BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS

In the Matter of	)	
	)	
L.D	)	OAH No. 25-1563-PER
	)	

DECISION ON SUMMARY ADJUDICATION

I. Introduction

The AlaskaCare Retiree Insurance Plan ("AlaskaCare" or the "Plan") is a self-insurance program administered by the Division of Retirement and Benefits (the "Division") that provides medical coverage to retired members of the Public Employees Retirement System ("PERS"). Under longstanding rules, Plan members must pay an annual out-of-pocket deductible of $150, along with coinsurance of 20% on the first $4,000 of covered expenses. Once these deductible and coinsurance requirements have been met, AlaskaCare will typically pay 100% of a retiree's covered medical expenses.[1]

Once retirees reach age 65, AlaskaCare coverage becomes secondary to that provided by the federal Medicare program. Like AlaskaCare, Medicare also requires payment of a deductible for medical coverage (which was $240 as of 2025), and a 20% coinsurance requirement.[2] This raises the question of what out-of-pocket costs retirees will pay when Medicare and AlaskaCare apply their separate deductible and coinsurance requirements to a given medical bill.

Here, Mr. D incurred an out-of-pocket expense of $94.91 for a medical bill where Medicare and AlaskaCare applied their separate deductible and coinsurance requirements. Mr. D contends that AlaskaCare should have paid everything that Medicaid refused to pay. However, as will be discussed below, the Division correctly applied the AlaskaCare rules, and Mr. D has offered no justification for deviating from them. Therefore, the Division's processing of the $94.91 medical bill at issue here is AFFIRMED.

II. Facts

The terms and conditions for the coverage provided by AlaskaCare are set out in a Retiree Insurance Information Booklet (the "Information Booklet") that is published by the Division on an annual basis. Since "there is no other document setting out the contractual

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[1] AlaskaCare coverage is provided at no cost to retired PERS members who began working for a participating employer prior to July 1, 2006, along with certain eligible members of a retiree's family. *See generally* https://drb.alaska.gov/docs/flyers/newlawin.pdf (accessed November 24, 2025).

[2] *See* https://www.cms.gov/newsroom/fact-sheets/2025-medicare-parts-b-premiums-and-deductibles (accessed November 25, 2025). The Medicare deductible at the time of this decision is now $257.

obligations of the Plan, this Information Booklet is the insurance contract for Plan members."[3] The Plan requires an annual deductible of $150, along with a coinsurance of 20% on the first $4,000 of covered expenses.[4] Benefits provided by AlaskaCare "become supplemental" to members age 65 who are eligible for Medicare.[5]

Mr. D is a PERS member who retired in 2013 at age 55 after 37 years of state service.[6] Shortly before retiring, he attended a seminar sponsored by the Division where he recalls the following discussion regarding the coordination of benefits between AlaskaCare and Medicare:

> I was told that Medicare and AlaskaCare equated to dual coverage and essentially coverage would be 100% . . . I questioned the coordination of benefits example on [Page 103] of [the] then current retiree booklet showing a deductible, but also with 100% coverage. I was told this example demonstrated the concept that the dual Medicare + AlaskaCare coverage was 100%. As a result of this discussion, I budgeted for maximum deductible/co-pay for my wife and I until we achieved 65 and for required Medicare B expenses after that. I did not budget for the unanticipated deductible/co-pay after Medicare.[7]

Turning to the 2013 Information Booklet, the following coordination of benefits example appears at Page 103:[8]

Example

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

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

[3] *In re D.T.*, OAH No. 10-0577-PER at 2 (2011).

[4] Agency Record at 16. These provisions can be found at Sections 3.1.2 and 3.1.3 of the 2024 Information Booklet (accessible at https://drb.alaska.gov/docs/booklets/DB-RetireeInsuranceBooklet_2024.pdf).

[5] Agency Record 16-17; 2024 Information Booklet at Section 3.1.7.

[6] Mr. D's Motion for Summary Adjudication (the "D Motion") at 1.

[7] *Id.*

[8] *See* 2013 Information Booklet (accessible at https://drb.alaska.gov/docs/booklets/amendments/Retiree_Insurance_Booklet_2003_2013update.pdf).

This example was not altered to specifically reference Medicare until 2016, when it was revised by the Division as follows:[9]

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

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

This example has appeared in all versions of the Information Booklet the Division has published since that time.[10]

Mr. D applied for Medicare benefits after he turned 65 in 2023.[11] In May 2024, he had an office visit with a primary care provider for which the Medicare approved value of services was $363.01.[12] At that time Mr. D had not satisfied his deductible or coinsurance requirements for either Medicare or AlaskaCare. Thus, in processing this bill Medicare first applied its $240 deductible. This left a subtotal of $123.01 that was reduced by an additional 20% for coinsurance. These deductions meant that Medicare paid only $98.41 of this bill, leaving an unpaid balance of $264.60.[13]

When this bill was submitted to AlaskaCare for secondary coverage, two different program rules set out in the 2024 Information Booklet came into play. The first is a general rule which provides that, when AlaskaCare is providing secondary coverage, the amount it will pay is calculated by "subtracting the benefits payable by the other plan from 100% of expenses covered by [AlaskaCare] on that claim."[14] The second rule limits the scope of the first by providing that,

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9 *See* https://drb.alaska.gov/docs/booklets/amendments/retireePlanAmendment05252016.pdf. This example is also cited by the Division in its briefing. *See* Division Motion for Summary Adjudication (the "Division Motion") at 7.

10 *See* https://drb.alaska.gov/retiree/healthplans.html#retireebooklets.

11 D Motion at 1.

12 Agency Record at 15-16.

13 *Id.*

14 *Id.* at 47 (citing Section 14.1.1(a) of the 2024 Information Booklet).

when AlaskaCare is providing secondary coverage, it will not pay more than if there had been "no coordination of benefits" with the primary insurer.[15] Or phrased more succinctly, when providing secondary coverage AlaskaCare will not pay more than it would have had it been the primary insurer. Both these rules have been in place for at least two decades.[16]

Based on these rules, when AlaskaCare processed Mr. D's medical bill it first calculated what it would have paid had it been providing primary coverage. This was a straightforward mathematical exercise where the total claim of $363.01 was first reduced by the deductible amount of $150, which left a subtotal of $213.01. This was reduced by an additional 20% for coinsurance, which meant the maximum payment owed by AlaskaCare was capped at $170.41. Thus, of the total approved expense of $363.01, the amounts paid by Medicare and AlaskaCare totaled only $268.82.[17] This left Mr. D with an out-of-pocket expense of $94.91.[18]

Believing that AlaskaCare should have paid the full balance that was not covered by Medicare, Mr. D timely pursued informal appeals with the Division. When these were denied, he filed this formal appeal with the Office of Administrative Hearings ("OAH"). At the initial case planning conference, both sides agreed this dispute centered on questions of law best resolved through a motion for summary adjudication.

Throughout this appeal process, Mr. D has advanced two primary arguments. First, he claims that the AlaskaCare rules discussed above were not adopted by the Division until 2016 – which was well after Mr. D's state service and retirement. Since Alaska law prohibits retroactive reductions to the retirement benefits afforded to state employees, Mr. D asserts that, consistent with rules that existed prior to 2016, AlaskaCare should have paid 100% of the costs that Medicare did not pay.

Second, Mr. D argues that, consistent with the assurances he was given during the retirement seminar he attended, the Division is obligated to pay all of the costs related to his office visit. This argument implicates the legal doctrine of equitable estoppel that will be discussed below.

Finally, Mr. D notes that the Division failed to rule on a "third level" informal appeal within the time limits set out in the Information Booklet. He asks for the Division to be

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15 *Id.* (citing Section 14.1.1(d) of the 2024 Information Booklet).
16 *See* 2003 AlaskaCare Retiree Information Booklet at 102.
17 Agency Record at 15-16.
18 Division Motion for Summary Adjudication at 9.

penalized for its tardiness by having his appeal granted even if the other arguments he presents are found to lack merit.

III. Discussion

A. The Division correctly applied AlaskaCare program rules governing deductible and coinsurance requirements were well established prior to 2016.

The Division is responsible for administering the AlaskaCare Plan and has been delegated the duties of evaluating claims and publishing the annual Retiree Insurance Information Booklets which set out the Plan's terms and conditions.[19] The Division has the authority to modify the Plan's terms and conditions and adopt related internal management regulations.[20]

However, the Division's authority to modify AlaskaCare's terms and conditions is limited by Article 12, Section 7 of the Alaska Constitution, which provides that accrued benefits in public retirement "shall not be diminished or impaired." The terms "accrued benefits" has been broadly interpreted to encompass all benefits that "make up the retirement benefit package that becomes part of the contract of employment when the public employee is hired, including health insurance benefits."[21] To the extent the Division makes changes to the Plan, any "disadvantageous changes must be offset by comparable new beneficial changes."[22]

Mr. D contends that the AlaskaCare rules regarding the coordination of benefits that were applied to his claim were not adopted until 2016. Because of this, he believes these rules cannot be applied to him since doing so would retroactively diminish the benefits that were in place at the time that he began his state service. Understanding this argument requires familiarity with a past OAH decision, *In re C.P.*,[23] and the way the Division responded to that decision in 2016.

Akin to the facts here, *C.P.* featured a scenario where an AlaskaCare beneficiary incurred an out-of-pocket expense of $44.60 after Medicare and AlaskaCare applied their separate deductible and coinsurance requirements to a series of related medical bills. As Mr. D does here, the Plan member in *C.P.* argued that AlaskaCare should have paid everything that was not

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19 AS 39.35.004.

20 AS 39.35.005; 2 AAC 39.390.

21 *Duncan v. Retired Pub. Employees of Alaska, Inc*., 71 P.3d 882, 888 (Alaska 2003); *Hammond v.Hoffbeck*, 627 P.2d 1052, 1057 (Alaska 1981).

22 *Duncan*, 71 P.3d at 891-92.

23 OAH No. 15-0283-PER (2016).

covered by Medicare.[24] The administrative law judge ("ALJ") presented with this dispute focused almost exclusively on the following provision from the applicable Information Booklet:

> When the retiree health plan is secondary, the amount it will pay will be figured by subtracting the benefits payable by the other plan from 100% of expenses covered by the retiree plan on that claim. The plan pays the difference between the amount the other plan paid and 100% of expenses the retiree plan would cover.[25]

Since this provision does not reference any reduction in coverage to account for AlaskaCare's deductible and coinsurance requirements, the ALJ held that that Division could not apply those to the claim at issue in that matter.[26]

However, this decision failed to address the very next provision in the applicable Information Booklet, which capped AlaskaCare's liability when providing secondary coverage as follows:

> *Neither plan pays more than it would without coordination of benefits*. Benefits payable under another plan include the benefits that would have been payable whether or not a claim was actually submitted to the plan.[27]

As mentioned above, the effect of this provision is to cap AlaskaCare's liability as a secondary insurer at the amount it would have paid if it had been providing primary coverage. Since AlaskaCare would not have been responsible for the disputed out-of-pocket cost if it was the primary insurer, it was accordingly not responsible for paying this cost in its secondary role.[28]

For understandable reasons, the Division regarded *C.P.* as erroneously decided. For reasons not disclosed in the record, however, the Division did not appeal this decision to the superior court.[29] Instead, approximately one month after the *C.P.* decision was issued, the Division adopted an amendment to the AlaskaCare that added the following sentence at two different locations of the Retiree Information Booklet:

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[24] *Id.* at 3.

[25] *Id.* at 2. This is the same provision found at Page 102 of the 2013 Information Booklet.

[26] *Id.* at 5.

[27] *See* Footnote 8, *supra* (emphasis added).

[28] Insurance contracts are commonly structured in a manner where a broad statement regarding the scope of coverage is followed by a series of narrowing exclusions or limitations. The fact an insurance contract is structured in this manner does not allow a tribunal interpreting that contract to ignore those exclusions or limitations. *See, e.g., Whittier Props., Inc. v. Alaska Nat. Ins. Co*., 185 P.3d 84, 89 (Alaska 2008) (applying pollution exclusion to limit otherwise broad scope of property damage covered by a general liability policy).

[29] To be clear, there is obvious logic in the Division's decision not to incur the costs of appealing an administrative decision where the amount in dispute was less than $50. As discussed below, however, this approach left unsettled issues that would eventually require superior court litigation to resolve.

> Relevant deductibles, coinsurance and out-of-pocket limits continue to apply to both Medicare and the Plan.[30]

Additionally, the Division deleted the example showing the interplay between primary and secondary coverage that had been a part of the information booklet since at least 2003 and replaced it with the example referenced above where Medicare was shown as the primary insurer.[31]

In 2018, a non-profit organization representing the interests of retired Alaska public employees filed a superior court lawsuit that sought an order invalidating this amendment based on the *C.P.* decision.[32] This lawsuit was eventually dismissed through a summary judgment ruling in which the court noted that, since AlaskaCare's inception in 1975, the Plan's rules have required that "both Plan and Medicare deductibles must be satisfied for supplemental coverage."[33] Based on this longstanding approach, the court ruled that the amendment the Division issued in 2016 was a permissible clarification of Plan rules that appropriately corrected the erroneous administrative interpretation set out in the *C.P.* decision.[34] As the court noted in summarizing its decision, "The effect of the Amendment is the same before and after its adoption: in order to receive both health insurances, their requisite deductibles must be satisfied by the plan member."[35]

After this decision was issued, the Plan beneficiary in the *C.P.* matter pursued subsequent administrative appeals where he argued that the 2016 amendment did not apply to him. This was rejected in a second OAH decision which concluded as follows:

> Ultimately, [the Division] had authority to Amend the Plan. That Amendment did not change the Plan; it clarified [the Division's] longstanding practice of charging deductibles. Thus the Amendment did not diminish benefits for the Plan members as a whole. The prior OAH decision and superior court decision do not shield Mr. P. from that Amendment.[36]

For these reasons, the decision concluded that Mr. P. was obligated to satisfy the deductibles for both AlaskaCare and Medicare under the corrective amendment the Division issued in 2016.[37]

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30 AlaskaCare Retiree Health Plan Amendment No. 2016-2 (effective May 25, 2016), attached as Exhibit B to Division's Motion for Summary Adjudication.

31 *See* Page 3 above.

32 *The Retired Public Employees of Alaska, Inc. v. State Dep't of Admin., Division of Retirement & Benefits,* 3AN-18-06722CI.

33 Exhibit A to Division's Motion for Summary Adjudication at 13.

34 *Id.* at 14.

35 *Id.* at 20.

36 *In re C.P.,* OAH No. 20-0902-PER and 21-2489-PER at 1 (2022) (accessible at https://aws.state.ak.us/OAH/Decision/Display?rec=7084).

37 *Id.* at 13.

Thus, Mr. D's assertion that retirees were not required to satisfy the deductible and coinsurance requirements of both AlaskaCare and Medicare prior to 2016 is simply incorrect. To the contrary, this has been a longstanding requirement that was simply re-affirmed through the Plan amendment the Division adopted in 2016. This effectively forecloses Mr. D's argument that the terms of the 2024 Information Booklet should not be applied to the medical bill at issue here.

In his briefing, Mr. D tacitly concedes that his claim was processed in a manner consistent with the 2024 Information Booklet. There is little room for debate on this point, given the language in Section 3.17 of that booklet which directly provides that "[r]elevant deductible, coinsurance amounts and out-of-pocket limits continue to apply to both Medicare and the Plan." In short, the Division correctly followed the applicable AlaskaCare rules in calculating that Mr. D was responsible for the $94.91 out-of-pocket cost at issue here.

B. Statements allegedly made to Mr. D in 2013 do not prevent the Division from applying the AlaskaCare deductible and coinsurance rules discussed above.

Mr. D contends that he was told in late-2012 or early-2013 that AlaskaCare would be coordinated with Medicare in a manner that eliminated all out-of-pocket costs for Plan beneficiaries, and that the Division should not be allowed to depart from those assurances here. Whether the Division is bound by representations that an unidentified employee made over a decade ago is an issue that must be resolved under legal doctrine of equitable estoppel. Under this doctrine, a government agency is bound by representations made by its employees if the following four elements are present:

> (1) the governmental body asserts a position by conduct or words; (2) the private party acts in reasonable reliance thereon; (3) the private party suffers resulting prejudice; and (4) the estoppel serves the interest of justice so as to limit public injury.[38]

Under this last element, it has been held that equitable estoppel cannot be used to compel a state agency "to take unlawful or otherwise unauthorized action."[39]

The doctrine is intended to protect private parties from harm when they reasonably rely to their detriment upon official guidance that ultimately proves to be inaccurate.[40] Here, Mr. D asserts that a Division representative assured him that "Medicare and AlaskaCare equated to dual

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38 *Crum v. Stalnaker*, 936 P.2d 1254, 1256 (Alaska 1997).
39 *Alaska Trademark Shellfish, LLC v. State, Dep't of Fish & Game*, 91 P.3d 953, 960 (Alaska 2004).
40 *See, e.g., Veco International, Inc. v. Alaska Public Offices Comm'n*, 753 P.2d 703, 709-710 (Alaska 1988).

coverage and essentially coverage would be 100%."[41] Notably, however, Mr. D does not contend that he was told that he would never incur any type of out-of-pocket cost after enrolling for Medicare. This is a crucial distinction since the fact that a given cost is covered by medical insurance does not foreclose the possibility that a deductible or coinsurance requirement may also apply.

This analysis does not conflict with the hypothetical example found at Page 103 of the 2013 Information Booklet. That example illustrated how AlaskaCare would coordinate coverage with another insurer when a Plan member who had not satisfied either insurer's deductible had a covered medical expense of $1,000. The simple formulas used to calculate what these two unrelated insurers would pay are entirely accurate. While this example showed an outcome where AlaskaCare and the other insurer would cumulatively pay 100% of a covered medical cost of $1,000, as would be expected different results are obtained when a different starting number is plugged into those formulas. For example, if a covered cost of $400 is entered into these formulas, the result would show that a Plan member had a small out-of-pocket cost.[42] Thus, this is not a situation where the Division offered guidance to Mr. D that conflicted with the Plan's actual terms.

This obviously begs the question of how it is possible for an out-of-pocket cost to result from a $400 medical expense, while a $1,000 expense would not. The answer is driven by straightforward mathematics. As covered above, AlaskaCare will not pay more in a secondary role than it would have as the primary insurer.[43] Thus, even when providing secondary coverage AlaskaCare will apply its standard deductible and coinsurance requirements. Given this, whether a Plan member will have to pay an out-of-pocket cost on a given claim is controlled by the type of coverage provided by the primary insurer.

In 2024, Medicare would pay 80% of a member's covered medical costs after first assessing a $240 deductible.[44] In other words, for claims that were $240 or less, Medicare would pay nothing. As a result, for these smaller claims Plan members would pay the same AlaskaCare deductible and coinsurance as someone who was not yet Medicare-eligible. Accordingly, for a hypothetical claim of exactly $240, a Plan member who had not yet satisfied his annual

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41 D Motion at 1.

42 If a covered expense of $400 had been used in lieu of the $1,000 figure used in that example shown at Page 103 of the 2013 Information Book, those same formulas would have shown an out-of-pocket cost of $80.

43 *See* Section 14.1.1(d) of the 2024 Information Booklet ("[n]either plan pays more than it would without coordination of benefits").

44 *See* Footnote 2, *supra.*

deductibles would have an out-of-pocket cost of $168.[45] For claims increasing in size from that point, the out-of-pocket cost would go down. This follows from Medicare picking up 80% of all costs above its deductible amount. In effect, the payment made by Medicare would start filling the "out-of-pocket gap." As the amount paid by Medicare increases, the amount of this gap decreases. This is why Mr. D, who had a covered cost of $363.01, had an out-of-pocket cost of less than $95.

Playing the numbers forward shows that there is a "tipping point" where Medicare begins to pay enough that it will – consistent with the example that the Division added to the Information Booklet in 2016 – effectively eliminate any out-of-pocket cost. In 2024, this "tipping point" was $520.[46] Above this tipping point, Plan members would not incur any out-of-pocket cost – even if they have not previously paid down their Medicare or AlaskaCare deductibles. While it seems counterintuitive that a smaller claim could result in an out-of-pocket cost, while a claim greater than $520 would not, this result is compelled by the unambiguous terms of the Plan.[47] It is also consistent with the formulas show in the 2024 Information Booklet (which shows the interaction between Medicare and AlaskaCare for a covered medical expense of $1,000).

With this factual and mathematical backdrop, it becomes apparent that the Division did not provide inaccurate information to Mr. D that would justify application of the equitable estoppel doctrine here. This is not a situation where Mr. D was unambiguously advised that he would never have to pay anything out of his own pocket for medical expenses after he was covered by Medicare. Instead, in the context of a public retirement seminar, Mr. D was advised that the coverage provided by Medicare and AlaskaCare is "essentially 100%." Objectively viewed, this statement cannot be taken as a promise so definitive that it would override the Plan terms set out in the Information Booklet.

Even if Mr. D had been offered some iron-clad assurance that he would never have to pay any type of deductible or coinsurance once he was covered by Medicare, he would not prevail here due to his failure to prove the element of reasonable reliance. Equitable estoppel is a doctrine that comes into play when a private party facing alternative courses of action makes a

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[45] This is calculated by first subtracting AlaskaCare's $150 deductible, and multiply the resulting figure (i.e., $90) by the 80% coinsurance percentage. To be clear, this hypothetical assumes that neither the AlaskaCare or Medicare deductible had not been satisfied in whole or in part.

[46] It is vital to note that this number will go up by a small amount as the Medicare deductible, which is tied to inflation, increases incrementally on an annual basis.

[47] 2024 Information Booklet at § 3.17 and 14.1.

choice based upon inaccurate information provided by an agency employee.[48] Here, however, Mr. D did not have any choice to make upon reaching age 65. To the contrary, the Information Booklets published by the Division have consistently advised that Plan members must elect Medicare Part A and B when they reach age 65, with AlaskaCare providing strictly secondary coverage from that point forward.[49] While Mr. D claims that he failed to budget for the possibility of out-of-pocket costs based on the information he was provided at the retirement seminar he attended,[50] these were not costs that he could have avoided by making some different choice when he retired, or when he applied for Medicare benefits.

Finally, even if Mr. D was reasonably misled by the information he was provided at the retirement seminar he attended, any reliance on that misinformation would not have been reasonable after the Division amended the Plan in 2016 to make it clear that Plan members over the age of 65 would be responsible for paying both Medicare and Alaska deductibles. As the Alaska Supreme Court has noted, even in circumstances where an agency has offered misleading guidance to a private party, reliance upon that guidance ceases to be "reasonable" for equitable estoppel purposes after an agency provides corrective or clarifying information.[51]

For these reasons, the doctrine of equitable estoppel does not apply here. Regardless of how Mr. D subjectively interpreted the information provided at the retirement seminar he attended, he remains responsible for the out-of-pocket cost that is the subject of this appeal.

C. Delays in Processing Mr. D's informal appeals do not alter the outcome here.

Prior to filing this formal appeal, Mr. D went through the Division's multi-level appeal process set out in § 12.14 of the 2024 Information Booklet. Consistent with the requirements set out therein, Mr. D submitted a "third level appeal" that was received by the Division on December 3, 2024.[52] The Division's response was due within 60 days of that date (i.e., February 3, 2024).[53] The Division was unable to meet that deadline. On February 4, 2024, the Division issued a letter to Mr. D advising that the processing of his appeal had been delayed, and that a

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48 *See Boyd v. State, Dep't of Commerce & Econ. Dev., Div. of Occupational Licensing*, 977 P.2d 113, 116-17 (Alaska 1999) (to invoke equitable estoppel against the State, a party must show reasonable detrimental reliance).

49 2024 Information Booklet at § 3.17; 2013 Information Booklet at p. 16.

50 D Motion at 1.

51 *Veco International,* 753 P.2d at 709-10 (Alaska 1988).

52 Agency Record at 22.

53 2024 Information Booklet at §12.14.13.

decision would be issued by March 5.[54] The Division's decision denying the appeal was finally issued on March 13, 2025.[55]

Mr. D argues that the Division should be sanctioned for this delay by having his appeal granted – which would leave the Division responsible for paying the out-of-pocket cost of $94.91. However, Mr. D does not point to any provision in the Information Booklet that would render the Division liable for disputed costs whenever it fails to decide a Level 3 appeal within the 60-day deadline, nor does an independent review of the booklet's provisions disclose any such provision. Nor does there appear to be any statute or regulation that would penalize the Division in this manner for a tardy appeal decision.

Under Alaska law, procedural rules such as this are classified as either "directory" or "mandatory." A rule is considered directory, and thus only requires substantial compliance, if (1) the rule's wording is affirmative rather than prohibitive; (2) the intent of the rule was to create guidelines for the orderly conduct of public business; and (3) serious, practical consequences would result if it were considered mandatory.[56] In contrast, a mandatory rule requires strict compliance to avoid imposition of sanctions or loss of legal rights.[57]

In the absence of any express provision for a penalty or other consequence for untimely action, time limits on state agency action are generally considered directory, rather than mandatory.[58] As the Division correctly notes here, the apparent purpose of the 60-day timeframe is promotion of prompt appeals processing, rather than the establishment of substantive rights or penalties.[59] It is also clear that serious practical financial consequences would result if the Division's failure to comply with the 60-day deadline left it obligated to pay the full amount of a disputed claim. In this regard, it should be noted that while the amount in dispute here is less than $100, the appeals handled by the Division typically involve much larger claims.

While the Division clearly fell short of the timeliness goal set out in the 2024 Information Booklet, its delayed decision on Mr. D's Level 3 appeal substantially complied with the 60-day deadline. Accordingly, Mr. D's argument on this point is rejected.

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54 Exhibit D to Division Motion at 1.
55 Agency Record at 15-17.
56 *South Anchorage Concerned Coal., Inc. v. Mun. of Anchorage Bd. of Adjustment*, 172 P.3d 768, 771-72 (Alaska 2007).
57 *Id.*
58 *In re ASRC Communications, Ltd*., OAH No. 04-0007-CON, n. 23 (Comm'r Dept. of Administration, 2005) *citing State, Div. of Insurance v. Schnell*, 8 P3d 351, 257 (Alaska 2000).
59 Division Motion at 21.

IV. Conclusion

Mr. D is understandably puzzled by a system where Plan members can face out-of-pocket costs for medical bills that are roughly $500 or less, yet pay nothing for larger bills. However, this is the outcome mandated by clear and unambiguous Plan rules that have been in place for decades. While Mr. D clearly believes that it would be prudent to modify these rules, such relief is well beyond the authority of this tribunal to grant. Accordingly, the Division's denial of Mr. D's claim for reimbursement of the out-of-pocket cost of $94.91 at issue here is AFFIRMED.

DATED: December 23, 2025.

By: *Signed*
Max Garner
Administrative Law Judge

ADOPTION

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

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

DATED this 22nd day of January, 2026.

By: *Signed*
Max Garner
Administrative Law Judge

[This document has been modified to conform to the technical standards for publication. Names may have been changed to protect privacy.]