STATE OF NORTH CAROLINA COUNTY OF GASTON	IN THE GENERAL COURT OF JUSTICE SUPERIOR COURT DIVISION 12 CVS 1547
I. BEVERLY LAKE, JOHN B. LEWIS, JR., EVERETTE M. LATTA, PORTER L. McATEER, ELIZABETH S. McATEER, ROBERT C. HANES, BLAIR J. CARPENTER, MARILYN L. FUTRELLE, FRANKLIN E. DAVIS, ESTATE OF JAMES D. WILSON, BENJAMIN E. FOUNTAIN, JR., FAYE IRIS Y. FISHER, STEVE FRED BLANTON, HERBERT W. COOPER, ROBERT C. HAYES, JR., STEPHEN B. JONES, MARCELLUS BUCHANAN, DAVID B. BARNES, BARBARA J. CURRIE, CONNIE SAVELL, ROBERT B. KAISER, JOAN ATWELL, ALICE P. NOBLES, BRUCE B. JARVIS, ROXANNA J. EVANS, and JEAN C. NARRON, and all others similarly situated, Plaintiffs, vs. STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES, a corporation, formerly known as the North Carolina Teachers and State Employees' Comprehensive Major Medical Plan, TEACHERS' AND STATE EMPLOYEES' RETIREMENT SYSTEM OF NORTH CAROLINA, a corporation, BOARD OF TRUSTEES of the TEACHERS' AND STATE EMPLOYEES' RETIREMENT SYSTEM OF NORTH CAROLINA, a body politic and corporate, JANET COWELL, in her official capacity as Treasurer of the State of North Carolina, and the STATE OF NORTH CAROLINA, Defendants.	**DEFENDANTS' MEMORANDUM OF LAW IN SUPPORT OF SUMMARY JUDGMENT ON LIABILITY**

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The Plaintiffs, who are all retired former teachers or state employees, allege that they are entitled by contract to a certain level of healthcare benefits from the State for the rest of their lives. There is simply no lawful authority for the contracts that the Plaintiffs now allege and the Plaintiffs lack the evidence to sustain their claims.

UNDISPUTED MATERIAL FACTS

I. RELEVANT HISTORY OF THE STATE HEALTH PLAN

The State Health Plan[1] has changed significantly throughout its forty-plus year history. An understanding of certain aspects of that development is crucial to resolving the issues in this case.

A. The Creation of the State Health Plan and Its Considerable Variation Throughout Its Existence

Prior to 1972, individual state agencies in North Carolina were permitted to, and some did, offer healthcare coverage to their employees. But there was no centralized, broadly applicable healthcare coverage for state employees or retirees. Any healthcare benefits that were offered forty-five years ago or earlier were a patchwork across state government. (Rep. of the Teachers' & State Employees'

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[1] The term *State Health Plan* formally refers to both the healthcare benefits offered by the State and the entity that is tasked with overseeing those benefits. N.C.G.S. § 135.48.1(14). For convenience, in this memorandum the term will also be used more broadly to refer to the State's healthcare benefit program throughout its existence from 1972 to the present.

Benefits Study Comm'n at 28-30 (Nov. 1970) (attached to Basnight Certification, which is attached to this Memorandum at Tab 13)) During that period, employees could and did purchase group health insurance without the State's involvement or that of their employing agency. (Hanes Dep. 19:23-20:11)

The first statewide healthcare benefit offered to state employees was authorized by the General Assembly in 1971, with a start date of July 1, 1972. 1971 N.C. Sess. Laws 1009, §§ 1-2 (attached at Tab 28). The program was authorized only "to the extent that funds for such benefits are specifically appropriated by the General Assembly." *Id.* § 1. The 1972 plan was implemented through contracts of insurance with carriers, the terms of which were stated in the contracts and summarized in benefit booklets that were distributed to state employees. (Moon Aff. (2d) ¶ 19)

In 1982, the General Assembly enacted a new self-funded healthcare plan (the "Indemnity Plan"). 1981 N.C. Sess. Laws 1398 (attached at Tab 30). The Indemnity Plan fully replaced the previous plan. *Id.* The terms of the Indemnity Plan, including the deductible, coinsurance, copayments and coverages, were fully set forth in statute. *Id.* § 6. Those statutes defined "deductible" as follows:

> 'Deductible' - Deductible shall mean an amount of covered expenses during a calendar year which must be incurred after which benefits (subject to the deductible) become payable. The deductible for an employee, retired employee and/or his or her dependents shall be one hundred dollars ($100.00).

N.C.G.S. § 135-40.1(12) (1982). The statutes then provided:

> The Plan is divided into two parts. The first part includes certain benefits which are not subject to a deductible or coinsurance. The second part is a comprehensive Plan and includes those benefits which are subject to both a one hundred dollar ($100.00) deductible for each covered individual . . . and coinsurance of 95%/5%.

Id. § 135-40.4. The statutes then listed a litany of covered products and services that were "subject to" the "deductible" and thereafter "payable on the basis of ninety-five percent (95%) by the Plan and five percent (5%) by the covered individual." *Id.* § 135-40.6. (See Appendix A for definitions of the terms "coinsurance" and "deductible" and an example of how they work together.)

The Indemnity Plan remained in existence until June 30, 2008. 2007 N.C. Sess. Laws 323, § 28.22A(a). Between 1982 and 2008, the terms of the State Health Plan changed considerably and on a regular basis. Relevant changes will be discussed below.

On October 1, 2006, the State Health Plan debuted three new Preferred Provider Organization ("PPO") plans. (See Appendix A, which is attached at Tab 1, for a discussion of the concepts of PPOs and provider networks.) Two of the new PPO plans did not require individual employees or retirees to pay any portion of the premium. (The term "premium" is defined and discussed in Appendix A.) These new PPO plans had several differences in their financial provisions. One plan included a $600 deductible, $350 emergency room ("ER") copayments and a

70/30 coinsurance rate. A second included a $300 deductible, $200 ER copayments and an 80/20 coinsurance rate. The third new PPO plan, which did require employees and retirees to contribute to the premium, included a $150 deductible, $150 ER copayments and a 90/10 coinsurance rate. These differences are merely illustrative. These plans will be referred to as the 70/30, 80/20 and 90/10 PPO Plans, respectively.[2] (Moon Aff. ¶ 11 (attached at Tab 7); Moon Aff. (2d) ¶¶ 21, 23, 26 & Ex. B)

The 90/10 PPO Plan was terminated effective June 30, 2009. 2009 N.C. Sess. Laws 16, § 2(a). The 70/30 and 80/20 PPO Plans are still offered today, however, as of January 1, 2014 the 80/20 PPO Plan is no longer offered to Medicare-eligible retirees. (Moon Aff. (2d) ¶ 9)

In 2014, the State Health Plan introduced the new Consumer-Directed Health Plan ("CDHP") for non-Medicare members as well as Medicare Advantage plans from Humana and UnitedHealthcare for Medicare-eligible members. (Moon Aff. (2d) ¶¶ 27, 32) (See Appendix A for a discussion of Medicare and Medicare Advantage plans.)

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[2] These are not the formal names of the plans. The formal names of the plans have changed over the years. The only relevant detail about those names is that the coinsurance rate was not included in the formal names of any plans until Fall 2011. (*See* Moon Aff. (2d) ¶ 22 & Ex. A)

The evolution of some of the more pertinent provisions of these various plans is summarized in Appendix B to this memorandum, which is attached at Tab 2. One very important aspect of the State Health Plan that has never changed in the last thirty-four years is the Plan's right-to-amend statute. Since 1982, the State Health Plan statutes have always included the following language: "The General Assembly reserves the right to alter, amend, or repeal" the State Health Plan statutes. *E.g.*, 1981 N.C. Sess. Laws 1398, § 6 (enacting N.C.G.S. § 135-40.14); 2011 N.C. Sess. Laws 85, § 2.10 (enacting N.C.G.S. § 135-48.3). In fact, the right-to-amend statute is unquestionably a more consistent part of the Plan than the coinsurance rate that the Plaintiffs contend is part of their contracts.

B. Eligibility

The 1971 legislation authorizing the first State Health Plan made only "teachers and State employees" eligible and did not cover retirees. 1971 N.C. Sess. Laws 1009, § 1. Effective August 1, 1974, the Plan was amended to include retirees who were "vested at the time of retirement." 1973 N.C. Sess. Laws 1278, § 1 (attached at Tab 29). As relevant here, the vesting period for the monthly retirement benefit – the pension benefit – was fifteen years for employees retiring prior to 1967; twelve years for those retiring between 1967 and 1971; and five years for those retiring on or after July 1, 1971. *See* N.C.G.S. § 135-3(8)(a). (See Appendix A for discussion of the terms "monthly retirement benefit" and "vesting"

and important qualifications regarding the use of those terms in this memorandum.)

Retirees have been eligible to enroll in the State Health Plan ever since August 1, 1974. Beginning in 1988, in order to be eligible for retiree healthcare benefits, a retiree must also have completed five years of service as an employee of state government. 1987 N.C. Sess. Laws 857, § 9 (attached at Tab 31). The Plaintiffs alleged in the Complaint that this enactment created a "contract as a matter of law." (Compl. ¶ 49) However, this five-year requirement was added to address the practice – in which none of the Plaintiffs engaged – of long-time local government employees working a few months for the State at the end of their careers and then retiring as state employees with healthcare benefits from the State. Mem. from E.T. Barnes, Dept. of State Treasurer, Admin. Interpretation No. 87-6 (Sept. 9, 1987) (attached to Causey Aff. (2d) at Ex. J, which is at Tab 8).

C. Premiums

When retirees were first eligible to enroll in the State Health Plan in 1974, they were required to "pay[] the established applicable premium for the plan," 1973 N.C. Sess. Laws 1278, § 1, and the record shows that coverage was available only if the retiree paid the full premium. BlueCross BlueShield of N.C. ("BCBSNC"), "A Program of Hospital and Medical Benefits for Teachers and State Employees of North Carolina" at 8 (Jan. 1976) ("1976 Benefit Booklet")

(attached at Tab 15). (See Appendix A for a definition and discussion of the term "premium" and the important, related term "noncontributory," which refers to a plan that does not require the retiree to pay a portion of the premium) It was not until October 1, 1978 that the State began paying the full premiums for retirees. 1977 N.C. Sess. Laws 1136, § 18; *see also* N.C. State Employees Ass'n, Inc., History of the N.C. State Employees Ass'n, Inc. 1947-1983 at 64 (1983) ("Payment of Health Insurance for retired state employees begins October 1, 1978.") (attached to Haxton Aff., which is attached at Tab 11). At no time prior to 1978 did the State ever maintain a state-level program for teachers and/or state employees that provided premium-free coverage for retirees. The State paid retiree's healthcare premiums for a few years following 1978 by annual appropriation only. *See* 1979 N.C. Sess. Laws 838, § 2 (appropriating funds for "Retiree Benefits"); 1981 N.C. Sess. Laws 859, § 2 (same).

In 1982, coincident with the enactment of the Indemnity Plan, the General Assembly for the first time codified in statute that, "[r]etired teachers and State employees" (as well as active, fulltime teachers and state employees) were "eligible for coverage under the Plan, on a noncontributory basis." 1981 N.C. Sess. Laws 1398, § 6. The Indemnity Plan remained noncontributory for individual employees and retirees until it was terminated in 2008. *See, e.g.*, N.C.G.S. 135-40.2(a)(2) (2007).

The 70/30 PPO Plan has always been noncontributory for retirees since its creation in 2006. The 90/10 PPO Plan, for its three years in existence (2006-09), was never noncontributory. (*See* Moon Aff. (2d) ¶ 23 & Ex. B)

The 80/20 PPO Plan was only offered as a noncontributory option from October 2006 until August 2011 – less than five years. The premium contribution for the 80/20 PPO Plan paid by individual Medicare-eligible retirees beginning in September 2011 was $10 per month and for Fiscal Year ("FY") 2012-13 was $10.52 per month. For non-Medicare retirees, the premium contribution paid by the individual retiree beginning in September 2011 was $21.63 per month and for FY 2012-13 was $22.77. (Moon Aff. (2d) at Ex. B) It is the introduction of the premium contribution paid by retirees for the 80/20 PPO Plan that is the focus of the Plaintiffs' case.

The premium for the 80/20 PPO Plan was introduced along with a number of other changes to the State Health Plan's offerings for good reason. The last State Comprehensive Annual Financial Report that was issued prior to the introduction of the premium reported that the State had in excess of $32.8 billion in unfunded accrued actuarial liability for retiree healthcare. N.C., Comprehensive Annual Financial Rep. 149 (June 30, 2011). By the close of 2014, that unfunded accrued actuarial liability had been reduced to $26.6 billion. N.C., Comprehensive Annual Financial Rep. 157 (June 30, 2015). The General Assembly and the State Health

Plan, with the help of stakeholders, continue to explore options to ensure that the Plan can provide valuable benefits at sustainable costs going forward.

D. Coinsurance Rates and Other Plan Terms

From 1972 until the Plan was revamped in 1982, the Plan offered a "basic benefit" and "major medical benefits." The basic benefit paid 100% of costs for an extensive array of products and services including coverage for lengthy hospital stays. The major medical benefit was a "supplement" to the basic benefit in the event of "serious, lengthy or costly sickness or accident." *E.g.*, 1976 Benefit Booklet, *supra*, at 21. The coinsurance rate for only this supplementary major medical coverage was 80/20.[3] *Id.*

Beginning in 1982 with the advent of the Indemnity Plan, coinsurance under the State Health Plan was applied very differently. Unlike the previous Plan that covered most items at 100%, most products and services under the new Indemnity Plan were reimbursed on the basis of a $100 deductible and a coinsurance rate of 95/5. 1981 N.C. Sess. Laws 1398, § 6. Only a very few services – primarily regarding accidental injury and outpatient surgery – were covered at 100%. *Id.* In 1985, the aforementioned coinsurance rate was reduced to 90/10 and in 1986 the

[3] The record includes plan information from 1976, 1977 and 1981. (Moon Aff. (2d) at Exs. A-1, A-2 & A-3) The plans in these years were all BCBSNC plans that were structured as described above. No information is available for previous and intervening years' plans. Even if the plans in those years were different, this variation would only further undermine the Plaintiffs' claims.

deductible was increased to $150. 1985 N.C. Sess. Laws 192, §§ 1-4, 14-16.2. In 1991, the coinsurance rate was changed to 80/20 and the deductible was raised to $250. 1991 N.C. Sess. Laws 427, §§ 18, 19, 21, 23, 26, 33. The coinsurance rate for the Indemnity Plan remained at 80/20 until that Plan's termination in 2008. The deductible was increased in 2001 to $350, and then once again in the final year of the Plan (2007-08) to $450. 2001 N.C. Sess. Laws 253, §§ 1(b), (c), (f); 2007 N.C. Sess. Laws 323, §§ 28.22(b), (c), (e). Throughout this period, other financial terms, such as the coinsurance out-of-pocket maximum and copayments, similarly increased periodically. *E.g.*, 1991 N.C. Sess. Laws 427, § 33; 2001 N.C. Sess. Laws 253, § 1(1)(e). (See Appendix A for a discussion of the term "copayment.") A timeline of the changes over the years in the critical terms of the State Health Plan's various offerings is provided in Appendix B.

In 2006, the manner in which coinsurance was applied again changed as a result of the State transitioning to the PPO Plans. The PPO Plans have different coinsurance rates and deductibles for the same products and services depending on whether the provider is in-network or out-of-network. Therefore, for example, under the 80/20 PPO Plan, the coinsurance rate was 80/20 for in-network providers and 60/40 for out-of-network providers. The Indemnity Plan did not vary the coinsurance rate and deductible in this manner. Indeed, this is a defining feature of

a PPO plan that distinguishes it from an indemnity plan. (Moon Aff. (2d) ¶¶ 12, 25)

Although both the 80/20 PPO Plan and the Indemnity Plan had the same coinsurance rate for certain providers, they were not the same plan. As an illustration, in the final year of the Indemnity Plan, the 80/20 PPO Plan reimbursed members at a rate almost six percentage points higher than did the outgoing Indemnity Plan – 80.9% compared to 75.0%. (Fuhrer Aff. ¶ 6 & Ex. B at 9 (attached at Tab 10))

The suite of products and services covered by the State Health Plan has been amended regularly by the General Assembly since 1982 through the filing of the Complaint. Some of these changes have been sweeping and some more narrowly focused. Details of these changes – both large and small – made throughout this thirty-plus year period are included in Appendix C, which is attached at Tab 3. Accordingly, the State Health Plan in 2011 – the last iteration prior to the introduction of the premium that is at issue in this case – differs significantly in both structure and scope from the plans that existed in the 1970s and 1980s.[4]

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[4] Since the codification of the Plan in 1982, at least the following twenty-seven session laws have amended the terms of Plan: 1983-922, 1983-1110, 1985-192, 1985-732, 1985-1020, 1987-857, 1989-752, 1991-427, 1993-464, 1995-507, 1996-18, 1997-312, 1997-512, 1999-210, 1999-237, 2000-141, 2000-184, 2001-253, 2002-126, 2003-169, 2003-186, 2004-124, 2005-276, 2007-323, 2008-168,

(Footnote continued on next page.)

II. THE PLAINTIFFS, THE CLASS, AND THEIR ALLEGED CONTRACTS

A. The Plaintiffs and the Class

The Plaintiffs are twenty-six retired teachers and state employees. (Compl. ¶¶ 1-26) The Plaintiffs' dates of hire, retirement and either vesting in the pension benefit or becoming eligible for the retiree healthcare are collected in Appendix D (attached at Tab 4) and are set out in a timeline along with important dates regarding changes to the State Health Plan, in Appendix E (attached at Tab 5). As these summaries show, many of the Plaintiffs were hired before the State Health Plan existed and all but seven were hired before the State began paying premiums for retiree healthcare. In addition, most of the Plaintiffs vested in their monthly retirement benefit before the State Health Plan covered retirees at all. Several Plaintiffs retired before the State Health Plan ever offered an 80/20 coinsurance rate to employees or retirees, but one Plaintiff did not retire until after the State began charging retirees a premium for the 80/20 PPO Plan in 2011.

All of the Plaintiffs were enrolled in the 80/20 PPO Plan when the premium was introduced in 2011, but only two Plaintiffs ever participated in the 90/10 PPO Plan when that plan existed from 2006 to 2009. (Compl. ¶¶ 66-67; Barnes Dep. 57:6-8, 58:1-59:1; Carpenter Dep. 59:20-60:21, 88:13-15; Stip. of Fact

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2009-16 and 2011-85. Nearly all of these enactments changed several aspects of the Plan's terms.

(Enrollments of Named Pl. Reps. In PPO 70/30 Basic and NC SmartChoice Plus Plans (July 8, 2016))

In addition, the class includes over 1,500 members who retired before the State ever offered noncontributory healthcare benefits to any retiree. In excess of 22,000 class members retired before the State offered healthcare to its retirees at an 80/20 coinsurance rate.[5]

B. The Alleged Contracts

The Plaintiffs have alleged various contractual terms in unverified responses to written discovery and later in their depositions. These unverified and testimonial allegations differ considerably.

1. The Unverified Interrogatory Response

In March 2015 – over two and a half years after the Defendants' first interrogatory requesting such information – the Plaintiffs provided what they would later assert were the full terms of the contract that they allege the Defendants breached.[6] In relevant part, they asserted the following:

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[5] Data showing these facts were filed with the Defendants' Notice of Filing regarding class certification (July 14, 2016) at Tab 6.

[6] The Complaint only alleges that the Plaintiffs are entitled to an "80/20" and a "90/10" health plan, without explaining what those terms mean or what any other terms of the alleged contract might be. *E.g.*, Compl. ¶¶ 50, 53) The Defendants' Interrogatory No. 1 (July 2012) asked for "the complete and precise terms (i.e., rights, duties and obligations of each party) of each contract," to which the Plaintiffs initially responded in August 2013 generally "by reference to the

(Footnote continued on next page.)

> The State must offer a non-contributory comprehensive 80/20 Health Plan to each vested retiree. That health plan must provide comprehensive benefits to the retirees such that the overall cost-sharing of covered medical expenses is split between the State and the retiree on an 80% - 20% basis on average. . . . So long as the overall assemblage of benefits comply [sic] with this average cost-sharing allowance, the Defendants may change specific benefits offered (except that the premiums must always remain on a non-contributory basis . . .). . . . The normal methodology to determine this allocation is referred to as an actuarial valuation and the end result as an actuarial value.

(Pls.' 1st Am. to Resp. to Defs.' 1st Set of Interrogs. at 2-3 (Interrog. No. 1(iii)) (Mar. 4, 2015) ("Pls. Resp.") (attached at Tab 27)) The crux of the allegation appears to be that all retirees are entitled to a single, noncontributory healthcare plan that provides an average 80% reimbursement rate by the State Health Plan according to some type of analysis and upon some type of average basis. No Plaintiff has ever provided any verification in support of this Interrogatory response.

The Plaintiffs made similar allegations regarding the "90/10" plan. *Id.* The sole differences for the Plaintiffs' assertions regarding a "90/10" plan are that the "split" under the "90/10" plan must be "90% - 10%" and the State Health Plan may charge each retiree part of the premium that is otherwise paid by the State. *Id.* The

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Complaint." (Pls.' Resp. to Defs.' 1st Set of Interrogs. at 3-4 (Interrog. No. 1(iii)) (Aug. 9, 2013) (attached at Tab 25)) In December 2014 the Plaintiffs initially provided the terms discussed above. (Ltr. from M. Carpenter to M. Bernstein at 1-2 (Dec. 22, 2014) (attached at Tab 26))

Plaintiffs never assert any limitation on the premium term except that the State Health Plan may not charge each retiree the complete premium. Therefore, according to the Plaintiffs, the State Health Plan could charge retirees the entire premium less one cent. In 2009, which was the final year that the 90/10 PPO Plan was offered, retirees were only charged about $44 per month of the total premium, which was nearly $400 per month. (Moon Aff. (2d) at Ex. B)

2. The Plaintiffs' Testimony

At deposition, each Plaintiff was asked what he or she alleged to be the terms of his or her contract and/or what the Defendants promised him or her regarding healthcare coverage upon retirement. The Plaintiffs generally agreed on only one term: that the State Health Plan should not charge them a premium for individual coverage. (*But see* Carpenter Dep. 69:19-23) The Plaintiffs testified to differing terms regarding every other aspect of the healthcare plan about which they were asked, including such critical provisions as the deductible, the scope of covered products and services, the copayments, and even the coinsurance. For example, the Plaintiffs' deposition responses regarding the deductible ranged from one extreme (e.g., the deductible is limited to whatever it was on the date of retirement) to another (i.e., the State Health Plan can change the deductible in any manner it so chooses) with a variety of permutations in between. In some instances, individual Plaintiffs gave conflicting responses, such as first indicating

that he was made no promises regarding the deductible, but later expressing some sort of limit when asked if the State could increase the deductible significantly. (Barnes Dep. 47:13-15, 61:24-62:19; Hayes Dep. 64:19-25, 121:18-122:11) The Plaintiffs' deposition responses regarding other critical aspects of healthcare benefits exhibited a similar range and variety.

The Complaint focuses on the coinsurance rate, and the Plaintiffs' asserted on class certification that "[t]here is absolute unanimity amongst the deposed Plaintiffs that they were offered vested rights in an 80/20 premium-free health plan." (Pls.' Reply Br. in Supp. of Mot. for Class Certification at 13-14 (Aug. 10, 2016) ("Class Cert. Reply")) In support, they cited testimony from only twenty Plaintiffs. The other Plaintiffs, for example, testified that he did not know if the State was required to provide an 80/20 coinsurance plan but the State was "required to pay for everything for [his] health benefits" under whatever plan he chose (Carpenter Dep. 62:12-63:7, 66:20-67:22, 112:21-113:11), testified that the coinsurance rate could be changed at least minimally (Lewis Dep. 80:7-81:20), or never expressed any requirement regarding the coinsurance rate (Atwell Dep. 100:17-23, 103:7-9). Other Plaintiffs also failed to support this supposedly "unanim[ous]" view. (*E.g.*, Latta Dep. 118:5-119:22, 158:19-159:6, 167:19-23 (testifying that he was entitled to the coinsurance rate that prevailed when he

retired, which he incorrectly believed was 80/20)) Therefore, the Plaintiffs are wrong that there is "unanimity" among the Plaintiffs even as to this central term.

The Plaintiffs' testimony regarding the terms of their alleged contracts is summarized in Appendix F (attached at Tab 6).

The Plaintiffs' testimony did not, even by implication, resemble the unverified response to Interrogatory No. 1, which alleged that the contract required an "overall cost-sharing of covered medical expenses [that] is split between the State and the retiree on an 80% - 20% basis on average" as determined by "an actuarial valuation."[7] (*See* Pls.' Resp. at 2-3 (Interrog. No. 1(iii))) Several Plaintiffs were asked directly about the unverified response to Interrogatory No. 1. They generally agreed that the interrogatory response accurately represented their views, but they could not articulate how they reached that conclusion or even explain the terms that were set forth in the interrogatory response. *See* Appx. F.

Finally, two Plaintiffs testified that the State was required to offer them optional vision and dental insurance – neither of which are a part of the State Health Plan (Davis Dep. 25:25-27:3, 60:2-11; Futrelle Dep. 63:12-19, 68:15-24);

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[7] The closest testimony was probably that of Plaintiff Barnes, who stated that if he incurred $1,000 in medical expenses for the year, the State Health Plan would be required to pay $800. (Barnes Dep. 71:16-24) However, Plaintiff Barnes' version applied the "80% - 20%" "split" to actual costs on an individual basis whereas the response to Interrogatory No. 1 appears to apply the "80% - 20%" "split" only on an actuarial bases, averaged across some class of persons.

one alleged that the State was obligated to provide a BCBSNC plan (Narron Dep. 74:13-17) despite the fact that the State has not offered a BCBSNC plan in over fifteen years (Moon Aff. (2d) ¶ 37); and one contended that the State was required to offer a plan that includes copayments for routine services instead of having those services be subject to the deductible and coinsurance (Hayes Dep. 86:21-88:9).

With few exceptions, the Plaintiffs are not claiming that their contracts require the State Health Plan to provide to them exactly what was offered at any particular time.[8] Indeed, the Plaintiffs generally recognized that healthcare coverage has changed over time and will continue to change. (*E.g.*, Carpenter Dep. 28:23-29:5, 31:15-24, 111:3-12; Cooper Dep. 67:6-68: 15, 92:25-93:2; Jones Dep. 26:2-27:20)

ISSUE TO BE RESOLVED IN THE CASE

There is no dispute that all Plaintiffs (and all class members) have at all times since retirement been provided with at least one plan (and at many times multiple plans) that are noncontributory. Accordingly, the only issue for this court to resolve is whether the Plaintiffs have a right to have a certain term – an 80/20

[8] Plaintiffs Evans and Latta testified that they were entitled to the full terms that were in place when they retired. (Evans Dep. 44:15-45:15; Latta Dep. 123:12-125:4, 158:19-159:6, 167:19-23, 168:20-170:4)

coinsurance rate – included in one of the State Health Plan's noncontributory offerings.

APPLICABLE JUDICIAL STANDARD

Summary judgment must be granted "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that any party is entitled to a judgment as a matter of law." N.C.G.S. § 1A-1, Rule 56(c). More particularly, "[s]ummary judgment is appropriate if: (1) the non-moving party does not have a factual basis for each essential element of its claim; (2) the facts are not disputed and only a question of law remains, or (3) if the non-moving party is unable to overcome an affirmative defense offered by the moving party." *Griffith v. Glen Wood Co.*, 184 N.C. App. 206, 210, 646 S.E.2d 550, 554 (2007) (citation and footnote omitted).

SUMMARY OF ARGUMENT

A healthcare plan is a complex suite of terms that is developed as an integrated whole to provide a benefit to its members. The Plaintiffs' alleged contracts focus on just two of these terms – the monthly premium and the coinsurance rate.

The State never undertook, nor was any state agency authorized, to offer Plaintiffs any such contracts. The Plaintiffs have conceded, and precedent

requires, that the State Health Plan statutes themselves are not an offer to contract. Further, the plain language of the State Health Plan statutes and the legislative development of the State Health Plan show that at every turn the General Assembly took care to ensure that the State's healthcare benefits could be regularly amended. This conclusively demonstrates that no agency was authorized to offer a contract to employees or retirees that would lock-in any terms of the Plan for fifty-plus years into the future.

Coinsurance is one of many healthcare terms and it accounts for only a fraction of healthcare costs. The Plaintiffs' narrow focus on the coinsurance rate fails to address the terms of a complete and enforceable contract for healthcare benefits. Several Plaintiffs, when pressed, testified to vague and varied limitations on other healthcare terms, such as the deductible and copayments (which terms together control far more healthcare costs than does coinsurance). Yet these alleged limitations differed from Plaintiff to Plaintiff and had no basis in fact. No precedent supports this sort of *ad hoc* proliferation of contract terms for state employees or retirees.

Even if the Plaintiffs' alleged contracts were complete and authorized by law, the evidence of their existence does not add up. For example, the documentary evidence fails to show that the Plaintiffs were offered any specific coverage terms during their retirement. The Plaintiffs alleged that oral

representations were made to them regarding the State Health Plan, but these alleged representations contradicted the codified terms of the State Health Plan. The Plaintiffs' unsupported inferences that two of the many terms that were offered to them during annual enrollment at some points as employees would continue for decades into their retirement does not create a contract. Regardless, the Defendants have complied any contracts that may exist.

In large measure, the Plaintiffs seek shelter under the precedents in *Simpson*, *Faulkenbury* and *Bailey*. Those cases all dealt with the specific terms of those plaintiffs' monthly retirement benefits and the courts in those cases found that the plaintiffs "had a contractual right to rely on the terms of the retirement plan as these terms existed at the moment their retirement rights became vested." *E.g.*, *Bailey v. State*, 348 N.C. 130, 145-46, 500 S.E.2d 54, 62-63 (1998) (quotation marks omitted). That is, the State could not alter the retirement benefits once the employees had vested. In all of these cases, the courts found that the terms of the contract were codified in a generally applicable statute, regardless of what representations were also made orally or in writing.

Here, the Plaintiffs are asserting that because they "vested" they have a contractual right to two of the many terms of an ever-changing State Health Plan, which terms were not even in existence, much less codified in statute, when the

large majority of the Plaintiffs "vested." The *Bailey* line of cases provides no support for such a claim.

For these and many other reasons, as set forth below, the Plaintiffs cannot prevail on any of their claims.

ARGUMENT

I. THE PLAINTIFFS HAVE CONCEDED THAT THE STATUTES THEMSELVES DO NOT CREATE THE CONTRACTS THAT THEY ALLEGE AND THEY CANNOT SHOW THAT ANY AGENCY HAD THE AUTHORITY TO CREATE SUCH CONTRACTS.

On interlocutory appeal in this case, the Court of Appeals reiterated that it did not, at that time, resolve issues that went to the merits of the case. Quoting *Sanders v. State v. Pers. Comm'n*, 183 N.C. App. 15, 644 S.E.2d 10, *disc. review denied*, 361 N.C. 696, 652 S.E.2d 653 (2007), the Court reiterated that "arguments that the alleged contract is . . . not an authorized and valid contract went to the merits of the plaintiffs' breach of contract claims" and were reserved for later resolution. *Lake v. State Health Plan*, 234 N.C. App. 368, 374, 760 S.E.2d 268, 273, *cert. denied*, 367 N.C. 806, 766 S.E.2d 840 (2014) (quotation marks omitted). Accordingly, the question of whether the Plaintiffs' alleged contracts are "authorized and valid contract[s]" is now before the court. *Id.*

The Supreme Court has held that statutes that govern the relationship between the government and its employees may, in and of themselves, be offers of contract and create contracts when accepted by employees. *E.g.*, *Faulkenbury v.*

Teachers' & State Employees' Retirement Sys., 345 N.C. 683, 691, 483 S.E.2d 422, 427 (1997). The Plaintiffs alleged in their Complaint that two statutes "created a contract as a matter of law." (Compl. ¶¶ 45, 49) However, they have long-since represented otherwise to this court and the Court of Appeals. (*E.g.*, Pls.' Br. in Opp. to Defs,' Mot. to Dismiss at 3, 40 (Feb. 25, 2013) ("Pls.' MTD Opp.") (attached at Tab 24)) Judicial estoppel prevents them from returning to that position. *Price v. Price*, 169 N.C. App. 187, 191, 609 S.E.2d 450, 452 (2005). Regardless, even if the Plaintiffs are maintaining that the statute is the contract, the argument must fail.

The Supreme Court recently held that in order for a statute to be deemed contractual, there must be "explicit indications of legislative intent" to be bound by contract. *N.C. Ass'n of Educators v. State*, 786 S.E.2d 255, 263 (N.C. 2016); *see also id.* at 262 ("the legislature [must] manifest[] a clear intention to be contractually bound"). This requirement is based on the "presumption that a state statute is not intended to create private contractual or vested rights but merely declares a policy to be pursued until the legislature shall ordain otherwise." *Id.* (quotation marks deleted). To prevail, the "party asserting that a legislature created a statutory contractual right bears the burden of overcoming" this presumption. *Id.* Courts must be "deeply reluctant" to convert a statute into a contract absent "compelling supporting evidence." *Id.* at 263. Finally, the Court

has observed that many state actions "may seem to hold out promises to individuals" but nevertheless "cannot be treated as contracts." *Id.* at 263 (quotation marks omitted). The statutory analysis discussed later in this section clearly demonstrates that there are no "explicit indications of legislative intent," *id.* at 263, that would transform the statutes at issue in this case into the contracts alleged by the Plaintiffs.

Because the General Assembly itself did not create any alleged contracts, any such contracts must arise, if at all, through the actions of state agencies. However, "[t]he State is liable only upon contracts authorized by law." *Smith v. State*, 289 N.C. 303, 322, 222 S.E.2d 412, 425 (1976). The State is not liable on contracts – even express, written agreements – that are created without authority. *McCaskill v. Dep't of State Treasurer, Ret. Sys. Div.*, 204 N.C. App. 373, 396, 695 S.E.2d 108, 125 (2010), *aff'd per curiam*, 365 N.C. 69; 706 S.E.2d 226 (2011); *State Hospital v. Fountain*, 129 N.C. 90, 92, 39 S.E. 734 (1901) (It is "too well settled that" the State's "agents or officers can not bind the State by any contract they may make, when not so authorized to do."); *Smith v. Thompson*, 122 N.C. 215, 219, 220, 29 S.E. 223, 224-25 (1898) (declaring void a contract that was "was made without authority of law" despite fact that it was "executed in good faith and was greatly for the benefit and advantage of the State"); *Whitfield v. Gilchrist*, 126 N.C. App. 241, 244-48, 485 S.E.2d 61, 63-67 (1997) (held, State is not bound by

implied-in-fact contract that is not authorized by statute), *rev'd on other grounds*, 348 N.C. 39, 497 S.E.2d 412 (1998); *Carl v. State*, 192 N.C. App. 544, 553, 665 S.E.2d 787, 795 (2008) ("When a State agency attempts to enter into a contract which does not come within the scope of its powers, the contract thereby formed is *ultra vires*" and "wholly void" and "no recovery can be had against the [State]," even by estoppel (quotation marks omitted). As described below, the General Assembly has never authorized the contracts that the Plaintiffs are now alleging.

A. The Plain Language of the General Statutes Does Not Express or Imply Any Authority for the State to Enter Into the Healthcare Benefits Contracts Alleged by the Plaintiffs.

Whether an agency possesses the power to contract on a given subject is determined by the agency's statutory authority. *E.g.*, *Fountain*, 129 N.C. at 92, 39 S.E. at 734 (holding that verbal representations made by state official were not contractual because they were not supported by statutory authority); *Smith*, 122 N.C. at 218-20, 29 S.E. at 224-25 (holding, based on review of authorizing statutes, that express contract signed by the Secretary of State was void); *Whitfield*, 126 N.C. App. at 244-48, 485 S.E.2d at 63-67 (reviewing statutes to determine validity of alleged implied-in-fact contract). The statutes at issue in this case contradict that any statutory authority existed to form the Plaintiffs' alleged contracts.

From 1972 to 1982, the State Health Plan's statutes used the word "contract" only to authorize the State to contract with an entity that would provide benefits, such as an insurance provider. 1971 N.C. Sess. Laws 1009. Nothing in the statute expresses or implies any authority to create the Plaintiffs' alleged contracts.

The 1982 session law, 1981 N.C. Sess. Laws 1398, which codified the legal framework for the State Health Plan for decades, contained many more references to the State Health Plan's contracting authority. The word "contract" was used in the 1982 statute eighteen times (excluding references to the Division of Purchase and Contract). The vast majority of these references are to contracts to administer the State Health Plan, such as by contracting with a third-party administrator like BCBSNC. *E.g.*, 1981 N.C. Sess. Laws 1398, § 6 (then codified at N.C.G.S. § 135-40(b)). One reference is a savings clause regarding the contracting authority under the previous statute. *Id.* § 1. The 1982 session law also discusses contracts between hospitals and physicians, *id.* § 6 (then codified at N.C.G.S. § 135-40.6(b)(1), and contracts with insurers to provide continuation coverage for terminated employees, *id.* (then codified at N.C.G.S. § 135-40.12(a)). The final two references in the 1982 session law deal with non-State plans for purposes of coordinating benefits with the State Health Plan. *Id.* (then codified at N.C.G.S. § 135-40.13(b)(1)).

The 1982 law also prohibited the State Health Plan from making any modifications to the then-current request for proposal regarding the State Health Plan except to reduce benefits if financially necessary, or to make typographical corrections. It also allowed the State Health Plan to "negotiate cost-containment measures" so long as those measures did not conflict with the detailed coverage and financial terms in the statute. *Id.* (then codified at N.C.G.S. § 135-39.4). Yet, even this limited authority given to the State Health Plan was stripped away in 1986. 1985 N.C. Sess. Laws 1020, § 2.

Since 1986, the State Health Plan has been authorized to allow members to be covered for up to three months under a previous plan provision on a case-by-case basis, where specific coverages were discontinued and this caused an "exceptional situation[] creating undue hardships or adverse medical conditions." 1985 N.C. Sess. Laws 1020, § 16 (currently codified at N.C.G.S. § 135-48.50(6)). The Plan has no other authority to allow members to continue on outdated terms.

The State Health Plan's statutes do not include any express or implied delegation of contracting authority. The frequent mention of contracting authority in the State Health Plan statutes in other contexts, along with other very narrow grants of authority, strongly suggest that the General Assembly specifically intended to delegate contracting authority only for certain purposes, did so in a

carefully limited manner, and did not permit any agency to enter into long-term contracts for retiree healthcare benefits.

B. The Purpose of the 1982 Statute Was to Ensure That the General Assembly Retained Control Over the Terms of the State Health Plan.

The legislative history of the 1982 statute conclusively demonstrates that the General Assembly did not delegate to the State Health Plan or any other agency the authority to enter into any decades-long contracts. Prior to 1981, the authority to offer a health plan to employees and retirees was delegated to a board of trustees in the State's Executive Branch. 1971 N.C. Sess. L. 1009, § 1. Coverage was offered to employees and later to retirees through contracts of insurance purchased by the State from insurers such as BCBSNC. (Moon Aff. (2d) ¶ 19) Effective July 1, 1981, the Committee on Employee Hospital and Medical Benefits ("Committee"), which consisted entirely of legislators, was substituted for the Executive Branch board as the entity responsible for formulating the health plan. 1981 N.C. Sess. Laws 859, §§ 13.12-13.19. In the wake of *State ex el. Wallace v. Bone*, 304 N.C. 591, 286 S.E.2d 79 (1982), and *In re Separation of Powers*, 305 N.C. 767, 295 S.E.2d 589 (1982), the General Assembly was advised that the Committee unconstitutionally usurped executive authority. (Ltr. from Rufus L. Edmisten to All Legislators (Feb. 19, 1982) (attached to Basnight Certification)) Shortly thereafter, instead of amending the membership of the Committee to allow

Executive Branch control over the details of the State Health Plan, the General Assembly codified in statute the entire State Health Plan, including all terms of coverage. *See* 1981 N.C. Sess. Laws 1398. The purpose of this codification was to ensure that the Legislature retained control over the terms of the State Health Plan and not to transfer that very authority to any agency.

In fact, as relevant here, five years after the General Assembly codified the terms of the State Health Plan, the Legislature gave notice that it may, if financially necessary, impose premiums on retirees. 1987 N.C. Sess. Laws 857, § 23(a) ("noncontributory premiums for . . . retirees" may be "replaced with partially contributory premiums"). This legislative enactment is completely inconsistent with any intent to authorize the creation of lifetime contracts that included noncontributory premiums for retirees.

If there were any question as to whether the statutes imply any authority for the Defendants to contract for long-term retiree healthcare benefits, it is erased by the words of the Legislature itself. Since 1982, the State Health Plan statutes have continually included a provision that is not found in any other benefit for government employees in North Carolina. This provision states: "The General

Assembly reserves the right to alter, amend, or repeal this Part." 1981 N.C. Sess. Laws 1398, § 6 (currently codified as amended at N.C.G.S. § 135-48.3).[9]

The effect of a "simple" reservation clause such as this "has been settled" for well over a hundred years. *Bowen v. Public Agencies Opposed to Soc. Sec. Entrapment*, 477 U.S. 41, 53, 91 L. Ed. 2d 35, 47 (1986). That effect is to negate the creation of immutable contract rights. For example, in *Nat'l R. Passenger Corp. v. Atchison, T. & S. F. R. Co.*, 470 U.S. 451, 467, 84 L. Ed. 2d 432, 447 (1985), the United States Supreme Court concluded that a statute that 'expressly reserved' [Congress'] rights to 'repeal, alter, or amend' the Act at any time. . . . is hardly the language of contract." *See also, e.g., Bowen*, 477 U.S. at 51-54, 91 L. Ed. 2d at 46 (finding that a statute stating that "[t]he right to alter, amend, or repeal any provision of this Act is hereby reserved to the Congress" made explicit that the statutory program could not be contractual).[10]

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[9] This provision became effective in October 1982. From the inception of the State's healthcare benefit in 1972 to September 1982, the State only offered benefits "to the extent that funds for such benefits are specifically appropriated by the General Assembly." 1971 N.C. Sess. Laws 1009, § 1 (then codified at § 135-33). The State only appropriated funds to pay retiree premiums – on a year-to-year basis – beginning in October 1978.

[10] The North Carolina Supreme Court addressed a right-to-amend statute with regard to government retiree benefits in *Faulkenbury*. Due to an express qualification included in that right-to-amend statute, the Court found that the statute was limited to "coordinat[ing] the retirement system with the Social Security Act" and therefore "ha[d] no application to this case." 345 N.C. at 691,

(Footnote continued on next page.)

The reservation of the General Assembly's right to amend recognizes the nature and needs of the State Health Plan. The State Health Plan cannot become ossified by overlaying on it long-term contractual requirements. Like virtually no other benefit, it must be allowed to respond to the dynamic medical, scientific and economic forces that bear on healthcare in order to provide the best coverage for the most members. *See Flemming v. Nestor*, 363 U.S. 603, 610-611, 4 L. Ed. 2d 1435, 1444 (1960) (finding that right-to-amend provision expressed "the institutional needs" of a federal benefits program where the program demanded "the flexibility and boldness in adjustment to ever-changing conditions").

The Plaintiffs have no viable alternative explanation for this statute. Before this Court, they contended that the purpose of the statute was to reserve the General Assembly's right to amend the State Health Plan statutes as to those individuals who had not yet "vested." (Pls.' MTD Opp. at 39) But they later conceded that "[l]egislative bodies always have the right to amend their own statutes." (Br. for the Pls.-Appellees at 34, *Lake v. State Health Plan*, No. COA13-1006 (Dec. 16, 2013)) Accordingly, the Plaintiffs' argument is that the statute merely reserves to the General Assembly a right that it was in no jeopardy of losing. This Court should avoid a construction of a statute that renders the statute

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483 S.E.2d at 427. The right-to-amend clause regarding the State Health Plan has no express limitations or qualifications.

entirely "useless or redundant." *Porsh Builders, Inc. v. Winston-Salem*, 302 N.C. 550, 556, 276 S.E.2d 443, 447 (1981).

More recently, the Plaintiffs argued that "what the Legislature is saying" to state agencies through the right-to-amend statute "is 'We get the final word. We have the right to the final word on this.'" (Video Tr. at 10:24:53 AM, *Lake v. State Health Plan*, No. COA13-1006 (argued Mar. 6, 2014) (copy on file; available on request)) That is exactly the point: If the statute is a directive to the agency that the agency does not "get the final word," then no agency has any authority to create contracts that, according to the Plaintiffs, are the final word.

As such, nothing in the 1982 session law (or any of the subsequent enactments that built on it) suggests any authority to enter into the long-term contracts with members for retiree healthcare coverage as alleged by the Plaintiffs.

C. The Frequent Amendment of the State Health Plan Statutes and the Time-limited Nature of the State's Healthcare Benefit Offerings Further Demonstrate the Lack of Any Authority to Create Contracts That Freeze Benefits Long-Term.

The General Assembly has enacted at least thirty session laws amending the terms of State Health Plan since the details of the Plan were codified in 1982. Some of these changes were major revisions, and some were complete overhauls. *See* Appx. C. In particular, the two terms that the Plaintiffs have alleged are contractual – the coinsurance rate and the retiree premiums – have both changed since the Plan's inception in 1972, including during the tenures of most of the

Plaintiffs. *See* Appx. E. The coinsurance rate has changed, not only in its amount, but with regard to how it is structured and to what products and services it applies. *See* Facts § I.D, *supra*.

Similar to private, commercial health insurance plans, the terms of the State Health Plan have generally varied from year to year in order to account for current healthcare, legal, financial and other considerations. All State Health Plan members, including the Plaintiffs, generally receive periodic enrollment information that notes these amendments and offers the opportunity to enroll each year in whatever plan or plans the State Health Plan is offering at the time. (Moon Aff. (2d) ¶ 16) The inherently time-limited nature of these offerings over the years directly contravenes any allegation that the State Health Plan was intended to be static in any way. For all of these reasons, the State Health Plan statutes decisively negate any suggestion that the statutes themselves create contracts and any alleged grant of authority to any agency to create any contracts for long-term retiree healthcare coverage. Accordingly, the contracts that the Plaintiffs allege are barred by law.

II. MANY OF THE CONTRACT TERMS ALLEGED BY THE PLAINTIFFS HAVE NEVER EXISTED AS PART OF THE STATE HEALTH PLAN.

The contracts that the Plaintiffs allege go beyond and contradict the General Statutes and any offerings ever made by the State Health Plan. Under the

contractual terms set forth in the Plaintiffs' unverified interrogatory response, the recurrent term "80/20" refers to an actuarially-determined, aggregated, average sharing of costs between the Plan and its members. No statute connected with the State Health Plan and no documentation provided by the State to employees or retirees has ever suggested this construct as a term of the State Health Plan. Under the State Health Plan, terms like "95/5," "90/10" and "80/20" have always referred to coinsurance rates. *E.g.*, 1981 N.C. Sess. Laws 1398, § 6 (then codified at N.C.G.S. § 135-40.4) (discussing "coinsurance of 95% / 5%."). Coinsurance has always applied only to a subset of covered transactions, and only after certain financial obligations – the deductible – are met. *E.g.*, *id.* (then codified at N.C.G.S. § 135-40.1(12)) (defining "deductible"). Yet according to the Plaintiffs' response to Interrogatory No. 1, the alleged contractual term "80/20" applies to every transaction that is covered by the State Health Plan and applies regardless of the deductible.

"When [an insurance] policy contains a definition of a term used in it, this is the meaning which must be given to that term wherever it appears in the policy, unless the context clearly requires otherwise." *Leach v. Monumental Life Ins. Co.*, 118 N.C. App. 434, 437-38, 455 S.E.2d 450, 452 (Lewis, J., dissenting) (quotation marks omitted), *rev'd*, 342 N.C. 408, 464 S.E.2d 46 (1995) (adopting dissenting opinion). The Plaintiffs' explanation of the term "80/20" as set forth in response to

Interrogatory No. 1 impermissibly contradicts the applicable statutes and Plan documents and therefore cannot be a contractual term.

In addition to the response to Interrogatory No. 1, the Plaintiffs testified to many different iterations of what the State is allegedly required by contract to provide. For example, several Plaintiffs testified that the State is required to provide them premium-free healthcare coverage, with a coinsurance rate of 80%, and that all of the other terms of the plan, such as the deductible and copayment amounts, may change from year to year according to a variety of vague standards that varied from Plaintiff to Plaintiff. See Appx. F for a summary of this testimony. However, there have never been any statutes or iterations of the State Health Plan that have set any restriction on how much deductibles, copayments, etc. can change year over year.

Nearly all of the Plaintiffs do not contend that they are entitled to a specific version of the State Health Plan that existed at law or in fact at any specific point in time, as the complainants did with other retiree programs in *Faulkenbury* and *Bailey* and their progeny. Instead, the undisputed facts show that they are claiming a right to terms that never existed at any point in time. The law has never recognized such a claim.

III. THE PLAINTIFFS' ALLEGED CONTRACTS LACK ESSENTIAL TERMS AND ARE TOO VAGUE TO BE ENFORCED.

Healthcare plans comprise many terms. Although the Plaintiffs focus on the premium and coinsurance rate, several other terms of healthcare coverage are at least, if not more, important. (Moon Aff. ¶¶ 6-7; Collins Aff. ¶¶ 4-7 (attached at Tab 9)) First and foremost, the Defendants are not aware of, and the Plaintiffs have not identified, any health plan that has not detailed what products and services are covered. At all times during the existence of the State Health Plan, the Plan has always described in detail what products and services are covered by the Plan. (Moon Aff. (2d) ¶ 6) As the statutes and the State Health Plan's literature in the record make clear, there is a wide range of services that can be covered. *E.g.*, N.C.G.S. § 135-40.6 (2007).

Next, although a health plan is not required to have a deductible, the State Health Plan has had a deductible continuously since its inception in 1972.[11] (*E.g.*, 1976 Benefit Booklet, *supra*, at 21; Narron Dep. 31:18-19 ("[T]here was always a deductible.")) Similarly, the State Health Plan has had a coinsurance out-of-pocket maximum at all times since 1982 and has included copayments since 1986. *E.g.*,

[11] For 1982 to the present, the terms of the State Health Plan are documented for every year. Regarding the evidence of the terms of the State Health Plan from 1972 to 1982, see footnote 3, *supra*. The Medicare Advantage Plans, which were introduced as options in 2014, do not have a deductible.

1981 N.C. Sess. Laws 1398, § 6 (then codified at N.C.G.S. § 135-40.8); 1985 N.C. Sess. Laws 1020, § 4 (then codified at N.C.G.S. 135-40.6(8)a).

The State Health Plan has never consisted of only a premium and a coinsurance rate. (Moon Aff. ¶ 7) The deductible and copayments are major drivers of retirees' healthcare costs because they both apply to first-dollar coverage, whereas the coinsurance does not. (Moon Aff. ¶¶) Unrebutted data show that less than a third of retirees pay any coinsurance at all during the plan year, yet nearly 90% pay copayments and almost half pay at least something toward their deductible. (Collins Aff. ¶¶ 4, 5, 7) Similarly, less than 30% of retirees' medical payments are paid to coinsurance, meaning that over 70% of the retirees' costs are based solely on the deductible and copayment amounts. (Collins Aff. ¶¶ 6-7)

A contract does not exist unless there is agreement on all essential terms. *Cheek v. Southern R. Co.*, 214 N.C. 152, 156, 198 S.E. 626, 628 (1938); *Northington v. Michelotti*, 121 N.C. App. 180, 184, 464 S.E.2d 711, 714 (1995). The Plaintiffs cannot credibly contend that a statement of the covered products and services is not an essential term of a contract to insure those very services. Nor can the Plaintiffs show that the State or the State Health Plan ever intended to enter into any contract without any statement as to the parties' cost-share obligations, including but not limited to the deductible, copayments, and the coinsurance out-

of-pocket maximum. The State Health Plan is a complex undertaking that carefully balances many variables, only a few of which have been discussed here. The Plaintiffs cannot create a contract by simply ignoring the many other integrated healthcare provisions that so pervasively govern the parties' relationships.

Even if a contract includes all necessary terms, "the terms must be sufficiently definite to enable the court to determine ultimately whether the contract has been performed or not." *Elks v. North State Life Ins. Co.*, 159 N.C. 619, 626, 75 S.E. 808, 811 (1912); *see also Brooks v. Hackney*, 329 N.C. 166, 170, 404 S.E.2d 854, 857 (1991). The Plaintiffs were largely unable to articulate sufficiently definite standards. For example, one Plaintiff testified that the State was required to provide him with a "reasonable" deductible and copayments that may be "tweaked a bit." However, when asked how the State Health Plan would determine what changes were "reasonable," he repeatedly responded "I don't know." (Jones Dep. 39:23-47:22) Other Plaintiffs provided similarly indeterminable standards. (*E.g.*, P. McAteer Dep. 62:1-64:4, 67:25-68:22, 143:1-20 (testifying that the Plaintiff's understanding was that the deductible would remain "reasonably close" to what it was when he retired); Lewis Dep. 71:25-75:15, 98:18-99:12, 205:22-25 (testifying that any changes are subject to the "rule of reason")) The end result of such a contract would be to place the court in the

position of writing the terms of the State Health Plan every year and conducting the complex policy balancing that the Generally Assembly has rightfully delegated to an expert state agency.

Nevertheless, where essential terms of a contract are indeterminate, courts may supply such terms "by implication under appropriate circumstances." *Gray v. Hager*, 69 N.C. App. 331, 333, 317 S.E.2d 59, 61 (1984). Whether a court can supply a missing term depends in part on the nature of the missing term. Where the missing terms "can be shaped in an extensive variety of forms . . . . the courts have no basis for assuming that the parties intended to choose one of those forms over a multiplicity of potential others." *Id.* at 334, 317 S.E.2d at 61. The deductible, copayment amounts, extent of the provider network, out-of-network coinsurance level, scope of products and services, etc. can be shaped in literally an endless variety of ways. There was no agreement on such terms and this court has no basis for assuming that the parties intended to choose one suite of benefits over any other combination of benefits. Therefore, there is no basis on which this court may conclude that any enforceable contracts exist.

IV. BECAUSE THE LAW PROVIDES THAT ANY CONTRACT TERMS ARE SET AT THE DATE OF VESTING, THE PLAINTIFFS CANNOT SUPPORT THEIR CLAIM THAT THEY ARE ALL ENTITLED TO THE SAME HEALTHCARE PLAN.

In *Faulkenbury v. Teachers' & State Employees' Retirement Sys.*, the Court of Appeals, indicated that "[p]laintiffs . . . had a contractual right to rely on the

terms of the retirement plan **as these terms existed at the moment their retirement rights became vested.**" 108 N.C. App. 357, 370-71, 424 S.E.2d 420, 427 (1993) (quoting *Simpson*, 88 N.C. App. at 224, 363 S.E. at 94) (emphasis added). This holding has been reiterated numerous times by both the Supreme Court and the Court of Appeals. *E.g.*, *Bailey*, 348 N.C. at 146, 500 S.E.2d at 63 (same); *Cashwell v. Dep't of State Treasurer*, 196 N.C. App. 80, 89, 675 S.E.2d 73, 79 (2009) (same); *Faulkenbury II*, 345 N.C. at 690, 483 S.E.2d at 427 ("At the time the plaintiffs' rights to pensions became vested, the law provided that they would have disability retirement benefits calculated in a certain way. These were rights that they had earned and that may not be taken from them by legislative action."); *Wells v. Consol. Jud'l Ret. Sys. of N.C.*, 136 N.C. App. 671, 673, 526 S.E.2d 486, 488-89 (2000) ("The contract is embodied in state statute and governed by statutory provisions as they existed at the time the employee's contractual rights vested"), *aff'd*, 354 N.C. 313, 553 S.E.2d 877 (2001); *Whisnant v. Teachers' & State Employees Ret. Sys.*, 191 N.C. App. 233, 662 S.E.2d 573 (2008) (same), *cert. denied*, 555 U.S. 1174, 173 L. Ed. 2d 591 (2009); *Stone*, 191 N.C. App. at 410-11, 664 S.E.2d at 38 (reiterating, based on *Faulkenbury II*, "that vested state employees have contractual rights to . . . benefits calculated pursuant to the method in place when they vested"); *Tripp v. City of Winston-Salem*, 188 N.C. App. 577, 584, 655 S.E.2d 890, 895 (2008) ("Plaintiff alleged no genuine

issue of material fact that the [Winston-Salem Police Department] failed to follow the terms of the retirement plan as it existed in the Winston-Salem Code of Ordinances when plaintiff became vested.").

Even assuming that a retiree can be "vested" in the State Health Plan – a supposition that is refuted above – the consequence of this "vesting" would in itself create an insurmountable bar for almost all of the Plaintiffs. Ten of the Plaintiffs vested in the retirement benefit before the State offered any healthcare coverage to retirees. Eight more Plaintiffs vested in the retirement benefit prior to when the State began offering noncontributory coverage for retirees or when the payment of retiree premiums was subject to year-to-year appropriations and was not codified in statute. *See* Appx. E. Therefore, even if these Plaintiffs had a right to an 80/20 coinsurance plan, the State would have no obligation to offer it without a contribution from them to the monthly premium. Four Plaintiffs vested in the monthly retirement benefit between 1982 and 1991 when the retiree healthcare benefit was codified as noncontributory, but no 80/20 coinsurance plan was offered. *See* Appx. E. That leaves only four of twenty-six Plaintiffs who vested in the monthly retirement benefit when the State Health Plan consisted of a noncontributory, 80/20 coinsurance rate benefit for retirees.

The Plaintiffs make arguments that circumvent the problems caused by their date of "vesting" by relying on various other theories as to how their retirement

healthcare benefits were established. For example, Plaintiff Hanes did not have any health insurance at all through his employer for most of his career, including when he vested in his monthly retirement (i.e., pension) benefit. Therefore, Plaintiff Hanes testified that he was entitled to 80/20 coinsurance retiree coverage because "it was an 80/20 plan" that the Personnel Office discussed with him when he was preparing to retire. (Hanes Dep. 36:20-37:15) The State was not offering premium-free healthcare benefits to retirees when Plaintiff Jarvis vested in his monthly retirement benefit. He testified that he was entitled to a premium-free retirement benefit because his healthcare benefits as an employee were always premium-free. (B. Jarvis Dep. 66:16-67:4)

The Plaintiffs' various theories of how their retiree healthcare benefits were determined were hardly applied consistently. Plaintiff Davis (who vested in his monthly retirement benefit before the State Health Plan existed) testified that the terms of his retiree healthcare benefit were set according to his retirement date. (Davis Dep. 26:8-19, 41:6-12) However, at the time Plaintiff Buchanan was retiring, the State Health Plan was already charging a premium for the 80/20 coinsurance plan. Therefore, Plaintiff Buchanan took the position that his contract was at least in part based on the coverage that he had for most of his career, but not on what he had when he retired. (Buchanan Dep. 91:3-21, 96:23-97:18, 121:10-19) The law does not support these inconsistent contentions.

Several Plaintiffs relied, at least in part, on the notion that the benefit that they are owed in retirement is whatever that benefit was through the majority of their career. (*E.g.*, Hayes Dep. 84:21-85:19; Jones Dep. 36:19-37:23, 77:17-78:7) Aside from there being no support in law for this position, it also fails on the facts. No Plaintiff had any particular plan through "most" of his or her career because the Plan changed every year or two. Simply because the Plaintiffs did not recall or appreciate the many changes to the Plan does not mean that those changes were not practically or legally significant. The Plaintiffs cannot maintain the position that the Plan's terms were essentially static by ignoring the indisputable fact that the terms were not static.

The Plaintiffs contend that these differences are immaterial because their "theory of the case" is "that retirees are entitled to an 80/20 premium-free plan." (Class Cert. Reply at 22) The Plaintiffs' "theory of the case" is nothing more than a requested remedy to which the Plaintiffs have unilaterally agreed. The fact that they have requested this remedy says nothing about the legal or factual theories necessary to get each or all Plaintiffs and the class from their particular facts to that remedy. As Plaintiff Jones candidly conceded under oath: "The whole 80/20 business comes about as a result of this lawsuit because the lawsuit has to ask for a specific remedy." (Jones Dep. 38:13-15; *see also id.* 77:20-22 (reiterating this testimony); Hayes Dep. 46:18-25, 197:11-198:1 (testifying that from a "legal

perspective" he was entitled to the benefits on the date he "vested" but "[f]rom a practical perspective" he "expected to receive" something different))

From another perspective, the "vesting" dates of the Plaintiffs result in a lack of consideration. For example, the moment that the State authorized healthcare benefits to retirees in 1974 (even on a contributory basis), ten Plaintiffs were already eligible upon retirement for these benefits. None of these Plaintiffs needed to work a single minute longer in order to be eligible. There were no mutual exchanges of promises or exchanges of labor for a promised benefit. Therefore, there was no consideration and no contract.

Further, applying the rule of *Simpson*, *Faulkenbury*, *Bailey*, *Cashwell*, *Whisnant* etc. would create the staggering problem of the State Health Plan being required to retain and offer every version of the Plan that has existed from any year until the last person who "vested" in that year dies. (Evans Dep. 60:8-11 ("[W]e would retire with the health plan that was in place at the time, each retiree, and I'm sure over time that's different for people.")) It is simply implausible that the State would authorize such a program or that an employee could reasonably conclude that such a program had been offered. The Plaintiffs cannot avoid this logistical

consequence by simply agreeing among themselves what the terms of the contract should be without putting forth a defensible supporting factual and legal theory. [12]

V. NO CASE SUPPORTS THE CREATION OF RETIREE-SPECIFIC CONTRACTS THAT VARY FROM RETIREE TO RETIREE.

The Plaintiffs testified to a wide variety of contractual restrictions regarding a number of terms of their healthcare coverage. For example, the Plaintiffs gave the following varying accounts of the State's alleged requirements under their contracts regarding the State Health Plan's deductible:

- The deductible must be fully paid by the State.
- The State must limit the deductible to no more than the deductible amount at the time the Plaintiff retired (which was in 1991).
- Although no promises were made regarding the deductible, the State is required to provide a plan that was the same as or very similar to the plan that the Plaintiff had during his final few years of work and therefore the deductible may increase in the manner that one might expect.
- The State is required to provide the same type of deductible as the Plaintiff had during his working career, and the State must consider, at least, historical deductible levels and the cost of medical services

[12] If the Plaintiffs had pleaded that that each was entitled to the Plan as it existed when each Plaintiff "vested," then each Plaintiff's claim would have arisen as soon as he or she retired and was offered a different plan from the plan that prevailed at "vesting." Because all but four Plaintiffs retired more than three years before the Complaint was filed, *see* Appx. E, the claims of almost all of the Plaintiffs would be barred by the three-year statute of limitations. N.C.G.S. § 1-52(1). Likewise, if the Plaintiffs had pleaded some right to the Indemnity Plan, those claims would be barred as well because the Indemnity Plan was terminated more than three years before the Complaint was filed. *See* Appx. E.

when determining what deductible amount is reasonable and acceptable.

- The State may change the deductible because the State is permitted to decrease benefits (but not increase costs), although the extent of any changes may be subject to the "rule of reason."

- Although no promises were made regarding the deductible, the deductible may not be increased to such an extent that it undermines the Plaintiffs' alleged right to an "80/20" plan.

- The alleged contract does not limit at all how much the State Health Plan may increase the deductible or the Plaintiff was not made any promises regarding the deductible.

- The Plaintiff testified that an increase of the deductible from its current level to $1,500 would be a breach of her contract, and later testified that the same increase would not be a breach of her contract.

The Plaintiffs' responses were equally heterogeneous on other terms. (See Appx. F for details and citations.)

The Plaintiffs' position that the "terms" of the contract "include representations made to employees in employee handbooks or in oral representations" (Pls.' MTD Opp. at 40) resulted in this variety of responses. Further, at least a few Plaintiffs testified that their contracts are verbal agreements or are based solely on what was told to them orally and not on any documents. (Davis Dep. 58:3-18 (testifying that he had a "[v]erbal agreement" and not a "written contract"); Carpenter Dep. 49:4-54:14 (testifying that the basis for his conclusion regarding his rights is solely verbal communications); Hanes Dep. 50:9-22 (same); Narron Dep. 53:12-55:13 (same)) Although Plaintiffs' counsel have

argued that there is but one unilateral contract that applies to all retirees (Class Cert. Reply at 10-16), the Plaintiffs' deposition testimony, the ever-changing terms of the State Health Plan, the widely varying periods of employment of the class members and other factors thoroughly undermine that position. In theory, on the undisputed facts, each retiree could have a contract that is slightly or even dramatically different from every one of his or her fellow retirees.

The courts in this State have never endorsed any theory that would require the State to administer such an immense variety of contractual relationships with its former employees. In general, the Plaintiffs have alleged that the case law supports that non-statutory communications can evidence contractual terms. But even the few cases that the Plaintiffs cite for that proposition never suggest that such evidence could create the unwieldy patchwork of contract terms that the facts of this case would generate. *E.g.*, *Bailey*, 348 N.C. at 136-50, 500 S.E.2d at 56-66 (relying in part on verbal communications but finding that entire class had a contractual right to the identical statutory term); *Stone v. State*, 191 N.C. App. 402, 411-15, 664 S.E.2d 32, 38-40 (2008) (finding, based on statutory analysis, that all class members had the same contractual right, which was corroborated by state-issued documents), *disc. rev. denied*, 363 N.C. 381, 680 S.E.2d 712 (2009); *Pritchard v. Elizabeth City*, 81 N.C. App. 543, 551-54, 344 S.E.2d 821, 826-27 (finding that all plaintiffs had a right to the same contractual provision which was

based in part on written and verbal communications), *disc. rev. denied*, 318 N.C. 417, 349 S.E.2d 598 (1986). No law supports the proliferation of the multiplicity of contract terms that would result from the Plaintiffs' contentions in case.

VI. PLAINTIFFS' EVIDENCE DOES NOT SUPPORT ANY ALLEGED CONTRACTS

To support their alleged contracts, the Plaintiffs relied on three types of evidence: documents, verbal representations and circumstantial evidence. None of this evidence, separately or taken together, demonstrates the existence of any contract. The most prominent documents, verbal representations and circumstances are discussed in turn.

A. The Documents on Which the Plaintiffs Rely Do Not State or Imply That Retirees Are Entitled to a Noncontributory, 80/20 Coinsurance Plan for Their Lifetimes.

The Plaintiffs testified that a variety of documents supported their alleged right to a noncontributory, 80/20 coinsurance healthcare benefit. Their conclusions are based on their own assumptions and not the documents themselves.

1. TSERS Handbooks

One of the primary documents from which the vast majority of state employees learn about their retirement benefits is likely the document that is commonly referred to as the "TSERS handbook" ("TSERS" being the abbreviation for Teachers' and State Employees' Retirement System). The TSERS handbook has been published and updated regularly for decades. The TSERS handbook is

available to employees and retirees. (Causey Aff. (2d) ¶¶ 4, 5 (attached at Tab 8) Several Plaintiffs testified that they had received one or more iterations of the handbook or that they were at least familiar with the handbooks. (*E.g.*, Barnes Dep. 32:8-33:2; Blanton Dep. 112:25-113:4, 113:19-21, 117:20-24; Jones Dep. 24:4-11, 24:18-25:17)

The primary content of the TSERS handbook is the monthly retirement benefit. (Causey Aff. (2d) ¶ 4) The TSERS handbook did not include any information about retiree healthcare benefits until the January 1980 edition. (Causey Aff. ¶ 7 (attached at Tab 8)) In 1980, the following language was added to the handbook: "As an active or retired teacher or State employee, you are eligible to enroll in the State Group Hospital-Medical Program. Contact your employer for forms and additional information." The handbook neither stated nor implied anything about the premium, coinsurance or continued availability of healthcare benefits. TSERS, "Your Retirement System" at 22 (Jan. 1980) ("1980 TSERS Handbook") (attached at Tab 14). The subsequent editions in July 1980, 1983, 1985 and 1986 included identical language, except that the title of the health plan had changed to "State Comprehensive Health Benefit Plan." *E.g.*, TSERS, "Your Retirement Benefits" at 28 (Mar. 1, 1985) (attached to Causey Aff. (2d) at Ex. F-7).

This language was expanded in 1988 to read as follows:

> When you retire, if you have at least 5 years of service as a contributing teacher or State employee, you are eligible for coverage under the State's Comprehensive Major Medical Plan with the State contributing toward the cost of *your* coverage. Dependent coverage, if any, must be paid for by you. At retirement, contact your employer or the Retirement System for forms and more information.

TSERS, "Your Retirement Benefits" at 27 (Aug. 1, 1988) (attached at Tab 14). This revised text indicated that the State would "contribute" to individual premiums, but did not state or imply that the State would pay for them entirely. As before, the TSERS handbook did not mention any coinsurance rate or any other terms of coverage for retirees.

In 1990, the following language was used in the TSERS handbook: "Under current law, the State contributes toward the cost of *your* coverage under the regular State insured plan or a Health Maintenance Organization ["HMO"] . . . ." TSERS, "Your Retirement Benefits" at 32 (Oct. 1, 1990) (attached at Tab 14). Again, the word "contribute" is used. Moreover, the State did not then pay, and at no time since paid, the full premiums for any HMOs. (Moon Aff. (2d) at ¶ 36 & Ex. B) This reinforces the limited nature of the term "contribute." Further, the phrase "[u]nder current law" was designed to notify employees that the terms stated could be changed by future laws. This modifier was carried forward to every later edition of the TSERS handbook regarding retiree healthcare benefits but was never used with regard to the monthly retirement benefit. (*See generally* Causey Aff. (2d) at Ex. A)

In 1993, the text was revised again and, for the first time, indicated that "[u]nder current law, the State pays the full cost of your individual coverage if you select the regular State insured plan." TSERS, "Your Retirement Benefits" at 33 (1993) (attached at Tab 14). Seven of the Plaintiffs had retired by this time and all but three had also fulfilled the eligibility requirements – "vested" in the Plaintiffs' view – in the retiree healthcare benefit by then. *See* Appx. E. It is worth observing that the handbooks did not refer to the State paying "the full cost of individual coverage" or any like text until after the handbooks began prefacing these representations with the phrase "under current law."

From 1993 to 2007, the relevant text of the TSERS handbooks remained essentially the same. The handbooks during that period informed employees and retirees that "under current law" "the State" "pays the full cost of" (or "will pay for") "individual coverage" for the "regular State insured plan." Beginning in 2008, the program eligibility requirements became more complex, which was reflected in the handbooks. (*See* Causey Aff. (2d) at Ex. A) All of the Plaintiffs had fulfilled the retiree healthcare benefit eligibility requirements long before 2008 and all but five had retired by then.[13] *See* Appx. E.

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[13] Additionally, the TSERS handbooks and the SHP benefits books (discussed below) have at all time included disclaimers that have variously indicated that the handbooks and benefits books are only summaries, that the State retains the right to amend program terms, and that the General Statutes and any

(Footnote continued on next page.)

Although the TSERS handbooks reference the State Health Plan by formal name or through the term "regular State insured plan," the handbooks never specified the coinsurance rate to which the Plaintiffs allege a contractual right. Nor did the handbooks identify any other terms of coverage, except the premium. There is nothing in the shorthand term "regular State insured plan" or anywhere else in the TSERS handbooks that indicates that an 80/20 coinsurance rate is an inherent feature of such a plan and cannot be changed. And there is no valid explanation how the TSERS handbook could be interpreted to lock in the coinsurance rate but not render static all other terms of the State Health Plan.

Finally, the authors of the TSERS handbooks demonstrated that they knew how to indicate whether a benefit was not subject to change. For example, the 1980 TSERS handbook specifically stated for each of the six monthly retirement benefit options that payments are "for life." 1980 TSERS Handbook, *supra*, at 7-8. The 2011 handbook provided examples of monthly benefits and then indicated that the specific dollar amount calculated in the example would "continue for the rest of [the retiree's] life." TSERS, "Your Retirement Benefits" at 7-8 (Jan. 2011) (attached at Tab 14). These are not isolated examples from the history of the

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applicable state policies are controlling. *E.g.*, N.C. , "Teachers' and State Employees' Comprehensive Major Medical Plan," at p. following table of contents (Nov. 1989) (attached to Moon Aff. (2d) at Ex. A-8); TSERS, "Your Retirement Benefits," at 2, 47 (Mar. 1, 1995) (attached to Causey Aff. (2d) at Ex. F-14).

TSERS handbooks. This type of language is tellingly absent from any discussions in the TSERS handbooks of the retiree healthcare benefit, which instead use the phrase "under current law."[14]

Regardless, beginning in 1981 and continuing through the period relevant to this case, TSERS has had no authority over the State Health Plan. Until January 1, 2012, the State Health Plan was a separate agency of state government. *E.g.*, 1981 N.C. Sess. Laws 1398, § 6 (then codified at N.C.G.S. § 135-39). The Supreme Court has held that a contract with one agency cannot, unless authorized, bind another agency to provide retirement benefits to former state employees. *McCaskill*, 365 N.C. at 69, 706 S.E.2d at 226. (This also applies to other

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[14] Other documents also use the term "lifetime" or "life" regarding the monthly retirement benefit. Ret. Sys. Div., "Frequently Asked Questions," at 1 (Aug. 9, 2010) ("lifetime monthly retirement benefits") (Hayes Dep. 106:8-107:1 (authenticating document); Ltr. from D. Whaley, Ret. Sys. Div., to Pl. Fisher (Dec. 21, 2012) ("monthly retirement benefit, which is a lifetime benefit") (Fisher Dep. 84:24-86:1 (authenticating document)). The only instance of similar language being used with regard to the State Health Plan that the Plaintiffs have been able to identify appears in an internal training manual from late 2006 and refers only to an extremely limited group of "surviving spouses," who are not retirees but who are spouses of retirees who died prior to October 1, 1986. (K. Jarvis Dep. 71:9-72:19, 81:24-83:2) The document states, "This special group is entitled to free health insurance paid premiums for life." (K. Jarvis Dep. 82:21-83:2) It refers only to the "special group" of surviving spouses and not to retirees generally. (K. Jarvis Dep. 121:19-123:7) In any event, by the date of that document, all Plaintiffs had "vested" and most had retired. Even if these documents evidence any ambiguity at all, "courts should not construe ambiguous writings to create lifetime promises." *M&G Polymers USA v. Tackett*, 135 S. Ct. 926, 936, 190 L. Ed. 2d 809, 820 (2015)

documents, discussed below, published by TSERS and other state entities, such as UNC-Chapel Hill.)

Therefore, the TSERS handbooks did not create, and are not evidence of, any retiree healthcare contracts.

2. State Health Plan Benefit Booklets and Other Periodic Distributions From the State Health Plan

The State Health Plan regularly publishes summaries of its offerings. These benefit booklets are designed to assist plan members in understanding the benefits that are being offered to them at a given time. In general, a new edition of this booklet was distributed every one or two years. More recently they have been provided every year. (Moon Aff. (2d) ¶¶ 15, 16 & Ex. A)

The State Health Plan benefit booklets regularly included an eligibility section. (Moon Aff. (2d) at Ex. A) The Plaintiffs referenced this language from the 1988 State Health Plan benefit booklet in the Complaint. (Compl. ¶ 48) The relevant language states:

> Please review the information in this section for a general understanding of eligibility enrollment guidelines.
>
> **ELIGIBILITY**
>
> The State of North Carolina pays for coverage under the Plan for the following individuals on a **noncontributory (no cost to you)** basis:
>
> - All permanent full-time teachers and State employees . . . .;

- Employees of State agencies . . . who are employed in permanent positions on a recurring basis and who work 30 or more hours per week for nine or more months per calendar year . . . .;
- Employees of the General Assembly . . . .;
- Retired North Carolina public school teachers and State employees . . . .
- [Other categories omitted.]

N.C., "Comprehensive Health Benefit Plan," at 3 (Mar. 1, 1988) (attached at Tab 15). Separately, the State Health Plan benefit booklet indicated that retirees are eligible for coverage only if they are "receiving monthly retirement benefits" and if they worked for the State for five years.[15] (*Id.* at 9) There is nothing in this language that suggests that, of the multitude of coverage terms in the State Health Plan benefit booklet, two of those terms – the premium and the coinsurance rate – are immutable for one of the eligible categories of members, specifically retirees.

Moreover, as several Plaintiffs recognized,[16] these documents are merely statements of the terms of a benefit program at a specific point in time, and are not

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[15] As discussed at page 6, *supra*, the five-year provision was added in 1988 to address a narrow practice in which no Plaintiff engaged.

[16] B. Jarvis Dep. 65:2-66:15 (testifying that the State Health Plan benefits books stated the benefits only for a point in time and, for example, the 1992 book did not state the terms for retirees in 2002); Jones Dep. 26:19-22 (testifying that the Plaintiff "receive[d] in general each year a new book that explained what the benefits were that were being offered for that year"), 105:10-16 (testifying that the State Health Plan benefit booklets were a "summary of the benefits that the State Health Plan was offering for the year that this package was in effect"); E. McAteer

(Footnote continued on next page.)

statements of future offerings. They are current documents only until they are superseded by changes to the State Health Plan. (Moon Aff. (2d) ¶ 16)

In fact, the very first State Health Plan benefit booklet that was published after the General Assembly first codified the coinsurance rate in the statute specifically notified all members that the coinsurance rate may change. The 1982 publication stated that the rising costs of healthcare "could mean higher out-of-pocket expenses for you in the form of **higher** contributions and/or **copayments**." N.C., "Comprehensive Health Benefit Plan," at 5 (Oct. 1, 1982) (emphasis added) (attached at Tab 15). At that time, the term "copayment" referred to the percentage

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Dep. 67:23-68:6 (testifying that the 1983 State Health Plan benefit booklet was the Plan's offering for the 1983 fiscal year and replaced the previous offering), 157:7-158:7, 160:20-161:2 (testifying that the enrollment packages "just show[] what's available at the time"); Nobles Dep. 33:15-25 (testifying that "[w]hen [she] enrolled each year" she "signed up for benefits that were specific to that particular plan year" and that the "benefits . . . under the State Health Plan changed from time to time and from year to year"); *see also* Blanton Dep. 48:18-50:3 (testifying that a statement in 1976 State Health Plan benefit booklet that retirees would be responsible for the "total cost of coverage" did not apply to him because he was not a retiree at that time); Cooper Dep. 65:3-20 (testifying that the State Health Plan benefit booklets state the benefits for active employees, not retirees); Davis Dep. 55:1-14 (testifying that he could not "recall receiving anything from the State Health Plan that specified what [his] co-insurance rate would be when [he] retired"); Atwell Dep. 73:8-15 (not recalling benefit booklets saying anything about retirement)) This limitation on the applicability of these documents undermines the evidentiary value of all of the State Health Plan's periodic communications regarding its benefits offerings, except as to the year that they were communicated. (*See, e.g.*, Cooper Dep. 112:12-18 (conceding that annual enrollment cards that indicated his coinsurance rate among other health plan terms did not state what any benefits would be for a future year or for retirement))

cost-share that is now commonly called "coinsurance." (*Id.* at 31) This document means exactly what it says, i.e., that the "copayment" – which is the healthcare provision that the Plaintiffs allege must be static – may be changed (which, in fact, it has been). This excerpt also indicates members may be subject to "higher contributions." Considering that on the following page of the document, the term "noncontributory" is used to mean "no cost to you" regarding the premium, this is a direct indication that premiums may increase. (*Id.* at 6)

The State Health Plan's benefit booklets are not a contract or evidence of any contract.

3. Individualized Retirement Benefits Statements

A few Plaintiffs cited their individualized retirement benefits statements as evidence of their contracts. (Currie Dep. 35:16-42:21; Hayes Dep. 30:6-12, 90:24-103:4; Jones Dep. 114:7-116:11; Latta Dep. 44:7-45:9, 92:9-95:8) The primary form of these statements are the annual documents from TSERS that were sent to each employee showing their contributions to the Retirement System and other information related to the monthly retirement benefit. The record includes examples of these documents from each year from 1982 to 2006 (except 1983). (*See* Causey Aff. (2d) ¶ 8 & CD submitted with this Memorandum) These written annual statements were discontinued in 2010. (Causey Aff. (2d) ¶ 8)

These two-page form documents included one or two sentences about the State Health Plan, as follows:

1982 & 1984-1987:	"At any age, as an active or retired teacher or State employee you are eligible to enroll in the State Comprehensive Health Benefit Plan." [The 1982 form used the phrase "State Group Hospital-Medical Program."]
1988:	"At any age, as a retired member with at least 5 years of retirement credit as a teacher or State employee, you are eligible to enroll in the State Comprehensive Health Benefits Plan."
1989-1993:	"At any age, as a retired member you are eligible to enroll in the State Comprehensive Health Benefits Plan, if you contributed to this Retirement System for at least 5 years while employed as a teacher or State employee." [The phrase "State Employee" was used in 1992 and 1993.]
1994:	"At any age, as a retired member you are eligible to enroll in the State Comprehensive Health Benefits Plan, with the State paying the cost of basic individual coverage, if you contributed to this Retirement System for at least 5 years while employed as a teacher or State employee."
1995-2000	"At any age, as a retired member you are eligible to enroll in the State Comprehensive Health Benefits Plan, if you contributed to this Retirement System for at least 5 years while employed as a teacher or State employee. However, there may be a cost to you depending upon your date of hire and your years of service."
2001-2005:	"STATE COMPREHENSIVE MAJOR MEDICAL PLAN – At any age, as a retired member, you are eligible to enroll in the State Comprehensive Major

> Medical Plan, if you have at least 5 years of contributing membership service in this Retirement System while employed as a teacher or State employee." [The phrase "if you contributed to this Retirement System for at least 5 years" was substituted in 2001.]
>
> 2006: "STATE COMPREHENSIVE MAJOR MEDICAL PLAN – At any age, as a retired member, you are eligible to enroll in the State Comprehensive Major Medical Plan, with the cost determined by when you began State employment and which health coverage you select, if you have at least 5 years of contributing membership service in this Retirement System while employed as a teacher or State employee."

Examples of forms with the language set forth above are provided at Tab 16.

These forms have never said anything about a coinsurance rate or any other term of coverage. They also said nothing about the cost of the benefit until the 1994 statements, by which time all but two of the Plaintiffs were "vested" in the retiree healthcare benefit according to the Plaintiffs' theory. Other mentions of cost indicated that "there may be a cost to you" or "the cost [will be] determined" by certain factors. In the twenty-five year period covered by these documents, only once – in 1994 – did the document indicate that the State would pay "the cost of basic individual coverage" or use any similar language. These forms do not evidence any guarantee of noncontributory coverage.

A second type of individualized benefits statement was issued by UNC-Chapel Hill to two Plaintiffs. The record contains copies of these forms from

1997, 1998 and 1999 (attached at Tab 17; *see also* Currie Dep. 35:21-42:35 (authenticating and discussing forms)). These forms all include the following language.

> If you were first employed prior to October 1, 1995, your Comprehensive Major Medical Plan or HMO coverage, coordinated with Medicare, continues for life if you receive a monthly State Retirement System benefit. If you were first employed on or after October 1, 1995, your health benefits will continue; however, if you retire with 5 but less than 10 years of service you will pay the full employer contribution, if you retire with 10 but less than 20 years of service you will pay 50 percent of the employer contribution, if you retire with 20 or more years of service the State will pay the full employer contribution.

For pre-1995 hires, this form "doesn't say anything about a premium" (Currie Dep. 38:9-18) or any other healthcare term. The form only "states that your health benefits will continue" but "[i]t does not go into detail" about the coinsurance rate. (Currie Dep. 42:19-21) The form does indicate that the "Comprehensive Major Medical Plan . . . continues for life." "Comprehensive Major Medical Plan" is one of the formal names of the Indemnity Plan. The Indemnity Plan was terminated June 30, 2008 when the State Health Plan transitioned to the PPO plans. The Plaintiffs have not alleged that their contracts require that the Indemnity Plan be resurrected.

4. Retirement Leaflets and Flyers

The Plaintiffs testified that they received leaflets and flyers regarding retirement that included language regarding healthcare benefits. Some Plaintiffs identified a flyer entitled "Highlights of Your Retirement Benefits," which was published by TSERS. (Buchanan Dep. 105:1-15; Hayes Dep. 110:1-113:5; E. McAteer Dep. 166:4-168:6; Nobles Dep. 67:2-70:13, 93:8-18; Savell Dep. 128:2-15, 132:10 – 133:9) The 2004 and 2005 versions of this leaflet (attached at Tab 18) include the following about healthcare benefits:

> When you retire, you are eligible for coverage under the State's Comprehensive Major Medical Plan provided you have at least 5 years of retirement membership service earned as a teacher or State employee. Under current law, the State pays the full cost of your individual coverage under the regular State insured plan (Credit received for unused sick leave, or credit transferred from the Local Governmental Employees' Retirement System does not count toward eligibility for health insurance coverage.) In all cases, the full cost of dependent coverage, if elected must be paid by you.

The 2006 version (attached at Tab 18) substituted the following for the last sentence:

> Under current law, if you were first hired prior to 10/1/06, and retire with 5 or more years of State System membership service, the State will pay for your individual coverage under the regular State insured plan and either all or most of the cost if you select one of the Preferred Provider Organization (PPO) plans, depending on the plan chosen. Based on the conditions described above if you were first hired on or after 10/1/06 in order to receive individual coverage at no cost, you must retire with 20 or more years of retirement service credit, if you have 10 but less than 20 years of retirement service credit, you will have lo pay 50% of the cost for your coverage, and with 5 but less

> than 10 years, you will have to pay the full cost for your coverage. In all cases, the lull cost of dependent coverage, if elected must be paid by you.

Like the text from the UNC forms, above, this document fails to state or provide evidence of a contract for similar reasons. (*See* Hayes Dep. 110:1-113:5 (testifying that this flyer did not indicate what the premium or coinsurance rate would be for retirees)) The reference to the "regular State insured plan" plainly indicates the Comprehensive Major Medical Plan (i.e., the Indemnity Plan) that is identified previously in the same document, as distinguished from the then-new PPO plans. Regarding the PPO plans, the flyer indicates that the State will pay "all or most of the cost" of the PPO plans "depending on the plan chosen." At all times, the State has paid "all . . . of the cost" (i.e., the premium) of at least one PPO plan. The document also never represents what the coinsurance rates would be under any of these plans or whether the rates would remain the same for any period of time.

The record also includes copies of a second flyer titled "Things Retirees Need to Know" from 1997, 2000 and 2001 (attached at Tab 19), with which a few Plaintiffs were familiar. (Currie Dep. 91:16-19; B. Jarvis Dep. 43:6-25; E. McAteer Dep. 152:16-154:20) This document contains language that is similar to the above documents, except that it adds the following qualifier: "Currently, the General Assembly provides the funds necessary to pay the full cost of individual

hospital-medical coverage under the regular State insured plan." This language is an unmistakable warning that the General Assembly's funding of retiree premiums is not permanently established for years into the future. The document also makes no representations regarding a coinsurance rate or any other healthcare benefit terms.

Regardless, many of the Plaintiffs retired and all were "vested" before any of these documents ever existed. *See* Appx. E.

5. Retiree Healthcare Enrollment Materials and Forms

Several Plaintiffs testified that the retiree healthcare enrollment form informed their opinion that they have a contract for noncontributory, 80/20 coinsurance healthcare. (*E.g.*, Nobles Dep. 79:5-83:6) For many years, retirees would submit a form near the time of their retirement in order to enroll in the State Health Plan's retiree group. (Causey Aff. (2d) ¶ 11) Attached at Tab 21 are copies of these forms for each year in which any Plaintiff retired. The 1985 form stated "Comprehensive Health Benefit Plan" in the form's title, and stated nothing else relevant to this issue. From 1988 to 2004, the form allowed the retiree to check a box for the "Regular State Health Plan" or an "HMO," for example, as follows:[17]

[17] An alternative form that was used in 1992 and 1998 listed the options as "State Self Insured Plan" (or "State Self Funded Plan"), "HMO" and "Decline Coverage." It is not clear if this form was used in any other years.

□ Regular State Health Plan □ HMO_____
(Fill in Name of HMO)

Following 2004, the form again provided no options and the term "Regular State Health Plan" was used in the form's title. From 2007 to 2011, the forms included the following options (depending on the availability in any year): "Indemnity Plan," "PPO 70/30 Plan (Basic)," "PPO 80/20 Plan (Standard)," and "PPO 90/10 Plan (Plus)."[18] The PPO 70/30 and PPO 80/20 Plans were the only two that were available throughout that entire period.

Twenty of the twenty-six Plaintiffs and over 110,000 class members retired before any of these forms listed a coinsurance rate, e.g., "PPO 80/20 Plan." *See* Appx. E; footnote 5, *supra*. Some of these Plaintiffs testified that the phrase "Regular State Health Plan" was a reference to the then-current State Health Plan, which had an 80/20 coinsurance rate and did not require a payment of a premium for individual coverage.[19] (*E.g.*, Barnes Dep. 103:20-104:15; Cooper Dep. 123:13-124:21; B. Jarvis Dep. 120:3-121:4) It is an unsupported leap from the fact that the

[18] The monikers for the PPO plans used on the forms varied slightly, but not materially, from year to year throughout the period from 2007 to 2011. It is reasonable to assume that the form began using specific references to the PPO coinsurance rates beginning October 1, 2006 when the PPOs were first offered. The record does not confirm or contradict this. Data regarding the class assume that the form was changed on October 1, 2006.

[19] This testimony was not accurate in all cases. One Plaintiff testified that the reference to the "Regular State Health Plan" on a form that she completed in April 1990 referred to "80/20" but the 80/20 coinsurance rate was not enacted until over a year later. (Narron Dep. 48:24-50:6)

"Regular State Health Plan" had an 80/20 coinsurance rate and no premium in the year that the Plaintiff retired to the conclusion that the coinsurance rate and the premium would remain the same for the duration of the Plaintiff's retirement. Nothing on the form during this period evidences such a promise. The form during this period also does not differentiate among any healthcare terms of the Plan and therefore would necessarily also require all other terms of the State Health Plan from the year in which any class member retired to remain absolutely constant for decades, just as the Plaintiffs are alleging the coinsurance rate must. The Plaintiffs routinely testified, however, that those other terms could change. *See* Appx. F.

Although the later retiree enrollment forms state a coinsurance rate, like the earlier forms they contain no language that evidences a promise that this coinsurance rate would never change for the Plaintiff or class member completing the form, or that the premium (which was not stated on the form) would also never change.

All of the retiree healthcare enrollment forms – whether they stated a coinsurance rate or not – suffer from another legal impediment: They were completed coincident with retirement. In *Faulkenbury*, the Supreme Court indicated that if the State enhances a vested retirement benefit, the employee can accept the revised benefit "by continuing in their employment." 345 N.C. at 693, 483 S.E.2d at 428. Assuming that the form was a promise, the Plaintiffs did not

accept any benefit "by continuing in their employment" because the entire purpose of the form was to enroll members in the Plan as retirees upon termination of their active employment.

These forms are nothing more than a version of a common healthcare enrollment form. For example, when the form first began listing Plans by reference to a coinsurance rate, e.g., "80/20 PPO Plan," the form was accompanied by an associated guide document. The form was always distributed with the accompanying guide. "Guide E" is a table of the monthly premiums for the retiree healthcare options. For example, in 2008 Guide E listed "$0" for the 70/30 and 80/20 PPO Plans. Guide E in that year is conspicuously labeled "Plan Year 2007-2009." Forms in other years were similarly formatted. (Causey Aff. (2d) ¶¶ 12-14 & Ex. I) Two examples of the Guides are attached at Tab 20. Accordingly, the undisputed fact is that the form stated a $0 premium for the 80/20 PPO Plan only for a limited period of time. The Plaintiffs cannot transform this document into evidence of a lifetime contract by ignoring its specifically stated time limitation. (*See* Hayes Dep. 186:13-22 (conceding that his retiree healthcare enrollment form only indicated his "initial selection" of a retiree healthcare plan and did not "indicate anything about what [his] coverage would be the following year"))

6. Other Documents

The record includes various other documents that discuss retiree healthcare benefits. These other documents say nothing more, and in many cases much less, about the Plaintiffs' alleged rights than the documents discussed above. For example, in 2005 Plaintiff Atwell wrote a letter to the Retirement Systems Division specifically asking about, *inter alia*, her healthcare benefits at retirement. The response was: "Under current legislation, we will pay for your health insurance at retirement." (Atwell Dep. 57:5-58:23) As Plaintiff Atwell testified, "All it's telling me is that I'm going to be provided with health insurance. That's all I understood. I didn't know exactly the plan." (Atwell Dep. 59:20-60:2) Plaintiff Atwell contacted the Retirement Systems Division again in 2009. In an email, she was informed, "As far as health insurance, since you are on Medicare, this will be your primary health insurance, and the State Health Plan will be your secondary plan, and there is no cost to you for the individual coverage." (Atwell Dep. 63:14-67:7) Again, there is no mention, directly or by inference, of the terms or duration of any coverage. The emails are attached at Tab 22.

As another example, several Plaintiffs received a form letter from the State contemporaneous with their retirement. The letter (example attached at Tab 23) included the following passage:

> If a deduction for medical insurance premiums is made from your retirement check, it represents the cost for dependent

> coverage, if you enrolled under the State Health Plan, or represents the cost of individual coverage or individual and dependent coverage if you enrolled under an HMO.

(*E.g.*, Futrelle Dep. 96:12-97:1) However, this language does not "include a promise that the State won't change your health benefit coverage as a retiree." (Futrelle Dep. 97:2-8) It also does not say anything about any terms of the State Health Plan.

Even if these documents evidence a promise to provide noncontributory healthcare, there is no dispute that the State has at all times provided a noncontributory option.

Accordingly, the documents of record do not evidence any contract.

B. Verbal Representations Made to the Plaintiffs Do Not Establish and Are Not Evidence of a Contract.

Almost all of the Plaintiffs relied at least in part on verbal representations as a basis for their alleged rights.[20] Some relied exclusively on such representations. (Hanes Dep. 50:9-22 (testifying that his basis for believing that he has a contractual right is a "conversation that [he] had with the Personnel Department when [he] retired" and not "on anything else"); Narron Dep. 53:12-55:13 (testifying that the contract was not written and was based on what the Plaintiff

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[20] The Defendants here assume the admissibility and competence of this testimony and reserve the right to argue against the admission into evidence of any statement upon reviewing what statements the Plaintiffs intend to rely, if any.

was told when she was hired and when she retired)) Beyond the question of whether any state employee had any authority to make representations regarding the benefits that would be allegedly guaranteed to future retirees, or whether the representations are even admissible, the verbal representations to which the Plaintiffs testified fail to support the existence of any contracts.

The content, context and timing of these representations varied significantly. The most common theme for these verbal representations was that the Plaintiff was told only that he or she would be provided with healthcare benefits during retirement "at no cost" or "without charge" or that the retiree would not "have to pay for" the benefits or that "healthcare would be taken care of by the State." (*E.g.*, Barnes Dep. 34:23-35:19, 124:3-13; Fisher Dep. 22:4-23:12; Cooper Dep. 83:17-84:3, 113:12-114:4; Currie Dep. 12:6-13; Futrelle Dep. 48:2-9; Narron Dep. 15:1-16:12, 32:25-33:4) The Plaintiffs took these and similar representations to mean that the benefit would not require the payment of a monthly premium. (*E.g.*, Barnes Dep. 124:3-13; Evans Dep. 16:8-23; Kaiser Dep. 61:17-68:8; Jones Dep. 130:16-22; Narron Dep. 15:1-16:20) Because there is no dispute that the State has always provided at least one noncontributory healthcare plan to all retires, these representations do not advance the Plaintiffs' claims.

Moreover, for some Plaintiffs, their interpretation of such statements as offering noncontributory healthcare coverage during retirement is contrary to law.

As discussed above, the General Assembly did not appropriate any money to pay retiree premiums until October 1, 1978 and did not codify in a continuing statute that retiree coverage was "noncontributory" until October 1982. Over a third of the Plaintiffs testified that they were told prior to October 1982 that the State would provide noncontributory healthcare benefits at retirement (or at least that they were told something that they interpreted as such).[21] This testimony is contrary to law and therefore cannot create a genuine issue as to any material fact or support the existence of any contract.

Some representations allegedly made to the Plaintiffs were even more vague. For example, Plaintiff P. McAteer recalled only being told that he "would receive full benefits from the State of North Carolina until [he] died." (P. McAteer

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[21] Barnes Dep. 34:23-35:19 (reported being told in September 1973 that healthcare during retirement "would be taken care of by the State"); Carpenter Dep. 15:19-16:3 (contended that he was told in 1961 that if he "worked 30 years, [he] would have [his] complete retirement benefit," including "insurance"); Cooper Dep. 113:12-114:4 (believed that he was informed in 1976 that he would have "free health benefits" during retirement); Jones Dep. 18:25-19:5 (allegedly told in 1979 that the State Health Plan would "go with [him] into retirement"); Kaiser Dep. 61:21-63:1 (represented that he was told in 1973 that retiree healthcare benefits would be "at no cost," meaning premium-free); Lewis Dep. 23:12-26:5, 181:5-15 (reported being informed in mid-1982 that "they covered your health"); E. McAteer Dep. 36:14-38:4 (thought she was told in January 1982 that retiree healthcare "would be paid for"); Narron Dep. 15:1-8 (believed to have been told in 1958 that she "would not have to pay anything for your retirement healthcare coverage"); Nobles Dep. 9:17-23,19:2-20:11 (claimed to have received information in 1974 that she would have healthcare "with no premium after [she] retired").

Dep. 52:5-21) Plaintiff Lewis testified that he learned from future co-workers that "they covered your health." (Lewis Dep. 23:12-26:5) These representations say nothing about either the premium or any terms of the retiree's health plan.

Another group of Plaintiffs testified that they were told, with varying degrees of specificity, that their healthcare benefit would remain the same when they retired. (Atwell Dep. 32:9-33:13, 36:22-37:13; Carpenter Dep. 25:10-27:6; Davis Dep. 22:18-25:5; Jones Dep. 18:25-19:5, 129:2-131:17; E. McAteer Dep. 39:16-19, 41:15-18, 40:16-23) These representations ranged from the very general ("healthcare would continue when I retired" (Atwell Dep. 32:9-33:13, 36:22-37:13)) to the more specific ("[e]xactly what you had when you were on the job, the same plan." (E. McAteer Dep. 40:16-23)). The more general language lacks sufficient specificity to support a contract. *See* Argument § III, *supra* . Even assuming such language does support a contract, the Plaintiffs cannot show a breach. For example, Plaintiff Atwell interpreted a representation made to her to indicate only that her "healthcare would continue when [she] retired" (Atwell Dep. 32:9-33:8) and there is no dispute that it has. The more specific representations fail to explain why the alleged promise only applies to the premium and the coinsurance rate, and not to every other healthcare term.

Finally, eight Plaintiffs testified that at some point a representation was made to them that specifically referenced the term "80/20." Plaintiff Kaiser

testified that when he was first hired, he was told at an orientation session that he would be provided with "80/20" coverage when he retired. (Kaiser Dep. 103:25-104:21, 107:20-108:9) This allegedly occurred in August 1973. (Kaiser Dep. 25:8-11, 58:5-10) Plaintiff Kaiser's assertion is contrary to law. The State did not offer any healthcare coverage to retirees until July 1, 1974. 1973 N.C. Sess. L. 1278, §§ 1, 4. Plaintiff Nobles' testimony that she was told in 1972 that she would have "an 80/20 plan with no premium after [she] retired" fails for the same reason. (Nobles Dep. 9:17-23, 109:2-12, 18:21-19:4)

Similarly, Plaintiff Hanes testified that he was told about his retiree healthcare benefits in 1989 when he retired and "it was an 80/20 plan that they talked about." (Hanes Dep. 37:3-15, 40:11-15) This allegation is also contrary to law. In 1989, by statute, the coinsurance rate for all members, including retirees, was not 80/20. N.C.G.S. §§ 134-40.4, -40.6 (1989). The Plaintiffs cannot conjure up a genuine dispute of material fact simply by making assertions that are contrary to law.

For the five remaining Plaintiffs, all of them testified that specific references to an 80/20 coinsurance rate were made in relation to the Plaintiff seeking information regarding their impending retirement and all of these five Plaintiffs retired within three years of being made these representations. (Blanton Dep. 88:11-90:20, 175:3-10; Buchanan Dep. 67:11-68:6, 71:18-72:9; Evans Dep. 24:7-

25:1; Hayes Dep. 113:9-117:20; Savell Dep. 76:8-25, 82:11-84:22) As discussed above with respect to the retiree healthcare enrollment forms, *see* Argument § IV.A.5, *supra*, the Plaintiffs could not have "accepted" these alleged offers "by continuing in their employment," *Faulkenbury*, 345 N.C. at 693, 483 S.E.2d at 428, because they were at the time specifically acquiring the information for the purpose of terminating their employment, not continuing it.[22]

C. The Plaintiffs' Reliance on Circumstantial Evidence Fails to Support Their Alleged Rights.

The Plaintiffs also cited circumstantial evidence. For example, several Plaintiffs cited the fact that they had an 80/20 coinsurance plan throughout, or during a significant part of, their working career. This does not support a contract.

At the outset, a substantial amount of this testimony is simply contrary to law. At least nine Plaintiffs testified that they had an 80/20 coinsurance plan at all times during their careers when they had healthcare coverage through the State Health Plan, which for many was their entire careers with the State.[23] As discussed

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[22] In addition, some of these representations were made, for example, by co-workers, future co-workers, family members, and employees of non-governmental organizations. (*E.g.*, Blanton 46:11-21; Hayes Dep. 28:15-25; Lewis Dep. 23:12-26:5; Savell Dep. 82:11-84:22) The Plaintiffs could not have reasonably believed that these individuals had any authority to make any official representations of this nature.

[23] Blanton Dep. 20:25-21:15 (testifying that "from '73 until 2004, [he] had 80/20 coinsurance"); Cooper 136:18-21 (testifying that for his first year and "[e]very year after," which was from 1975 to 2002, "it was 80/20"); Kaiser Dep.

(Footnote continued on next page.)

above, *see* Facts § I.D, *supra*, from 1982 to 1991 the coinsurance rate, as a matter of codified law, was not 80/20. Not one of the twenty-six Plaintiffs was offered an 80/20 coinsurance plan throughout his or her employment with the State, or even throughout the portion of each of their careers for which they were offered health coverage by the State. For example, Plaintiff Lewis testified (Lewis Dep. 184:13-16) that he believed he had an 80/20 coinsurance plan for his entire career (which spanned from 1982 to 2011), but he actually had an 80/20 coinsurance plan for only about half of his state tenure (from mid-1991 to 2001). Over 20,000 retirees never had an 80/20 coinsurance plan at any time during their employment. Over 60,000 class members worked the majority of their careers while the State was not offering 80/20 coinsurance benefits (and in many cases not offering premium-free benefits and in some cases not offering any benefits at all) to retirees. *See* footnote 5, *supra*.

78:6-22, 84:6-8, 112:10-17 (testifying that he had 80/20 coinsurance his entire career, from 1973 to 1998); Latta Dep. 164:5-13 (testifying that he "assumed [he] was always in the 80/20 plan" until he retired in 1991); Lewis Dep. 184:13-16, 197:5-199:3 (testifying that he believed he had 80/20 coinsurance his entire career, from 1982 to 2001); E. McAteer Dep. 41:25-42:6 (testifying that her recollection was that she had "an 80/20 traditional plan throughout [the] entire time that [she was] working," which was from 1981 to 2010); P. McAteer Dep. 36:4-7, 127:1-2 (testifying that he "always thought [he] had 80/20;" employed from 1961 to 1998); Narron Dep. 18:12-21, 26:9-11 (testifying that she was enrolled in the 80/20 plan "[t]he whole time from 1958 until 1990"); Nobles Dep. 36:2-10, 137:13-138:3, 139:20-24 (testifying that she "always had some form of an 80/20 co-insurance type health plan from the State of North Carolina" "throughout" her entire career from 1972 to 2007)

Regardless, the fact that the coinsurance rate for the State Health Plan remained constant for many years does not support the existence of a contract. For over twenty-five years the coinsurance rate was specified in statute and "no person has a vested right in a continuance of the common or statute law." *Pinkham v. Unborn Children of Jather Pinkham*, 227 N.C. 72, 78, 40 S.E.2d 690, 694 (1946) The State should not be bound to continue certain terms of benefits in any way based on the stability of those terms over the years.

Several Plaintiffs also testified, at least in part, that they believed they were entitled to the healthcare coverage that was being offered at the time that they retired. (*E.g.*, Blanton Dep. 152:21-153:9; Davis Dep. 26:8-27:3, 41:6-44:19; Evans Dep. 20:15-22, 33:18-22; Futrelle Dep. 54:16-25, 74:12-17; B. Jarvis Dep. 75:9-19, 140:4-14, 147:14-17, 161:18-21; B. Jarvis Dep. 139:8-15, 140:4-15; Latta Dep. 107:2-108:22, 112:6-10; Lewis Dep. 70:9-72:11, 82:3-83:4, Dep. 200:15-201:19; E. McAteer 74:14-19, 184:18-21; Savell Dep. 98:4-24, 173:8-15) This position is also contrary to law. *See* Argument § IV, *supra*. Even if it were not, the Plaintiffs cannot explain why this supports that the coinsurance rate must always remain the same as it was on the date of retirement, but that all other terms may change.

For all of these reasons, the evidence of record shows that the Plaintiffs cannot prove the existence of any contracts.

VII. IF THERE WERE ANY CONTRACTS, THE STATE HAS NOT BREACHED THOSE CONTRACTS.

A. To the Extent That Any Plaintiff Can Show That He or She Is Entitled to a Noncontributory Health Plan Throughout His or Her Retirement, the Defendants Have Complied With Any Such Obligation.

The only piece of the alleged contract on which all of the Plaintiffs arguably agree is that the State is barred from charging them a premium. If that is the extent of the State's contractual obligation, then the Plaintiffs have provided no evidence that the Defendants have breached that contract. At all times relevant to this action (i.e., beginning September 2011), the State Health Plan has provided to the Plaintiffs at least one plan that is noncontributory. (Moon Aff. ¶ 10) From 2011 through today, all retirees have remained eligible to enroll in the 70/30 PPO Plan, which was and still is noncontributory. (Moon Aff. (2d) ¶ 23) In addition, beginning in 2014 and running through today, non-Medicare retirees were also offered the Consumer-Directed Health Plan ("CDHP"). This plan was and still is noncontributory for qualifying members. (Moon Aff. (2d) ¶¶ 27, 29) In 2014, 95% of retirees who selected the CDHP qualified for noncontributory coverage.[24] (Collins Aff. (2d) ¶ 12 (attached at Tab 9))

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[24] The premium for the CDHP is affected by the three "Wellness Activities." These activities are: (1) Selecting a primary care physician; (2) attesting that the member does not smoke or is enrolled in a smoking cessation program; (3) completing a healthcare questionnaire. Completion of each activity results in a

(Footnote continued on next page.)

In addition, beginning in 2014 each Medicare-eligible retiree has been and still is being offered two Medicare Advantage plans that have noncontributory options. These plans are presently offered under contract with UnitedHealthcare ("UHC") and Humana. (Moon Aff. (2d) ¶ 32)

There is no dispute about these facts. Therefore, even if the evidence, in the light most favorable to the Plaintiffs, can be interpreted to support the existence of contracts for noncontributory healthcare, this Court does not even need to adjudicate whether the Plaintiffs have such contracts because there is no controversy regarding the Defendants' compliance.

B. Since the Date of the Introduction of the Premium for the 80/20 PPO Plan, the State Health Plan Has Provided the Plaintiffs With a Noncontributory Plan That Has Reimbursed Retirees at a Rate of Over 80%.

Even if the Defendants are required to provide Plaintiffs with a plan that pays their expenses at an average of 80%, the Plaintiffs have produced no evidence that the State has not provided such a plan. Although the actuarial value of the 70/30 PPO Plan is below 80%, that does not mean that the actual benefit rate under the Plan is also below 80%. In fact, at all times relevant to this matter the 70/30 PPO Plan, which has remained noncontributory for retirees, has reimbursed non-Medicare retirees on average in excess of 80%.

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discount off the CDHP premium. Completion of all three activities results in the premium being reduced to zero. (Moon Aff. (2d) ¶ 29)

Data produced by BCBSNC at the request of the Plaintiffs show that from FY 2012 to FY 2015 the 70/30 PPO Plan reimbursed non-Medicare retirees at a rate of 80.2% of allowed amounts. (Collins Aff. (2d) ¶ 5; Fish Aff. ¶¶ 3-4 (attached at Tab 12)) This date range covers the entire period from July 1, 2011 to June 30, 2015. It covers the period during which the State Health Plan was charging the contested premium to retirees for the 80/20 PPO Plan, which began September 1, 2011. As such, the Defendants have not breached any alleged contracts.

C. Since January 1, 2014 the State Health Plan Has Provided All Retirees With Healthcare Plans That Include a Coinsurance Rate of at Least 80/20 and Do Not Require a Premium.

Beginning January 1, 2014, the State Health Plan has offered all retirees at least one plan that has been noncontributory and has included a coinsurance rate that was at least 80/20.

1. Medicare-Eligible Retirees

For Medicare-eligible retirees, the State Health Plan currently contracts with two vendors to make available Medicare Advantage plans. Each vendor offers one noncontributory plan. Like the 80/20 PPO Plan, some products and services under the noncontributory Medicare Advantage plans are subject to copayments and are not covered by the coinsurance rate. However, unlike the 80/20 PPO Plan, the Medicare Advantage plans do not include a deductible. Therefore, all costs that

are subject to the coinsurance rate are reimbursed at the coinsurance rate from the first dollar spent by the member. (Moon Aff. (2d) ¶ 34)

To the extent that products and services are subject to coinsurance under the Medicare Advantage plans, the coinsurance rates in the Humana Plan are 80/20 or better, depending on the covered item. The coinsurance rate under the UHC plan is 80/20. (Moon Aff. (2d) ¶ 35) Therefore, both of these plans are noncontributory, 80/20 coinsurance plans and satisfy the Plaintiffs' alleged contractual rights.

A few Plaintiffs conceded that the Medicare Advantage plans are noncontributory, 80/20 coinsurance plans. For example, Plaintiff Latta testified that the noncontributory Humana Medicare Advantage plan is "an 80/20 plan at least." (Latta Dep. 145:25-146:3; Cooper Dep. 151:5-7 (testifying that the Medicare Advantage plans are "80/20 co-insurance rate without a premium . . . . [r]ight now"); Davis Dep. 70:4-6 (testifying that the noncontributory Humana Medicare Advantage plan "appear[s] to be a zero premium 80/20 health plan"); Nobles Dep. 122:16-126:3 (testifying that she "consider[s] [the UHC] Medicare Advantage Base Plan an 80/20 co-insurance plan" for which she does not pay a premium); *see also* Lake Dep. 30:3-12)) Others Plaintiffs simply did not know whether the Medicare Advantage plans were 80/20 coinsurance plans or how they compared to an 80/20 coinsurance plan. (Barnes Dep. 69:9-13; Blanton Dep.

216:19-217:15, 220:22-221:4; Hanes Dep. 46:22-24; B. Jarvis Dep. 163:10-14; Lewis Dep. 109:18-111:22) Regardless, the Plaintiffs never have, and cannot, defensibly explain why the Medicare Advantage plans do not satisfy the promise that has been allegedly made to them. (*E.g.*, Narron Dep. 69:3-8 (testifying that the Medicare Advantage plans were not satisfactory because her contract requires her coverage to be through BCBSNC[25]))

Accordingly, the record shows that all Medicare-eligible Plaintiffs have been offered noncontributory, 80/20 coinsurance coverage since January 1, 2014.

2. Non-Medicare-Eligible Retirees

Beginning in 2014, the State Health Plan has offered the CDHP to non-Medicare-eligible retirees. The CDHP, like the 80/20 PPO Plan, is a PPO. However, the coinsurance rate for the CDHP is 85/15. Finally, unlike the 80/20 PPO Plan, the CDHP does not use copayments for specific products and services. All products and services are subject to the deductible and coinsurance. (Moon Aff. (2d) ¶ 27)

The premium for the CDHP reduces to zero if a member completes the three Wellness Activities, which are discussed above at footnote 25, *supra*. Nine

[25] Plaintiff Narron erroneously believed that BCBSNC was providing benefits under the State Health Plan. (Narron Dep. 74:6-10) BCBSNC is the Plan's third-party administrator. It does not provide benefits to state employees or retirees and has not provided an insurance product to state retirees for over fifteen years. (Moon Aff. (2d) ¶ 27)

Plaintiffs were eligible to enroll in the CDHP when it was introduced. Of the nine, eight completed all three Wellness Activities in 2014 in order to reduce their premium for the 80/20 PPO Plan and therefore could have enrolled in the CDHP without paying a premium. The ninth Plaintiff also could have completed all of the Activities, but did not actually do so. He chose instead to enroll in the 70/30 PPO Plan, which does not offer Wellness Activities incentives.[26] As indicated above, 95% of retirees who enrolled in the CDHP in 2014 received the Plan at no premium. Further, of the nearly 27,000 retirees who enrolled in the 80/20 PPO in 2014, 91% completed all of the Wellness Activities and therefore could have enrolled in the CDHP premium-free. (Collins Aff. (2d) ¶ 12) There is no legal reason why the remaining CDHP or 80/20 PPO enrollees could not have also completed the Wellness Activities. They may have chosen not to, or simply failed to complete the process by the deadline. (Moon Aff. (2d) ¶ 31)

As with the Medicare Advantage plans, the Plaintiffs could not show or explain why the CDHP did not comply with their alleged contracts. For example, one Plaintiff contended that the CDHP has a higher deductible than the 80/20 PPO

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[26] The 80/20 PPO Plan and the CDHP use the same Wellness Activities to provide members with a reduction in the premium. The records of the eight Plaintiffs discussed above show that they paid the lowest possible premium under the 80/20 PPO Plan in 2014, which confirms that they completed all of the Wellness Activities. (*See* Defs.' 4th Supp. & Am. Resp. to Pls.' 2d Set of Interrogs. at 2-3 (Interrog. No. 9) & Ex A-5 (Sept. 8, 2016))

Plan. (Hayes Dep. 84:5-20) The CDHP has a $1500 deductible, but the State pays the first $600 (or more[27]) of the deductible, effectively lowering it to $900 (or less). (Moon Aff. (2d) ¶ 30) The 80/20 PPO Plan has a $700 deductible. However, this Plaintiff had previously unequivocally testified that the State never promised him what the deductible would be during his retirement and that he was not aware of any limits that his contract placed on changes to the deductible. (Hayes Dep. 64:19-65:18) Therefore, if the Plaintiffs prove that they have a contract, the CDHP satisfies the Plaintiffs' alleged entitlement to a noncontributory, 80/20 coinsurance plan.

Finally, the available expert testimony shows that both the Medicare Advantage base plans and the CDHP comply with the terms asserted by the Plaintiffs in the unverified response to Interrogatory No. 1 as well. Both have had an actuarial value of 80% or more in 2014, 2015 and 2016 – each year that they have existed. (Fuhrer Aff. ¶ 10)

For all of these reasons, the Defendants did not breach any alleged contracts.

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[27] Under the CDHP, members can earn credits of a $100 or more per year on top of the State's initial $600 contribution for activities such as visiting their selected primary care provider. In addition, the money that the State contributes to the HRA is placed in a member-specific account. Any unused funds carry over to the next year. (Moon Aff. (2d) ¶ 30)

VIII. IF THERE WERE ANY CONTRACTS, THE STATE HAS NOT IMPAIRED THOSE CONTRACTS.

The Plaintiffs have alleged that the Defendants have impaired their contractual rights in violation of the North Carolina and United States Constitutions. (Compl. ¶¶ 76-78) This cause of action requires in part a showing that a contract existed and was "impaired." *Faulkenbury*, 345 N.C. at 690, 483 S.E.2d at 427. Because there are no contracts, the Plaintiffs have no claim.

Regarding "impairment," according to the federal courts, a State does not impair its own contract merely by breaching it. In order to prove an unconstitutional impairment, a plaintiff must show that despite a breach, intervening legislation has "extinguished any remedy that the plaintiff would otherwise have had" to redress that breach. *Cherry v. Mayor & Balt. City*, 762 F.3d 366, 371 (4th Cir.), *cert. denied*, 135 S. Ct. 768, 190 L. Ed. 2d 641 (2014) (citations, quotations marks and brackets omitted). The Plaintiffs have not shown that any legislation has extinguished their common-law breach action. Therefore, the Plaintiffs have no support for their impairment action from the federal courts.

The State's courts tend more to equate the impairment prong of the constitutional action with a common-law breach.[28] *See, e.g., Wiggs v. Edgecombe*

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[28] The difference between the state and federal courts does not appear to be based on any differences between the state and federal constitutions but instead on differing applications of the federal constitution. *See Bailey*, 348 N.C. at 140-41,

(Footnote continued on next page.)

County, 361 N.C. 318, 324, 643 S.E.2d 904, 908 (2007). Because the facts reveal that there has been no breach, there is no impairment in the view of the State's courts either.[29]

IX. THE PLAINTIFFS DO NOT HAVE A CONTRACTUAL RIGHT TO THE 90/10 PPO PLAN.

Despite the allegations in the Complaint and the unverified response to Interrogatory No. 1 that the Plaintiffs are entitled to a 90/10 coinsurance healthcare plan that requires payment of a partial premium, only one Plaintiff testified that he believed that this was part of his contract. (Hayes Dep. 101:5-10, 121:7-122; *but see id.* at 72:16-73:5 (testifying earlier that it was not)) Regardless, the Plaintiffs' claim to a 90/10 plan suffers from all of the same problems faced by their assertion of a right to the 80/20 coinsurance plan. In addition, all but six of the Plaintiffs, including the only Plaintiff who actually asserted a right to the 90/10 PPO Plan, retired before the 90/10 PPO Plan ever existed. *See* Appx. E. The benefits at issue in *Bailey* and similar cases were properly characterized as deferred compensation. *E.g.*, *Bailey*, 348 N.C. at 141, 500 S.E.2d at 60. For any employee who left the

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500 S.E.2d at 60; *Crosby v. City of Gastonia*, 682 F. Supp. 2d 537, 544 n.6 (W.D.N.C. 2010), *aff'd*, 635 F.3d 634 (4th Cir.), *cert. denied*, 565 U.S. 823, 181 L. Ed. 2d 37 (2011).

[29] The State does not seek summary judgment based on the third prong of the impairment test, which asks whether the impairment "was reasonable and necessary to serve an important public purpose." *Faulkenbury*, 345 N.C. at 690, 483 S.E.2d at 426.

employ of the State (by retirement or otherwise) before the 90/10 PPO Plan was ever offered to employees, the Plan cannot be deferred compensation because it could not have been accepted in exchange for the employees' work.

As to the Plaintiffs who were still working when the 90/10 PPO Plan existed, their argument – if they had made one – for a partially-contributory 90/10 coinsurance plan would fare no better. First, the 90/10 PPO Plan did not exist on the date that any Plaintiff "vested," which is the determinative date if the Plaintiffs did have contracts. *See* Argument § IV, *supra*. Second, the contention that a retiree has a right to a plan that existed at some point during their career again proves too much. It would force the State Health Plan to resurrect any iteration of any plan that was ever offered during any retiree's career as a state employee.

There is also no statutory basis for a claim to a partially-contributory, 90/10 coinsurance plan. At no time did the General Assembly codify together a 90/10 coinsurance rate and a partially-contributory premium for the retiree population. For all of these reasons, the Plaintiffs' claim to the 90/10 PPO Plan fails.

X. THE PLAINTIFFS' OTHER CLAIMS ARE GENERALLY ROOTED IN THE SAME BASIC CONTENTION THAT THEY HAVE SOME RIGHT TO THE HEALTHCARE PLANS THAT THEY HAVE ALLEGED, AND THEREFORE THESE CLAIMS LACK MERIT FOR THE REASONS DISCUSSED ABOVE.

The Plaintiffs have alleged a variety of other claims which, for the most part, are built around their alleged rights to 80/20 and 90/10 coinsurance plans. These

claims are for violation of due process protections, violation of equal protection principles, mandamus and/or injunctive relief, declaratory judgment, and a constructive trust or common fund. (Compl. ¶¶ 79-97) All but the equal protection claim are grounded on the allegation that the Plaintiffs have been deprived of some right to the healthcare plans that the Plaintiffs allege are contractual. For all of the reasons stated above, the Plaintiffs have no contractual or other right to have the Defendants provide the plans that the Plaintiffs seek and if they did, the Defendants have complied with their obligations.

The equal protection claim requires that the Plaintiffs demonstrate that they were dissimilarly treated arbitrarily from "those similarly situated." *Lea v. Grier*, 156 N.C. App. 503, 509, 577 S.E.2d 411, 416 (2003). When premiums were initiated for individual retirees for the 80/20 PPO Plan, identical or higher premiums were also initiated for individual employees for the 80/20 PPO Plan. (Moon Aff. (2d) ¶ 26 & Ex. B) When the 90/10 PPO Plan was terminated for retirees, it was also terminated for all members of the State Health Plan. (Moon Aff. (2d) ¶ 24 & Ex. B) These undisputed facts defeat the Plaintiffs' equal protection claim.

Accordingly, all of the Plaintiffs' remaining claims fail.

CONCLUSION

For all of the foregoing reasons, there are no material facts in dispute and the Defendants are entitled to judgment as a matter of law.

DATE: September 14, 2016.

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CERTIFICATE OF SERVICE

The undersigned certifies that the foregoing Defendants' Memorandum of Law in Support of Summary Judgment on Liability has been served on the following counsel for the parties by first-class USPS mail, postage pre-paid and by electronic mail at the following addresses:

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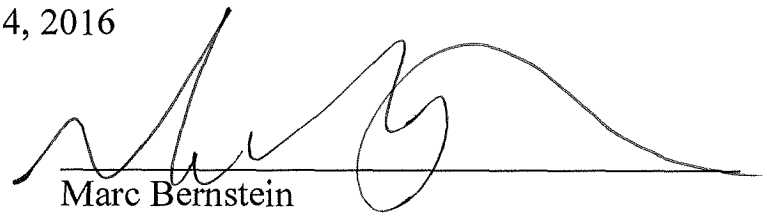

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