductibles, and other cost-sharing terms have *always* been part of the retiree benefit package, under both the PEHF and EUTF alike. *Again, the question for the Court is only whether any changes were unreasonable.*

(From State Defendants' Individual Responses . . . Dkt. 2577, Exhibit A, p. 12, response to Plaintiffs' para. 17.)(emphasis added). But State Defendants also take a different position, such as in their the State's proposed FOFCOL, pp 3-4, and paragraph 295 of Defendants' Dkt. 2577):

> "Similarly, because the Court found that Plaintiffs were *never* promised anything with respect to any form of cost-sharing terms, increases or changes to any form of cost-sharing terms do not, as a matter of law, constitute a breach of any contractual promise and, as such, no measure of damages can be based on them or related out-of-pocket costs. Indeed, State Defendants cannot be liable for breaching a promise this Court has concluded they never made."

The State Defendants' interpretations of this court's Phase 1 FOFCOL regarding cost-sharing goes too far. The above bolded language from this court's Phase 1 FOFCOL that cost-sharing would "***either never increase in retirement or never increase above a particular rate or proportion to service charges***," simply finds there was no promise to never increase the cost-sharing burden on retirees, and there was no promise that cost-sharing would be capped at some specific figure. This is just another way of saying cost-sharing can increase, and is not capped at any particular number. This finding falls (far) short of a finding <u>that cost-sharing increases can never result in a diminishment or impairment of accrued benefits under our constitution</u>. Certainly the amount or proportion and frequency of the increase matters. Every out-of-pocket increase on retirees becomes a potential barrier to access. The higher the increase, the higher the barrier. The court does not believe it was seriously disputed at trial that many State retirees live on modest fixed incomes, and the cost of living is extremely high in Hawai‘i. It is simple logic and common sense that higher prices (including cost-sharing measures on their medical

coverages) have a disproportional impact on retirees living on modest fixed incomes. An easy example demonstrates the fallacy of a position that cost-sharing increases can never constitute a diminishment or impairment. Imagine that the co-pay for certain expensive prescription drugs is increased to $100.00. Yes, workers were never promised that would not happen. But that is not the end of the analysis. The *value* of retiree benefits from the retirees' perspective (required by *Dannenberg*) cannot ignore *access* to those same benefits. Actually, State Defendants seem to agree, since a co-pay of $100 for prescription drugs would clearly be a "departure from the kind of modest, nominal increases that are assumed by their Accrued Benefits" (*Id.*, Dkt 2577 at paragraph 274). The bottom line is two-fold: a) this court rejects the State Defendants' attempt to enlarge the court's Phase 1 FOFCOL so as to make cost-sharing increases immune from the Non-Impairment Clause, and b) cost-sharing increases in and of themselves can result in an impermissible diminishment under our constitution, as discussed further, below.

13. While it is clear that substantial and sudden cost-sharing increases can constitute a diminishment under our constitution, what about relatively modest and incremental cost-sharing increases? The court's conclusion of law on this point is: relatively modest and incremental cost-sharing increases *may* result in a diminishment or impairment of accrued health care benefits. "Offsetting advantages and disadvantages must take into account how changes to health benefits impact retirees, as well as the government fisc . . ." *Dannenberg*, 139 Hawai'i at 57, citing *Duncan*. Further, "Nor should barriers to timely delivery of an evolving standard of care be erected in the name of efficiency or cost-savings." *Dannenberg*, 139 Hawai'i at 57. To this court, this language from *Dannenberg* allows this court to conclude that costs (e.g., cost-sharing) to retirees and costs to the State may both be considered as part of the larger effort to weigh offsetting advantages and disadvantages in determining whether accrued benefits have been diminished.

14. A reasonableness standard. In evaluating cost-sharing increases, what must the EUTF and the court look at in deciding whether there will be or has been an impermissible diminishment or impairment? The court's conclusion of law is: the test includes several, related factors, including what the court sees as the primary ones applicable to this case:

a) are the cost-sharing increases higher than what retirees would reasonably (and objectively) expect given the past course of conduct, and by how much;

b) is the impact of the cost-sharing increases on the retirees unreasonable?

c) what is the impact on the retirees and the government fisc?

d) ultimately, combining all the factors discussed in *Dannenberg*, the *Dannenberg* standard boils down to: "Health benefits can be modified so long as the modifications are reasonable, and *one condition of reasonableness is that disadvantageous changes must be offset by comparable new beneficial changes.*"" *Dannenberg*, 139 Hawai'i at 48 (emphasis added).

15. How does the court reach its reasonableness standard? First, the court acknowledges that *Dannenberg* did not expressly discuss or focus on the issue of cost-sharing *per se*. That is not unusual given the summary judgment motion *Dannenberg* decided. In deciding a summary judgment appeal, nobody would or should expect the *Dannenberg* court to think through all possible issues or areas of emphasis on remand and rule on all those legal issues in advance. So this trial court is doing what trial courts do after remand – applying the on-point law verbatim from *Dannenberg*, and ruling on new, more specific, or additional questions of law as necessary in light of the principles articulated in *Dannenberg*. *Dannenberg* repeatedly invokes weighing "reasonable" modifications, the "reasonableness" of changes, a "reasonable package" of benefits, and comparing advantages and disadvantages to see if changes are "reasonable." In *Dannenberg*'s ultimate language reversing summary judgment, the Supreme Court wrote: "This analysis, however, involves a weighing of evidence that is susceptible to divergent inferences as to the *reasonableness* of the changes and, thus, is inappropriate for

summary judgment." *Dannenberg*, 139 Hawai'i at 59 (emphasis added). Again, the court understands this specific analysis was not speaking directly to cost-sharing measures. However, this court is determined to stay within the boundaries of *Dannenberg* to the extent possible, and so this court's above conclusion of law incorporates *Dannenberg*'s principle of reasonableness to the issue of cost-sharing increases:

> "Finally, unreasonable changes to the retirement health benefits provided to Appellants by the Health Fund, e.g., disadvantages not offset by comparable advantages, ***may*** be considered a diminishment or impairment of their accrued retirement health benefits; but it is for the trier-of-fact to determine, in the first instance, whether Appellants have demonstrated that particular changes are unreasonable and constitute a diminishment or impairment of their accrued retirement health benefits."

Dannenberg, 139 Hawai'i at 58 (emphasis added). To this court, this simply means that unreasonable changes to the health benefit plans are changes where disadvantages not offset by comparable advantages, *may* be considered a diminishment.

16. Must changes be matched by "related" offsetting improvements?

A. Plaintiffs argue that if cost-sharing goes up, "any such changes needed to be matched by **related** offsetting improvements." (Proposed FOFCOL 42) (emphasis added). This court is determined to hew to the express holdings in *Dannenberg* to the extent possible. *Dannenberg* consistently uses the word "comparable" when discussing offsetting advantages -- both in quotes from the *Duncan/Hammond* cases from Alaska, and in *Dannenberg*'s own ruling, including the "closing" ruling of "Finally, *unreasonable changes* to the retirement health benefits provided to Appellants by the Health Fund, *e.g.*, *disadvantages not offset by comparable advantages, may be considered a diminishment or impairment of their accrued retirement health benefits*; but it is for the trier-of-fact to determine, in the first instance, whether Appellants have demonstrated that particular changes *are unreasonable and constitute a diminishment or*

impairment of their accrued retirement health benefits." *Dannenberg*, 139 Hawai'i at 58 (emphasis added).

B. *Duncan* also does not use the term "related." It uses "comparable," repeatedly and consistently.

C. This court is not sure what is meant by Plaintiffs' proposed standard of offsetting "related" advantages. This court sees no reason to substitute "related" for *Dannenberg*'s and *Duncan*'s "comparable." This court therefore will stay with the specific ruling of "comparable" offsetting advantages. Based on the above, this court's conclusion of law is: in evaluating changes in cost-sharing and any offsetting improvements or advantages, the offsetting improvements do not have to be "related" but they must be "comparable."

D. <u>The meaning of comparable</u>. Given the court's ultimate decisions in this case, it is not necessary to delve deeply into what "comparable" means. When this case returns to the appellate courts, this court respectfully suggests the appellate court define what "comparable" means in the specific context of increased cost-sharing on the one hand, and retiree medical coverages and therapies on the other hand. In any event, this court now decides two conclusions of law regarding the "comparable" standard that hopefully assist the appellate courts on this issue. First, the court agrees with Plaintiffs by establishing this conclusion of law: the addition of prescription drug plans in 1990 as a matter of law cannot be a "comparable" offset of advantages in the EUTF years—decades later. Second, this court also agrees with Plaintiffs by establishing this conclusion of law: the State's pre-funding of the future costs of retiree health benefits (hundreds of millions of dollars, which started in 2014) cannot be a "comparable" offset of advantages. The simple reason: taking prudent and responsible financial steps to meet a known legal obligation in the future cannot constitute a comparable offset under the principles set forth in *Dannenberg*.

17. Burden of proof.

A. Plaintiffs argue that an increase in cost-sharing, especially to save spending of the public fisc, violates the Non-Impairment Clause unless Defendants show that retirees also received new and comparable additional advantages. This equation may correctly state a duty placed on EUTF; however, it does not prove EUTF breached its duty. From *Dannenberg*:

> On remand, it remains Appellants' burden, of course, to demonstrate that the State diminished or impaired their accrued retirement health benefits in violation of the Non–Impairment Clause, in light of the principles articulated here.

Dannenberg, 139 Hawai'i at 59, Note 23. In other words, in this litigation Plaintiffs cannot simply prove what Defendants' duties are or were. Rather, Plaintiffs must show Defendants *failed* in their duty. In the same vein, Defendants do not have to prove they met their constitutional duty to avoid impermissible diminishments or impairments. Defendants do not have to prove that offsetting advantages are applicable, such as whether they are new or contemporaneous, or comparable, or were solely to shift costs to retirees. (*See,* for example, Appendix G to Dr. Baker's report (State's Exhibit 1992), which lists "additions and improvements" but without a specific value analysis of comparable offsetting advantages.) It is not Defendants' burden to prove the required offsets in this lawsuit, any more than it is Defendants' burden in a medical malpractice lawsuit to prove they did not violate the standard of care or prove they did not cause damages. Defendants are entitled to "play defense" and compel Plaintiffs to carry their burden. For these reasons, the court's conclusion of law is: Plaintiffs' burden in this lawsuit includes proving there were no comparable offsetting advantages to any disadvantages of increased cost-sharing measures. *Dannenberg*, 139 Hawai'i at 48.

B. Most of Plaintiffs' proof was focused on showing cost-sharing increases in various forms. As stated in the court's factual findings, *infra*, the evidence is clear that the cost-sharing burden on Plaintiffs was significantly increased over time (although later the cost-sharing increases were paused up to the present). It is also clear (and the court so finds, *infra*) that cost-sharing increases were at least in part due to cost concerns, e.g., the government fisc. As discussed in both the Phase 1 FOFCOL and herein, considering the government fisc is in no way barred by *Dannenberg*. *The question is whether there was an impermissible diminishment*. Cost-sharing increases *standing alone* do not prove a violation of the Non-Impairment Clause. *Dannenberg* requires State Defendants to offset unreasonable increases to cost-sharing terms with comparable advantages.

C. The court's burden of proof decision is not a close call in this case. The court (easily) finds that proving increases in cost-sharing is not enough. *Dannenberg* teaches that the overall benefits package must be evaluated. If a co-pay increase for a popular medication leads to an additional $5 million dollars being paid by retirees each year, that does not mean the Class has $5 million of damages each year after the cost-increase was instituted. Plaintiffs must also show the second step – that offsetting comparable advantages elsewhere were not received – such as a broader scope of medical services, or a lower deductible. If expanded medical coverages or lowered deductibles for the Class valued at $6 million per year were also instituted (whether or not causally related to the co-pay increase), then the accrued medical benefits for the Class have not been diminished in violation of the Non-Impairment Clause (barring the presence of one of the other factors, such as a deletion of a major or core component of the entire package of benefits, or the package for retirees falling out of the mainstream of the benefits package for the active employees. *Also, see* Determining Equivalent Value, below.

D. Finally, while not critical to this case given the court's ruling on burden of proof, the appellate courts may want to decide this issue if the case is remanded: under what circumstances can large cost-sharing increases result in an impermissible impairment even if there are offsetting comparable advantages in coverage? At some point cost-sharing increases impair *access* to the medical coverage benefits, no matter how large the offsetting comparable advantages. It may be possible to show in individual cases that the increased cost-sharing impairs access to benefits. But what about on a class-wide basis?

18. Group benefits. This court's conclusions of law are all in the context of group benefits. The court notes that in *individual* situations, thorny issues may present themselves. Reducing a medical coverage that is critical to a single person's health may well need a different analysis if the "offsetting" advantage/benefit is of no use to that person. This court does not attempt to decide such issues in this case (see footnote 18 in *Dannenberg*).

19. "Gifts" may be but are not necessarily comparable offsets.

A. Defendants argue that at times they bettered retirees' benefits even though they were not required to. An example of this is when vision, dental and drug benefits were first provided starting in 1990. Per the court's findings in Phase 1, for anyone who retired before 1990, these new benefits were at least initially not part of their *accrued* benefits because they were not part of a prior, consistent course of conduct and had not been promised at the time of hire or during the period of employment. However, when such new benefits were offered during the life of Chapter 87, the new benefits became part of the retirees' protected benefits because it was the State's consistent practice to give all retirees post-retirement improvements.

B. While the court's Phase 1 findings mean that after the PEHF or EUTF extend the new benefits to all retirees (not only those who retired after 1990), those benefits are then protected. None of this means the PEHF was *required* to *add in the first instance* the

prescription drug, dental, or vision benefits in 1990 to avoid a violation of the Non-Impairment Clause. However, the new benefits were substantive additions and have added value to retirees' health benefits packages for decades. This is even more true for those who retired before 1990. Based on the above, the court's conclusions of law are: a) when retirees are given new improvements, the improvements can be a counter-balance to recent cost-sharing increases, but they do not count for purposes of *future* cost-sharing increases; and b) to be permissible, a cost-sharing increase (a new disadvantage) must be counter-balanced by *new* and comparable advantages.

20. Intent. Throughout Phase 2 and especially in the respective proposed FOFCOL, Defendants' officials and trustees argue they had "no intent" to diminish accrued benefits. The court's conclusion of law is: whether Defendants' intended to diminish benefits (for example, pre-Everson) or lacked intent is of limited evidentiary value. *Dannenberg* says what matters is whether Plaintiffs proved that Defendants "diminished or impaired their accrued retirement health benefits in violation of the Non–Impairment Clause, in light of the principles articulated here." *Dannenberg*, 139 Hawai'i at 59, Note 23. The *reasons* for any changes in the retiree health plans are not what *Dannenberg* requires the court to analyze or compare. *Dannenberg* requires a comparison: what benefits accrued to retirees, and have they been diminished under the principles set forth in Dannenberg? For example, the State could *intend* to increase co-pays to save the government fisc, yet also obtain offsetting comparable advantages.

21. Inflation. Plaintiffs argue that the Non-Impairment Clause protects them from inflation – that retirees are entitled to *increases* in benefits to keep pace with inflation. The court disagrees. The court's conclusion of law is: the Non-Impairment Clause does not protect retirees from inflation. The constitution does not say so. There is nothing the court is aware of that indicates the framers of our Constitution thought so. Further, there is no evidence the State ever

promised retirees that their medical benefits would be inflation-proof or that cost-of-living adjustments would be part of the benefits package. The court agrees with the State Defendants that not *adding* benefits to the retiree package is not synonymous with *diminishing* anyone's accrued benefits.

22. Determining equivalent value.

How is the court to determine "equivalent value" in deciding the issues of offsetting comparable benefits and reasonableness?

> Further, we reiterate that equivalent value must be proven by reliable evidence. Just as with an individual comparative analysis, offsetting advantages and disadvantages should be established under the group approach by solid, statistical data drawn from actual experience—including accepted actuarial sources—rather than by unsupported hypothetical projections. We also believe that, apart from the individualized approach, the other guidelines concerning equivalency analysis set out in Hoffbeck should continue to be generally applicable. Further, we reiterate that equivalent value must be proven by a comparison of benefits provided—merely comparing old and new premium costs does not establish equivalency.

Dannenberg, 139 Hawai'i at p. 55 citing *Duncan. Dannenberg* went on to make clear that a) the "***reasonably equivalent value***" of the retirement health benefits must be compared, and b) the "trial court is best situated, in the first instance, to determine the method of such comparison, in light of evidence and arguments before it." *Dannenberg*, *Id*., at 59, Note 23.

23. Class definition. It is worthwhile to keep the class definition in mind. The following is from the Phase 1 FOFCOL:

> The Class and Sub-Class conditionally certified in this case Includes all employees (and their dependent-beneficiaries) hired before July 1, 2003, the end of the PEHF era, and who accrued post-retirement health benefits before July 1, 2003. (See Order Granting Plaintiffs' Motion Filed December 3, 2018, for Re-Certification of the Class and for Certification of a Damages Subclass entered June 21, 2019, Dkt. 506.) In other words, since the Class and Subclass Members were all hired and enrolled with

the ERS on or before June 30, 2003, which was the end of the PEHF era, what contractual health benefits accrued from 1961 through June 2003?

C. FINDINGS OF FACT

The court apologizes in advance for the somewhat random order of these findings of fact.

1. The court did not find any witness non-credible. There was surprisingly little disagreement on the essential facts in this case, despite the volume of evidence. There was, however, much disagreement about the applicable law, and about what the facts *mean*, but that was not a function of witness credibility. This is true even for the parties' respective expert witnesses – who differed substantially in their methodology and findings. The court found all the experts' presentations credible, they simply had different views on how the value analysis should be performed. This is far from unusual given an issue as complex as the value of retiree group insurance policies over a span of decades. Bottom line: none of the court's findings should be attributed to the court believing one witness over any other witness, as opposed to deciding which testimony was better on the merits under the applicable law and facts. Therefore, the court will not constantly opine that "witness X was credible" throughout these findings.

2. Plaintiffs concede ". . . there is no dispute that the array of benefits and services, over time, have not diminished for the HMSA and Kaiser medical and drug plans." (Plaintiffs' Response to Defendants' Proposed FOFCOL, Dkt. 2587, p. 25, response to para. 17; *see also*, Plaintiffs' Proposed Phase 2 FOFCOL, Dkt. 2561, p. 3.)

3. "Since 2003, the EUTF, like the PEHF before it, has offered retirees a range of medical coverages and services by procuring group insurance contracts with insurers (e.g., HMSA and Kaiser). The Parties do not dispute the terms of, or the benefits covered by, these plans. To the contrary, the Parties stipulated to numerous Hawai'i Rules of Evidence ("HRE") Rule 1006 summaries that compiled details about the retiree benefit packages over the past

several decades. Each includes citations to source documents (generally, periodic benefits guides, insurance contracts, and other materials describing the plans), and the Court has admitted these underlying documents into evidence." (From State Defendants' Phase 2 Proposed FOFCOL, Dkt. 2577, p. 9, para. 18. Plaintiffs agree the cited information is in the record, Dkt. 2587, p. 25.)

4. "Based on this undisputed evidence, it is clear to the Court that, since 2003, the EUTF Board has procured group insurance plans for retirees that consistently covered the same core categories of medical services and benefits, including physician services; hospital and outpatient needs; surgical; emergency; diagnostic, laboratory, and x-ray services; mental illness and substance abuse coverage; and a range of other similar benefits. *See supra* n.7 (citing HRE Rule 1006 summaries). Likewise, from 2003 to present, the EUTF consistently secured coverage for a range of prescription drugs, adult dental services, and vision benefits that were the same or better in scope than what the PEHF provided after introducing these additional benefits in 1990. *Id.* Moreover, as described further below (at Section II.E.), the undisputed evidence shows that the EUTF consistently *improved* the retiree benefits package over time, by adding new coverages, incorporating advancements in technology, adopting new drugs, and similar enhancements." (From State Defendants' Phase 2 Proposed FOFCOL, Dkt. 2577, p. 10, para. 19. Plaintiffs agree the cited information is in the record, Dkt. 2587, p. 26.) State Defendants' Proposed FOFCOL continue on this issue citing to specific witnesses including plaintiffs, EUTF trustees including Chief Justice Mark Recktenwald, expert testimony, and documentary exhibits. The court need not discuss all this source information in detail since it all supports and leads to the same place – there is no evidence of diminished *medical coverages* for retirees -- as more specifically described in the quoted Finding of Fact at the start of this paragraph, which the court hereby adopts.

5. Quality of benefits packages.

A. The evidence at trial established, and the court does not believe it is really disputed, that the health benefits packages for ERS retirees are among the best public employee retirement packages in the United States. This in no way means the retirees' health benefits should not be closely scrutinized to ensure compliance with the Non-Impairment Clause. The court simply establishes this fact in the record as context.

B. Although there are some differences between the active workers' health benefits and the retirees' health benefits, on balance the court finds that the retirees' package -- especially the core coverages for medical services and drugs -- is generally in keeping with the mainstream of health insurance packages offered to active public employees in terms of scope and balance. *Dannenberg*, 139 Hawai'i at 57, citing *Duncan* (internal quotation marks omitted while leaving text intact).

6. Cost-Sharing Increases Alleged. Since diminishment of accrued medical coverages or therapies was not shown, Plaintiffs throughout Phase 2 have emphasized cost-sharing as the source of their alleged diminishments or impairments. For example, Plaintiffs provide a chart summarizing the alleged cost-sharing diminishments as part of their Proposed FOFCOL No. 31 (Dkt. 2561, p. 15):

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Year	Plan	Change
2002	HMSA	Prescription drug copay increases: • Generic: $3 to $5 • **Preferred Brand: $10 to $15** • Non-preferred Brand: $10 to $30
2002	Kaiser	Prescription drug copay increases: • Retail Generic: $3 to $10 • Mail Order Generic: $5 to $15
2003	Kaiser	Regular Fee Copay increase from $8 to $10 Prescription drug copay increases: • Mail Order Generic: $15 to $20 • Mail Order Brand: $15 to $20
2004	Kaiser	**Supplemental Maximum Per Member increase from $1,000 to $1,500**
2005	Kaiser	Regular Fee Copay increase from $10 to $12
2006	Kaiser	Regular Fee Copay increase from $12 to $14 Lab/X-ray copay increase from 0 to 10%
2007	Kaiser	Regular Fee Copay increase from $14 to $15 Lab/X-ray from 10% to $15 Prescription drug copay increases: • Retail Generic: $10 to $15 • Retail Brand: $10 to $15 • Mail Order Generic: $20 to $30 • Mail Order Brand: $20 to $30
2010	Kaiser	ER Copay increase from $25 to $50 Supplemental Maximum Per Member increase from $1,500 to $2,000

7. Plaintiffs argue "The Government Defendants offered no evidence that the PEHF or EUTF analyzed or discussed making related offsetting improvements when approving any of these increased cost burdens." *Id*., Plaintiffs' Proposed FOFCOL No. 31. However, as discussed in this court's Conclusions of Law above, switching the burden of proof/production to Defendants is improper per general law on burdens of proof and per *Dannenberg* in particular: "On remand, it remains Appellants' burden, of course, to demonstrate that the State diminished

or impaired their accrued retirement health benefits in violation of the Non–Impairment Clause, in light of the principles articulated here." *Dannenberg*, 139 Hawai'i at 59, Note 23. Yes, Plaintiffs show there were cost-sharing increases as summarized in the above chart, but it is also incumbent on Plaintiffs to take the next step and show there were no offsetting comparable advantages.

8. What cost-sharing increases were instituted when? The parties seem to be in agreement on the specific cost-sharing increases in the above chart and the court finds they are accurate. The parties strongly disagree on whether the increases are reasonable and permissible without offsetting comparable advantages.

9. The burden of proof. In the above conclusions of law labeled "Burden of proof" and "Determining equivalent value," the court concluded that establishing an increased co-pay (even if an unreasonable increase) does not necessarily define equivalent value or damages; rather, "offsetting advantages and disadvantages should be established . . ." Offsets must be established by "solid, statistical data drawn from actual experience—including accepted actuarial sources—rather than by unsupported hypothetical projections."

10. Cost-sharing is a common feature. The court finds that cost-sharing is common in health benefits plan design. It is an accepted part of setting coverages and evaluating the broader medical benefits plan. But cost-sharing does not in and of itself determine plan value.

11. "Skin in the game." This issue came up throughout Phase 1 and Phase 2. Defendants argue cost-sharing, such as co-pays for prescriptions and office visits, helps prevent excessive use of services, saves money, and allows plan design changes that can be beneficial to retirees. The court finds there was little if any persuasive data showing retirees in Hawai'i are excessive users of medical services. Certainly it happens in individual situations, but there is no evidence of a significant or systemic problem amongst ERS retirees generally or the Class in

particular. Similarly, the court finds no persuasive evidence that increased co-pays or increased deductibles were instituted here in Hawai‘i because of allegedly *demonstrated* excesses in use of medical services or therapies. "Skin in the game" in Hawai‘i is more a concept than an established pattern of conduct. However, the court also finds that Kaiser and HMSA believe that cost-sharing is part of and is factored into a cohesive medical benefits package. So, despite no demonstrable problem of excessive use by ERS retirees in Hawai‘i, cost-sharing features are nevertheless industry-standard in both Hawai‘i and on the mainland, and are part and parcel of designing cohesive medical benefits packages including the ones in this case.

12. Findings regarding the cost-sharing in this case. The evidence is clear in this case (and the court finds) that the cost-sharing burden on Plaintiffs was significantly increased (although later the cost-sharing increases were paused including up to the present). The chart inserted above is a fair summary of extensive evidence on this issue. It is also clear (and the court so finds) that cost-sharing increases were at least in part due to cost concerns, e.g., the government fisc. However, as discussed in the Phase 1 FOFCOL, and herein, conserving the public fisc is not prohibited.

13. The burden of proof was not met. Here, even if any of the specific cost-sharing increases shown in the above chart were deemed unreasonable (this court expressly does not decide this issue one way or the other), Plaintiffs failed to prove the second step — the lack of offsetting comparable advantages. Again, increased cost-sharing *standing alone* does not prove a violation of the Non-Impairment Clause. *Dannenberg* requires State Defendants to offset unreasonable increases to cost-sharing terms with comparable advantages. But it is not Defendants' burden to prove the required offsets in this lawsuit, any more than it is Defendants' burden in a medical malpractice lawsuit to prove they did not violate the standard of care or prove there is no causation or prove there are no damages. As a result, Plaintiffs did not meet

their burden of proof. This is due in part to both the Plaintiffs' and Defendants' experts' testimony, including:

A. Plaintiffs' expert Mr. Meade focused on cost-sharing expenses, opining that they are a diminishment of benefits, or opining that benefits did not keep up with inflation. He did not opine on values for or the extent of sufficient offsetting comparable advantages.

B. Plaintiffs' actuary expert Mr. Brandon did not testify as to any scope or quality of medical services. His testimony was limited to his Plan Relative Value "PRV" analysis which focused on cost-sharing increases. He did not opine on values for or the extent of sufficient offsetting comparable advantages.

C. Plaintiffs' expert Mr. Tom, a former consultant to the EUTF Board, also did not opine in any real detail on offsetting comparable advantages. The court notes he broadly testified that the 2002 PEHF "basic + major medical" plan generally provided better health benefits to retirees than the 2003 EUTF plan; however, he did not quantify it in any way the court could perform the required comparison. He also did not sufficiently address a substantial cost-sharing change whereby the PEHF's 80% coverage/20% retiree co-pay improved for retirees to 90% coverage/10% retiree co-pay immediately upon transition to the EUTF. This was clearly a potentially major new "advantage" across the Class, but Mr. Tom did not quantify it in any way the court could perform the required comparison.

D. Although Defendants were not obliged to present testimony that there was no diminishment, they did present that testimony. Dr. Baker, an economist dealing in health issues, analyzed all the relevant retiree medical benefit packages. He also incorporated concrete utilization data. He testified that the PEHF and then the EUTF Boards *added* improved medical services and drug coverages. *See*, Dr. Baker's expert report, Exhibit SOH 1992, which was received in evidence. *See also*, the many and extensive HRE Rule 1006 summaries of retiree's

benefits packages (listed in footnote 7 in State Defendants' Proposed FOFCOL, Dkt. 2577) which the court concludes are generally reliable. This paragraph simply notes evidence that was introduced and is not a decision on the merits of the issues discussed.

E. Specialty drugs and bulk powders and creams. The court considers Plaintiffs' claim regarding specialty drugs and bulk powders and creams to also be a "cost-sharing"-based claim. The court denies that specific claim for the same reasons expressed above (burden of proof). The court also denies the claim because no evidence was produced from which the court could determine whether any of the disadvantages were offset by comparable advantages.

F. The change to the HMSA PPO plan in 2003. As the court understands it this theory also heavily relies on cost-sharing to show a diminishment. However, again, there was no persuasive evidence that the new PPO plan did not also present offsetting comparable advantages. Additionally, the switch to a PPO could not be considered unreasonable in and of itself. There was substantial evidence that the predecessor plan model -- a "base-plus-major-medical structure" – was outdated, inefficient, and may even contribute to unnecessary total plan costs by incentivizing more expensive hospital care rather than care by a physician (per Mr. Garner). The industry generally was switching over to the PPO model. In any event, as with the other cost-sharing arguments, ultimately the Plaintiff experts were measuring pieces of the analysis (for example the cost-sharing increases or disadvantages, including the lifetime maximum) without also showing there was no improvement in coverages. The change to the PPO plan in 2003 also involved moving from the prior model's 80-20 co-pay (retiree pays 20% of the cost) versus the EUTF's PPO's 90-10 coverage (retiree pays 10% of the cost). The court spent multiple sessions at several hours each trying to put all this (and more) together into a

cohesive comparison between the old plan and the new plan, and in the end just could not make a sufficient comparison. The court eventually, after substantial effort, decided Plaintiffs had not met their burden of proof.

D. OTHER CLAIMS (NOT BASED STRICTLY ON COST-SHARING) (COMBINING FINDINGS OF FACT AND CONCLUSIONS OF LAW)

1. In addition to alleged diminishment and impairment due to cost-sharing, addressed above, Plaintffs also alleged several other areas of diminishment in violation of the Non-Impairment Clause. The court addresses each one separately. These involve both findings of fact and conclusions of law, but since these are finite issues the court thought it best to raise and resolve them in the same place.

2. Chiropractic care. The court finds that chiropractic benefits were added for *active* employees only, and only *after* July 1, 2003. Therefore, the "course of conduct" and "continuation" finding in Phase 1 (for benefits started during the life of Chapter 87) does not apply. The court finds the *retirees*' benefits were not reduced by virtue of adding chiropractic coverage only for active employees. These new chiropractic benefits for active workers were not also extended or "gifted" to retirees as they were with prescription drugs, vision, and dental benefits. As a result, the court concludes the chiropractic benefits enjoyed by active employees were never available to retirees and are not part of retirees' health benefits. This same "non-continuation" rationale would apply to any health benefit that was added only to active workers after July 1, 2003.

3. Dental. Plaintiffs argue that the State Defendants diminished and impaired the retirees' dental benefits in two respects: by failing to keep up with inflation, and by failing to increase the retirees' annual dental maximum benefit from $1,000 to $2,000 to mirror the actives' increase. *See* Plaintiffs' proposed FOFCOL at pp. 25-26. The court disagrees. First,

as explained in the conclusions of law (*see* B.21), the Non-Impairment Clause does not protect retirees from inflation. Second, the annual dental benefit for actives increased from $1,000 to $2000 *in 2003, **after*** the PEHF/EUTF uncoupling of the (previously same) $1,000 maximum benefit benefits" for active workers and retirees. The retirees continued to receive the same $1,000 annual dental benefit they received as active workers – they just did not get the post-2003 new increase which the active workers received. The same "non-continuation" rationale the court applied o chiropractic care in Section D.2 above applies to the annual dental maximum for retirees. (The court notes that later, in 2015, the retirees' maximum dental benefit was increased up to the $2,000 level, but that is simply information-as-context. This was not a factor in the court's decision on this point.)

4. Vision. Plaintiffs argue that retirees' vision benefits were diminished and impaired by failing to keep up with inflation. *See* Plaintiffs' proposed FOFCOL at p. 27. The court disagrees. As discussed in the conclusions of law (*see* B.21), the Non-Impairment Clause does not protect retirees from inflation.

5. Other claims of diminishment related to retirees after 2003. Plaintiffs argue that a number of changes starting in 2003 constituted a diminishment or impairment in various ways, including higher maximum annual co-pays and deductibles (HMSA plan), loss of annual physical exams (HMSA plan), less orthodontic coverage, and lower coverage for basic dental. *See* Plaintiffs' proposed FOFCOL at p. 31, paragraph 86. The court respectfully disagrees. As discussed in several places in these FOFCOL, the same "non-continuation" rationale the court applied to chiropractic care (Section D.2 above) applies to these claims. Alternatively, and as discussed elsewhere in these FOFCOL, Plaintiffs did not meet their burden of proof to show these alleged diminishments were not accompanied by offsetting advantages.

6. Medicare Part D (IRMAA). HRS § 87A-23 requires the EUTF Board to coordinate benefits with Medicare, avoid duplication, and make the retirees' plan "secondary" to Medicare. Accordingly, EUTF requires all retirees to enroll in Medicare Part D. The Part D subsidies for prescription drugs benefit retirees. As near as the court can tell, Plaintiffs have no real objection to EUTF offering drug coverage through Medicare Part D. Most State retirees pay nothing for Part D coverage. However, single persons whose income is $97,000 and above or $184,000 (married) are charged an income-related monthly adjusted amount, or "IRMAA." In 2023, this charge ranged from $12.20 per month to $76.40 per month for those with annual income over $500,000. See Ex. SOH-1985. Plaintiffs claim that for the high-earning retirees subject to the IRMAA charges, their prescription drug benefits are thereby diminished. The court disagrees for the simple reason the IRMAA charge is by the federal government, and the charges are deducted from retirees' Social Security payments. No evidence was introduced that the Defendants have anything to do with this charge. The court concludes it may be a reduction in the value of retiree benefits, but since the "cost-sharing" is by the federal government, it is not in violation of the Non-Impairment Clause. Plaintiffs have presented no legal authority that the State has a duty to make up the difference. Nothing in *Dannenberg* calls for the State to correct for federal cost-sharing-type charges.

7. Dependents' coverage (under age 26). The Affordable Care Act requires EUTF (since 2011) to provide coverage for dependents of active employees up to age 26. See Ex. SOH-565. This does not include retirees' dependents, which were exempted. (Ex. SOH-565 at SD136480). Legislative efforts to extend these benefits to retirees have failed. *See* Ex. SOH-565; P-394. Active workers who had the coverage for their dependents lost that coverage upon retirement. Plaintiffs argue this "deletion" of benefits is a diminishment. The court respectfully disagrees. This is another example of the EUTF deciding not to add a benefit to

retirees. As with chiropractic benefits discussed above, this is not a diminishment under the Non-Impairment Clause. The "up to age 26 dependents" benefit was not added for active workers until 2011, long after the 2003 transition from the PEHF to the EUTF. The "up to age 26 dependent" benefit was never extended to retirees (as contrasted to what happened with prescription drugs, dental, and vision). The flexibility for EUTF to make different decisions as between active workers and retirees and consider the public fisc was exactly the purpose of the transition to the EUTF, as discussed in the court's Phase 1 findings. Accordingly, the court denies this claim.

8. Screening colonoscopies. In 2014, both active employees and Medicare-eligible (e.g., older) retirees enjoyed coverage for screening colonoscopies. The screening colonoscopies were not available to non-Medicare (e.g., younger) retirees and their dependents. Ex. SOH-605. Plaintiffs claim the failure to continue that benefit for active workers into retirement was a diminishment. The court disagrees for the same reasoning as the chiropractic care and dependents-up-to-age-26 coverage. The screening colonoscopies benefit was *added* for active employees after 2003. Retirees were never given this benefit so never lost it, so there is no diminishment per *Dannenberg*. The court therefore denies this claim.

9. Base Monthly Contribution ("BMC"). Under HRS 87A-33, the Legislature sets base monthly contribution amounts to be paid to EUTF by the State and Counties. This amounts to a budget the EUTF can spend to buy health benefits. As with the life insurance argument the court decided in Phase 1, the court's conclusion of law is that this is a cap the EUTF can spend up to – rather than an amount the EUTF must spend up to. However, it is undisputed and the court finds that the "budget" was never exceeded by the EUTF, so the court infers it was not a measurable barrier to providing benefits. Further, in the final analysis, even if the BMC somehow constrained spending on benefits or coverages, or incentivized cost sharing

increases, what really matters is whether there was a diminishment by the State Defendants. Since the court finds no impermissible diminishment was proven, whether the BMC contributed to it in some way fades away.

10. Spoilation/Request for a Special Master to work on damages. During discovery in this case, HMSA and Kaiser were not able to produce complete sets of claims data. For examples, Kaiser did not produce claims data for its medical plan for the period 2001-2005, and much of the data that was produced was allegedly unusable for various technical or actuarial standards/data quality reasons. Plaintiffs claim this adversely and disproportionately affected them, and State Defendants/EUTF should be held accountable since they had a duty to collect and preserve this evidence as part of their duties in designing and selecting the medical benefits plans from at least 2003 forward. The court strongly disagrees, largely for the reasons argued by the State Defendants in Dkt. 2577, Exhibit A, paragraphs 229-251. In a nutshell, the primary reasons for the court rejecting this theory are 1) spoliation generally requires a finding that evidence was negligently or intentionally destroyed and the court sees no evidence of this as to the State Defendants; 2) the court infers and finds that even if the missing claims data was produced and useable, the Plaintiffs' experts' use of it would likely have led to the same problem – expert opinions focused on cost-sharing without evaluating the bigger picture of offsetting comparable advantages and reasonableness; 3-4) the State Defendants did not destroy any of the unavailable evidence, and the EUTF contract terms about preserving information did not apply to the circumstances of this litigation; 5) the State Defendants are not agents of Kaiser and HMSA, nor are Kaiser and HMSA agents of the State, for purposes of capturing and producing the claims data involving the claims in this lawsuit; 6) the spoliation issue was not formally raised until now and at latest it should have been raised in time to address before the Phase 2 (damages) trial started; and 7) there is no showing that had the claims data been produced as stored by

Kaiser and HMSA it would have been useable in its "native" format. The above ruling applies to both Plaintiffs' contractual, negligence, and fiduciary duty claims.

11. The EUTF Board of Trustees not buying E&O insurance coverage. The court does not understand why this "claim" is relevant. It has nothing to do with diminishment of health care benefits for retirees. If it is a claim, it is denied.

12. Plaintiffs' argument that the EUTF had conflicted counsel. In retrospect, it arguably may have been more prudent for the "employer" Trustees and the "employee" Trustees to have their own separate counsel, but this is in retrospect and the court does not make a finding on this issue. This is especially so since per *State v. Klattenhoff,* 71 Hawai'i 598, 604 (1990) normal conflicts rules do not apply to the Attorney General where the Board is not sitting as an adjudicator in an agency proceeding. The more concrete issue is what difference would it make in this case? Certainly *Duncan* was not controlling on Defendants. The Hawai'i Supreme Court did not decide the disputed issue of whether health benefits were protected by the Non-Impairment Clause until the *Everson* decision in 2010, and did not set out how to evaluate retiree health benefit decisions until the *Dannenberg* decision in 2016. It is pure speculation for the court to find that if the "employee" Trustees had separate counsel the "employee" Trustees would have foreseen *Everson* and *Dannenberg* and taken different steps, and also would have convinced the "employer" Trustees to take those same different steps. It is arguably far more prudent to wait and see what the appellate court actually decides. The court notes Plaintiffs in *Dannenberg* were wrong on their key issue of parity. Defendants were wrong in *Everson*. So, it is clear that accurately predicting what an appellate court will do is demonstrably not easy for the complex issues in this case. Finally, Plaintiffs have not shown any connection between the claimed "conflicted advice" and any decision by the EUTF Board that unreasonably diminished retiree health benefits in violation of the Non-Impairment Clause.

E. PENDING MOTIONS

Many motions were pending during Phase 2. Some were previously denied, and then renewed during Phase 2; others were filed previously but deferred until Phase 2 for various reasons; and some were made during Phase 2 with the court taking them under advisement. *See* Dkt. 2628, filed January 24, 2024, for a full description of each such pending motion and its disposition. To the extent any of the rulings on the pending motions during Phase 2 are inconsistent with these final Phase 2 Findings of Fact and Conclusions of Law, these final Findings of Fact and Conclusions of Law shall be controlling and dispositive.

F. DISPOSITIVE ORDERS ON THE CLAIMS IN THIS CASE

The following claims are asserted in the Third Amended Complaint (Dkt. 303, filed December 28, 2017). *Dannenberg* was decided October 21, 2016. For the reasons stated in the Phase 1 FOFCOL and these Phase 2 Amended and Final FOFCOL, the court's dispositive rulings are as follows:

1st Claim: Declaratory Relief. This request for declaratory relief concerned increased out-of-pocket expenses on retirees and "decreased benefits." More specifically:

> WHEREFORE, Plaintiffs pray that the Court:
>
> a. Declare that Defendants have breached, and are continuing to breach, their constitutional and contractual obligations by failing to provide health benefits to Retirees and their dependents that are equivalent to the benefits that they had received during the period of Retirees' active employment with the State and/ or Counties;
>
> b. Declare that Defendants have breached, and are continuing to breach, their constitutional and contractual obligations through their improper and inaccurate application and interpretation of the Contribution Cap Statutes.

The above two requests are DENIED.

2nd claim: Injunctive Relief. It appears Plaintiffs have abandoned this request. *See* Plaintiffs' Proposed FOFCOL, Dkt. 2561, paragraph 287.

3rd claim: Breach of Contract. This claim requested money damages, essentially for increased cost-sharing and/or decreased benefits.

The claim is DENIED.

4th claim: Negligence. The claim is DENIED.

5th claim: Breach of Fiduciary Duty. The claim is DENIED.

The County Defendants. Since the court has found the State Defendants not liable for any requested relief, and since there is no evidence the court is aware of that would justify liability solely against the County Defendants, the court DENIES all claims made against the County Defendants.

G. CLOSING OBSERVATION

This case is remarkable in its scope and depth. It is among the most important cases this judge ever worked on. It is by far the most complex case this judge ever tried. The court assures counsel that the court devoted the necessary amount of time and attention to this case and made its best efforts. The court already thanked the attorneys for their skill and professionalism, and again thanks them here to memorialize the court's appreciation. In a case of this magnitude, with so much on the line, highly skilled counsel remained civil with one another and treated each other and the court with respect -- while at the same time fighting for every inch. The court also notes the effort put in by Plaintiffs' counsel who, despite suffering a heavy blow when parity of

benefits was rejected, continued to represent the Class with everything they had to work with. Defendants' counsel equally and admirably represented their clients zealously. It was all a trial judge can ask for.

H. NEXT STEPS

1. This is not an appealable order. It must be reduced to a Final Judgment.

2. The court's Interim FOFCOL (Dkt. 2624) are hereby vacated. (In the court's view, there are no substantive changes between the Interim FOFCOL and these Amended and Final FOFCOL. The few changes are brief clarifications or supplements on various issues raised by the parties after the court's invitation per the Interim FOFCOL.)

3. The court will execute and upload the Final Judgment shortly. The court thanks counsel for promptly preparing it and agreeing as to form.

DATED: Honolulu, Hawai'i, January 30, 2024.

/s/ Jeffrey P. Crabtree

Jeffrey P. Crabtree
Judge of the Above-Entitled Court

RE: Circuit Court of the First Circuit, State of Hawai'i
RE: *Dannenberg, et al vs. State, et al*; Civil No. 06-1-1141-06 JPC (Class Action)
RE: Amended and Final Findings of Fact and Conclusions of Law (Phase 2)