

IN THE SUPREME COURT OF MISSOURI

No. SC88954

**ST. LOUIS POLICE OFFICERS' ASSOCIATION,
GARY PHELPS and WILLIAM GOODEN,**

Appellants

vs.

**BOARD OF POLICE COMMISSIONERS OF THE CITY OF ST. LOUIS,
CHRIS GOODSON, JOANN F. MORROW, MICHAEL J. QUINN,
JULIUS K. HUNTER and FRANCIS G. SLAY,**

Respondents

**On Appeal from the Circuit Court of the City of St. Louis
State of Missouri
Twenty-Second Judicial Circuit
The Honorable Julian L. Bush**

SUBSTITUTE BRIEF OF APPELLANTS PURSUANT TO RULE 83.08(b)

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JURISDICTIONAL STATEMENT

The lawsuit from which this appeal arises involves the construction and application of §84.160.8(3), R.S.Mo. The principle issue is whether the drastic degradation in health insurance benefits for retired police officers implemented by the St. Louis Metropolitan Police Department satisfies the statute's mandate. This law requires that the Department provide health insurance coverage to retired police officers. It is Appellants' position that the reduction in benefits was so substantial that it failed to satisfy the Department's statutory obligation.

On December 18, 2007, this Court granted the Appellants' motion for transfer, and ordered the Missouri Court of Appeals, Eastern District, to send to it the record in this appeal. The December 18, 2007 transfer order was entered pursuant to Rule 83.04, and this Court now has jurisdiction over this appeal pursuant to Art. V, §10 of the Missouri Constitution.

STATEMENT OF FACTS

Missouri law requires that the Board of the Police Commissioners of the City of St. Louis ("Department") "provide health [and] medical . . . insurance coverage for retired officers . . . of the police department." § 84.160.8(3), R.S.Mo. ("Retiree Health Insurance Statute"). This case represents the second lawsuit in recent years between the Department and retired officers of the Department ("Retirees") with respect to the meaning of this provision. A discussion of the prior dispute follows.

I. The First Dispute

Prior to 2001, the Department provided health insurance coverage free of charge to the Retirees. Effective FY2001-2002, the Department altered this policy and passed on to the Retirees a substantial portion of the premiums it incurred in providing such coverage. Appellant St. Louis Police Officers' Association filed suit to enjoin the Department from requiring the Retirees to pay any portion of the premiums. The suit was styled *Charles Lane, et al. v. Edward Roth, et al.* and bore cause number 014-154 ("Lane Lawsuit"). (A 25).¹

The Honorable Timothy Wilson, a circuit judge of the Trial Court below, ruled in favor of the Retirees in the Lane Lawsuit on April 30, 2002 ("Lane Judgment"). The Lane Judgment declared that the statutory mandate to "provide" health and medical insurance contemplated coverage provided at no cost to the Retirees. (A 26). The Lane Court analogized a law mandating provision of health insurance coverage to one requiring an employer to provide safety helmets for construction. It reasoned that, if an employer subject to such a "hard hat" statute forced its workers to pay a share of the cost of the helmet or to go without one, the employer could hardly be considered to have "provided" hardhats. Consequently, the Lane Court ruled that the Retiree Health

¹ The Trial Court specifically considered and took notice of the Lane Judgment. (L.F. 30, Tr. 100-102). Although the Trial Court concluded that the Lane Judgment was not binding authority, it determined this prior judgment was entitled to *stare decisis* effect as a prior ruling of the Trial Court (L.F. 30).

Insurance Statute requires the Department to provide satisfactory basic health insurance coverage to the Retirees free of charge. (A 27-28).

In the Lane Lawsuit, the Trial Court ruled as to the central issue that is before this Court. The Lane Court ruled that although the Department need not afford a “Mercedes or Cadillac” quality of health benefits, it would be obligated to supply at least a “Honda Civic.” (A 27).

II. The New Base Plan

The dispute giving rise to this lawsuit arose just four years after the entry of the Lane Judgment. On May 5, 2006, the Department sent a letter to the Retirees announcing a substantial degradation of the health insurance benefits they would receive effective July 1, 2006. (A 18). Thus, rather than requiring Retirees to pay for health insurance coverage outright (which the Trial Court had declared was unlawful in the Lane Lawsuit), the Department proposed to provide a diluted “Base Plan” to Retirees at no cost and then permit Retirees to upgrade to a “Buy-Up Plan” by paying a portion of the premium for the better plan. The Department had previously offered both a Base Plan (“Previous Base Plan”) and a Buy-Up Plan, but its proposed Base Plan (“New Base Plan”) provided a seriously degraded array of benefits.

The separate Appendix filed contemporaneously herewith contains, among other items, Exhibits A and B.² (A 18-24). Exhibit A sets forth the changes in the New Base

² Exhibits A and B were admitted into evidence during the June 21, 2006 hearing on Appellants’ Application for Preliminary Injunction. These exhibits, along with all

Plan compared with the Previous Base Plan. The most important differences between the Previous Base Plan and the New Base Plan are summarized in this section of the brief, but Retirees refer the Court to Exhibits A and B for chart-form summaries of the respective benefits components of the two plans.

First, the annual deductible for an individual retiree increases from \$500.00 to \$2,250.00. (A 18). The annual deductible for family coverage jumps from \$1,500.00 to \$6,750.00. (A 18). The coinsurance percentages (the percentage of a particular health care expense covered by the plan) drops from ninety percent (90%) in-network and seventy percent (70%) out-of-network to seventy percent (70%) in-network and fifty percent (50%) out-of-network. (A 18).

In addition to covering a substantially smaller percentage of a Retiree's medical costs, the New Base Plan increases the ceiling on annual out-of-pocket expenditures from \$2,000.00 for in-network services and \$6,000.00 for out-of-network services to \$5,200.00 for in-network services and \$7,200.00 for out-of-network services. Further, it raises the co-payment for a doctor's visit by fifty percent (50%) from twenty dollars (\$20.00) to thirty dollars (\$30.00), and requires a Retiree to pay a \$250.00 co-payment per hospital visit; the Previous Base Plan imposes no such hospital visit co-payment requirement. (A 20).

evidence taken at the Preliminary Injunction Hearing, constitute part of the trial record herein. Rule 92.02(c). The transcript of the Preliminary Injunction Hearing shall be referenced herein as "P.I.Tr."

III. The Evidence Explaining The Significance Of The Changes In The Benefits Afforded By The New Base Plan

Retirees produced Susan Carpenter as an expert witness at trial. She holds a Masters degree in human resources, is a certified employee benefit specialist, and owns and operates a local employee benefits consulting firm. (Tr. 30-31). She has worked in the employee health benefits field for more than twenty years. (Tr. 32-33). Ms. Carpenter works with many large employers in the St. Louis area, including public entities, in designing and structuring health benefits plans. (Tr. 34-35). She testified that the Department's proposed change in the individual annual deductible for Retirees from \$500.00 to \$2,250.00 was "shocking" and that she was unaware of any group health benefits plan for either active employees or retirees with such a high deductible. (Tr. 36). Nor had she ever encountered or heard of a plan with an individual annual in-network out-of-pocket limit as high as \$5,200.00. (Tr. 38).

Ms. Carpenter elaborated that the synergy worked by the \$2250 individual annual deductible, the \$5200 annual limit on in-network co-insurance expenses, and various co-pay obligations would cause a Retiree to incur annual out-of-pocket expenses "well into the \$10,000 range by the time they had significant types of health events." (Tr. 39-40).³

³ Ms. Carpenter explained that the \$5,200.00 out-of-pocket maximum excludes the \$2,250.00 deductible that would be paid by an individual under the New Base Plan. In addition, each time a Retiree is admitted to a hospital, or has an outpatient procedure, x-ray or other service covered by the aforementioned deductibles, the deductible still

Ms. Carpenter was unaware of a health benefits plan with an individual annual deductible higher than \$2000.00 that was not accompanied some an HSA, HRA or other employer-provided feature where the financial impact of this cost to the participant would be ameliorated. (Tr. 40). Nor was she aware of any other plan with an in-network co-insurance percentage as low or an out-of-pocket maximum as high. (Tr. 40). In sum, in all of her experience, she could not think of a group health benefits plan for active employees or retirees that approached as meager a total benefits package as what is provided by the New Base Plan.⁴ (Tr. 42).

Samuel Steiner, a Senior Vice-President of AON Consulting, who served as the Department's benefits consultant, was proffered by the Department as an expert in employee benefits. (Sup.Tr. 42, 46, 53). He testified that he handles no accounts that feature either an individual annual deductible as high as the New Base Plan's or a 70/30

must be paid, even though the out-of-pocket maximum has been reached. As such, it is quite likely that a Retiree who would reach this "ceiling" of out-of-pocket expenses would actually pay in excess of \$10,000.00 in actual out-of-pocket expenses. (Tr. 39-40).

⁴ Ms. Carpenter also testified concerning the particularly onerous effects the New Base Plan would cause the Retirees to suffer. The members of this group are, by definition, between 40 and 65 years of age. (Tr. 41-42). Such a population is statistically more likely to encounter significant health problems than a younger group, so it is far more likely that the retiree group will actually incur significant medical expenses that will result in them paying these large deductibles and out-of-pocket limits. (Tr. 41-42).

co-insurance percentage for in-network expenses. (Sup.Tr. 60). And none of the health benefits plans he services have an out-of-pocket ceiling as high as the New Base Plan's. (Sup.Tr. 72).

Mr. Steiner conceded he could not recall any plan that was "as bad in terms of the scope and quality of benefits as what the police department proposes to impose effective July 1 [2006]." (Sup.Tr. 70). Nor did he believe any customers of AON have a benefits design as poor as the New Base Plan. (Tr. 235).

The Department also produced Richard Frank, the City of St. Louis' Personnel Director, to offer factual testimony and as an expert witness. Mr. Frank could not even think of any group health insurance plan that is actually being sponsored by any employer in the market that has an individual annual deductible higher than \$1,500.00, much less the \$2,250.00 contained in the New Base Plan. (Sup.Tr. 104-106). He also could not identify, nor was he even familiar with, any plan with an in-network co-insurance percentage as low as 70/30 or an out-of-pocket maximum as high as \$7,450.00. (Sup.Tr. 109, 114).

Additionally, Stephen Zoll of Blue Cross testified as an expert witness for the Department. He has extensive experience both in the St. Louis health benefits market, as well as the market at large. He conjectured that plans exist "out there" that provide as "skinny" a benefits package as the New Base Plan, but he could not think of any such plan in particular. (Sup.Tr. 128-129; Tr. 217-18).

The Department adduced evidence that several of the plans considered by Ms. Carpenter as examples required that the participant pay at least a portion of the cost of

coverage (Tr. 70-71). And Monica Green, the Department’s supervisor of compensation and benefits, testified that she was able to locate two group health insurance plans that had deductibles of at least \$2,000.00—one used by a St. Louis, Missouri trucking firm (\$2,500.00) and another used by a firm in Dallas, Texas (\$2,000.00). (Tr. 112; Sup.Tr. 9, p.14-16).

However, Ms. Green failed to inquire as to whether there was some other method of employer-funded amelioration of the out-of-pocket cost incurred by a beneficiary under these plans.⁵ She further acknowledged that it is impossible to meaningfully compare these plans to the proposed Base Plan without this information. (Sup.Tr. 12, p.35). Most saliently, Ms. Green could not think of any other health benefits plan as meager as the New Base Plan. (Sup.Tr. 17, pp.54-55).

In fact, Ms. Green ultimately opined that the New Base Plan, standing alone, provides inadequate health benefits to Retirees. (P.I. Tr. 52-54).

IV. Evidence Concerning The Department’s Process In Determining To Implement The New Base Plan

⁵ Employers sponsoring health insurance plans with high deductibles usually offset a significant out-of-pocket cost to beneficiaries by establishing a health retirement account (“HRA”), a health savings account (“HSA”) or other form of flexible savings account (“FSA”). Such accounts are made up of employer contributions, pre-tax employee contributions or both and can be used by the employee to defray the out-of-pocket cost of a high-deductible health insurance plan. (Sup.Tr. 9-10, pp.16-17, 19).

Ms. Green also explained the Department's decision-making process that resulted in the degradation of benefits afforded the Retirees. Major Paul Nocchiero ordered her to take the requisite steps to reduce the cost of the Retirees' base plan to the cost incurred by the Department in sponsoring its health benefits plan for its active officers; she was given no further explanation or instruction. (Sup.Tr. 14, 43-44). The decision to reduce the Retirees' benefits was singularly a cost-driven measure, without any regard for, or analysis of, the quality or level of benefits that would result. (Sup.Tr. 14, 44). The Department's outside benefits consultant confirmed that the edict to radically reduce the Base Plan's benefits was driven solely by the goal to reduce the Department's cost of providing health insurance benefits to the retirees to the level of its cost to afford coverage for its active officers. He also believed that the Department did not consider the extent of degradation of benefits that would result. (Sup.Tr. 55).

Larry Brockelsby, the Department's human resources director and a member of its "Benefits Committee", was involved in the implementation of the New Base Plan. (Sup.Tr. 26-28). He explained that the Benefits Committee's essential purpose is to consider and make recommendations to the Department regarding changes in benefits. (Sup.Tr. 27). But he revealed that the Benefits Committee never met to consider the New Base Plan or any alternatives thereto. He also testified that and that the Department's decision to degrade the Base Plan was a cost-cutting measure mandated by Major Nocchiero. (Sup.Tr. 29-30). Mr. Brockelsby offered no further rationale for the reduction in benefits or for Major Nocchiero's order that the cost for the Retirees' Plan must be the same as the plan for active duty officers.

Major Noccherio concurred that the Department's Benefits Committee was required to consider and assess potential changes to health insurance benefits. It had discharged that responsibility in the years prior to 2006, but it was not at all involved in the consideration of the changes that ultimately were incorporated in the New Base Plan (Sup.Tr. 80-82; Tr. 139-140). His testimony further confirmed that the only goal was to do what was necessary to cause the expense incurred by the Department to comply with the Retiree Health Insurance Statute to be reduced to the same level of cost the Department was incurring in affording health insurance coverage to its active officers. Major Nocchiero stated that he was the official who was responsible for directing implementation of this cost equivalence-driven change, but could not explain why he did so. He conceded he did not consider whether the consequence of his directive would produce unduly meager health insurance benefits for the Retirees. (Sup.Tr. 88-89).

The Department has taken the position consistently in this action that it proposed the massive reduction in Retiree benefits because of budgetary pressures. But, despite the radical reduction in Retiree benefits, active officers will retain a health insurance plan (at no cost to the officers) that has neither a deductible nor a co-insurance percentage. (Tr. 114-115). No Department official offered any meaningful explanation as to why the Retirees were singled out to bear the brunt of the Department's supposed budgetary constraints, other than that the Department felt like it "had control" of its level of expenditure for the Retirees' Base Plan. (Tr. 137).

The Department never explored alternative means of reigning in the cost to insure the Retirees: it never obtained quotes from any competing insurance carriers or

meaningfully considered any alternatives other than a wholesale reduction in benefits through the existing carrier. (Tr. 141-142). Major Nocchiero was, however, developing plans for a “pay raise for the Metropolitan Police Department” while concurrently directing a substantial degradation of the Retirees’ health insurance benefits plan. (Tr. 142-44).

V. Procedural Posture

On June 19, 2006, the Trial Court first heard evidence and argument on the merits of this case upon the Retirees’ Motion for Preliminary Injunction. (L.F. 2-3). On June 22, 2006, it entered a preliminary injunction prohibiting the Department from implementing the New Base Plan until a trial on the merits. (A 9-10). The Trial Court determined that the Retirees were likely to succeed on the merits of their claims. (A 14-15).

When it entered its preliminary injunction, the Trial Court interpreted the plain language of the Retiree Health Insurance Statute, and the obvious intent of the legislature in enacting this provision, to require the Department to provide “such health insurance as employers commonly provide employees and retirees.” (A 14). Applying that standard, the Trial Court ruled that the New Base Plan likely did not satisfy this mandate. It reasoned that each of the significant benefits components fell somewhere between unique and rare in the insurance market. (A 14). Thus, the Trial Court concluded, the New Base Plan lies below the “broad range” of insurance that is found in the market and fails to meet the beneath the minimum quality required by the statute. (A 14).

As a consequence of entering this Preliminary Injunction, the Trial Court ordered the Retirees to post a bond in the amount of \$169,600.00. Retirees promptly posted the required bond. (A 10; L.F. 3-4).

Following a trial on the merits, the Trial Court rejected its prior reasoning and entered judgment in favor of the Department on August 4, 2006. (A 2). It held that, although the New Base Plan affords exceptionally meager insurance, it still provides insurance, and that is all the Retiree Health Insurance Statute requires. (A 6). The Retirees appealed from the Trial Court's judgment.⁶

⁶ The Court of Appeals issued its opinion in this appeal on October 9, 2007. However, this Court "review[s] the cause as though on original appeal. *Buchweiser v. Estate of Laberor*, 695 S.W. 2d 125, 127 (Mo. banc 1985). See Rule 83.03. The Court of Appeals opinion has no precedential value. *Carroll v. Loy-Lange Box Co.*, 829 S.W. 2d 86, 90 (Mo. App. ED 1992).

POINTS RELIED ON

I. THE TRIAL COURT ERRED IN RULING THAT THE DEPARTMENT'S NEW BASE PLAN SATISFIES THE STATUTORY MANDATE OF THE RETIREE HEALTH INSURANCE STATUTE TO "PROVIDE...HEALTH INSURANCE", BECAUSE IT PROVIDES SUCH A UNIQUELY MEAGER BENEFITS PACKAGE THAT IT DOES NOT SATISFY THE MANIFEST PURPOSE OF THE STATUTE AND CONSEQUENTLY THE TRIAL COURT COMMITTED REVERSIBLE ERROR IN DENYING PERMANENT INJUNCTIVE RELIEF TO THE RETIREES.

United Pharmaceutical Corp. of Missouri v. Missouri Bd. of Pharmacy, 208 S.W. 3d 907 (Mo. banc 2006)

Ming v. General Motors Corp., 130 S.W.3d 665 (Mo. App. E.D. 2004)

§ 84.160.8(3), RSMo

II. THE TRIAL COURT ERRED IN RULING THAT THE DEPARTMENT'S ACTIONS IN DRAMATICALLY REDUCING THE HEALTH INSURANCE BENEFITS THAT IT IS REQUIRED TO PROVIDE TO RETIREES DID NOT CONSTITUTE A VIOLATION OF RETIREES' SUBSTANTIVE DUE PROCESS RIGHTS UNDER THE DUE PROCESS CLAUSES OF ART. I, SECTION 10 OF THE MISSOURI CONSTITUTION AND THE FOURTEENTH AMENDMENT TO THE U.S. CONSTITUTION, BECAUSE THE DEPARTMENT'S ACTIONS CONSTITUTED "TRULY IRRATIONAL" STATE ACTION IN VIOLATION OF THE RETIREE HEALTH INSURANCE STATUTE.

Furlong Companies, Inc. v. City of Kansas City, 189 S.W.3d 157 (Mo. banc 2006)

Art. I, §10, Missouri Constitution

ARGUMENT

The evidence adduced at trial in this matter makes a few matters apparent. First, although the Department's health insurance experts may have offered vague conjecture that there are plans "out there" that may be as meager as the New Base Plan, none of these health professionals was able to identify even one such plan. The Department's experts were asked at their depositions if they could identify as "skinny" a plan as the one the Department was foisting on the Retirees, and none could think of one. Then, after presumably preparing further for trial, their inability to identify a comparably poor plan persisted when they testified before the Trial Court.

Second, the Department, upon being precluded from charging premiums for health coverage to Retirees by virtue of the Lane Court Judgment, merely found another way to pass these apparently unwanted but statutorily mandated costs on to the Retirees by gutting their health benefits.

Third, the Department's decision to balance its budget on the backs of the Retirees was based upon Major Nocchiero's unilateral and coldly cost-driven decision. He decided that the Department would take whatever steps were necessary to immediately reduce the Department's cost in satisfying its statutory obligation to the Retirees to the level of expense it was incurring in providing health insurance to its active officers. This radical change was neither reviewed nor considered by the Department's Benefits Committee, and the Department never explored marketplace alternatives that might have enabled it to avoid or soften its evisceration of the Retirees' base plan.

The record evidence overwhelmingly establishes that the New Base Plan falls short of satisfying the mandate of the Retiree Health Insurance Statute to “provide” Retirees with health insurance coverage. It is so deficient that it literally has no analog in the relevant marketplace. The New Base Plan is “health insurance” in name only, as it is a mutant program created by a plan sponsor that admittedly gave no consideration to the quality of the benefits package that it was statutorily obligated to provide. The callous sea-change was ordered unilaterally by Major Nocchiero as a draconian cost-cutting measure, without any input whatsoever from the Department’s Benefits Committee. An objective and sensible review of the record practically compels the conclusion that the Department’s decision was “truly irrational” and, as such, constituted a violation of the Retirees’ substantive due process rights under Art. I, §10 of the Missouri Constitution and the Fourteenth Amendment to the United States Constitution.

I. THE TRIAL COURT ERRED IN RULING THAT THE DEPARTMENT’S NEW BASE PLAN SATISFIES THE MANDATE OF THE RETIREE HEALTH INSURANCE STATUTE TO “PROVIDE...HEALTH INSURANCE”, BECAUSE IT PROVIDES SUCH A UNIQUELY MEAGER BENEFITS PACKAGE THAT IT DOES NOT SATISFY THE MANIFEST PURPOSE OF THE STATUTE.

A. Standard of Review

Murphy v. Carron, 536 S.W.2d 30 (Mo. banc 1976) generally describes this Court’s standard of review in this appeal. This Court should affirm the decision of the Trial Court in this bench-tryed case “unless there is no substantial evidence to support it, unless it is against the weight of the evidence, unless it erroneously declares the law, or

unless it erroneously applies the law.” *Id.* at 32. This standard has been interpreted, however, to require an appellate court to reverse a judgment entered after a bench trial if it firmly believes the Trial Court was wrong and that its judgment was contrary to the weight of the evidence. *Id.*; *Norber v. Marcotte*, 134 S.W.3d 651, 661 (Mo. App. E.D. 2004).

This appeal principally involves, however, questions relating to the proper construction and application of the Retiree Health Insurance Statute. Statutory construction is a question of law. *City of St. Joseph v. Village of Country Club*, 163 S.W. 3d 905, 907 (Mo. banc 2005). Therefore, this Court reviews *de novo* the Trial Court’s construction and interpretation of this legislation. *Williams v. Kimes*, 996 S.W. 2d 43, 44-45 (Mo. banc 1999).

- B. The Trial Court erroneously declared and applied the law in holding that the Department satisfied the Retiree Health Insurance Statute’s mandate by implementing a policy that “insures against some expenses incurred through the illness of the insured.”

The fundamental issue to be resolved by this Court is whether the Retiree Health Insurance Statute requires the Department to provide reasonable health benefits to the Retirees. The language provides only that the Department “shall provide health...insurance for retired officers.” *Id.* Consequently, the words of this statutory mandate do not expressly indicate the extent or scope of the Department’s duty to “provide” such coverage.

Nevertheless, as will be discussed later, Missouri law dictates that a court should construe a statute that lacks specificity in a reasonable manner that respects the spirit that

motivated its enactment. The Trial Court got it right in its preliminary injunction order, but inexplicably neglected to properly apply principles of statutory construction when it reversed itself and ultimately entered judgment for the Department.

1. The Lane Judgment is dispositive of the issue of whether the Department is obligated to provide health insurance to retirees free of charge.

The Lane Lawsuit involved a recent challenge to the Department's decision to pass along a portion of the Department's monthly health insurance premium to its Retirees. The Lane Judgment resolved that that the Department's decision to charge Retirees for health insurance coverage did not constitute was inconsistent with its statutory obligation to provide such coverage. (A 25-28). As discussed in the Statement of Facts above, the Lane Judgment indicated that if a statute required a company to provide safety helmets, and they agreed to make them available at a cost or not at all, it could not be said that they are "providing" helmets. (A 26).

The logic of the Lane Judgment is inescapable. As the Trial Court noted, even if the Lane Judgment is not binding, it is at least entitled to *stare decisis* respect. (A 4).

Although the Lane Judgment may not be dispositive here, its importance is difficult to understate. What the Department was unable to accomplish through the front door—charging premiums to Retirees to defray the health insurance expense to the Department—it instead attempted to accomplish through the side door. Instead of passing along premium costs, the Department created a skeletal plan that is so stingy in its provision of benefits that it has no commercial analog.

It provides this plan for no premium, but the Retiree still pays the cost through astronomically increased out-of-pocket expenses. As Kathleen Bell, one of the Department's health insurance experts, explained at trial, that the cost-sharing by participants in any health plan is made up of both the premium they pay as well as the out-of-pocket deductibles, co-payments and other charges that they are forced to bear. (Tr. 161-162). The New Base Plan merely shifts this cost-sharing from premium payments, which the Lane Judgment ruled could not be transferred, to excessive out-of-pocket expenditures that the Retirees must pay due to the inadequate coverage now afforded. This shifting of cost goes no further toward satisfying the mandate in the Retiree Health Insurance Statute to provide health insurance than the Department's first attempt that was thwarted by the Lane Judgment. It is just another impermissible effort to off-load onto the Retirees' the cost of their statutory entitlement to health insurance.

2. The dramatic reduction in benefits effected by the New Base Plan violates Retiree Health Insurance Statute if this statute is given a construction that comports with applicable legal principles.

The record evidence establishes that the New Base Plan affords the Retirees grossly degraded health insurance coverage. All of the Department's health insurance experts⁷ who opined on this issue concurred with the two experts proffered by the Retirees.⁸ None of the experts had ever encountered or could identify even one health benefits plan with as meager a quality and scope of benefits as what is afforded by the

⁷ Monica Green, Samuel ("Sandy") Steiner, Richard Frank, Kathy Bell and Stephen Zoll.

⁸ Susan Carpenter and Marilee Laughlin.

New Base Plan. A fair reading of the Retiree Health Insurance Statute that utilizes well-established principles of statutory interpretation leads inescapably to the conclusion that the New Base Plan fails to satisfy this mandate. The Trial Court erred in ruling otherwise.

The goal in interpreting a statute is to determine the intent of the legislature by looking to the words used therein. *State ex rel. Womack v. Rolf*, 173 S.W. 3d 634, 638 (Mo. banc 2005). One must first apply the plain language used by the legislature and seek to accord the words their ordinary and common meaning. *United Pharmaceutical Corp. of Missouri v. Missouri Board of Pharmacy*, 208 S.W.3d 907, 909-910 (Mo. banc 2006). However, to accomplish this, the Court must “examine the words used in the statute, the context in which they are used and the problem the legislature sought to address with the statute.” *Ming v. General Motors Corp.*, 130 S.W.3d 665, 668-69 (Mo. App. E.D. 2004).

“When the legislative intent cannot be determined from the plain meaning of the statutory language, rules of statutory construction may be applied to resolve any ambiguity.” *United Pharmaceutical, supra*, 208 S.W. 3d at 910. If confronted with an ambiguous statute, the Court properly seeks to discern legislative intent by, for example, “consider[ing] that the problem that the statute was enacted to remedy.” *Id.* at p. 912.

Statutes must not be “construed in a way that produces unreasonable, oppressive or absurd results.” *Id. See also, Zimmerman v. Missouri Bluffs Golf Joint Venture*, 50 S.W.3d 907, 911 (Mo. App. E.D. 2001). Even though statutory interpretation should begin with the plain language of the statute, the law recognizes that statutory terms that

are “necessarily implied” or that, if absent and not inferred, would produce absurd results in the application of the statute, should be supplied to effectuate the legislature’s intent. *Ming* at 668-69. *See also, School Board of Kansas City v. Williamson*, 141 S.W.3d 418, 424 (Mo. App. W.D. 2004) (when intent underlying statute cannot be gleaned from words used, the court should give the statute a reasonable reading consistent with its purpose).

In attempting to determine the legislative intent underlying an ambiguous statute, the Court may be compelled to draw necessary inferences: “While we avoid imparting words into a statute that are not plainly written or necessarily implied, we may supply missing words when, as written, the statute leads to absurd results.” *Ming, supra*, at p. 669. Using this framework, the *Ming* court held that a lawsuit for damages tolls the statute of limitations only when the employee filed suit within either two or three years of the injury (it was not necessary to determine which time limit to apply, because the claimant filed suit more than four years after the injury). *Id.* Although the court recognized that it was imparting words into the statute that were not in its text, it determined that its supplied terms were necessarily implied. The court ruled that application of a strict and plain reading would produce an absurd result that the legislature could not possibly have intended. *Id.* at 669-670. *See also, Dahlin v. Missouri Commission for the Blind*, 262 S.W. 420, 423-24 (Mo. App. S.D. 1924) (“A statute that is clear in its terms, and leaves no room for construction must be enforced as written, but if it is not clear, and there is any room for construction, then the reason and sense of the statute will in determining its meaning...The blind pension law is remedial,

and therefore should be liberally construed; also it should be construed with the object in view that was sought to be accomplished.”); *Rutter v. Carothers*, 223 Mo. 631, 122 S.W. 1056, 1060 (Mo. 1909) (“[T]he letter killith while the spirit maketh alive...[T]he naked letter of the law must gently and a little give way to obvious intendment.”).

The Trial Court’s narrow interpretation of the Retiree Health Insurance Statute contravened the principle that laws affording retirement benefits must be accorded a liberal construction that favors the beneficiaries thereof. *See Williams v. Board of Trustees of Public School Retirement System*, 500 S.W.3d 31, 34 (Mo. App. W.D. 1973); *Price v. State Social Security Comm’n*, 232 Mo. App. 721, 121 S.W.2d 298, 299 (Mo. App. S.D. 1938); *Dahlin, supra*, 262 S.W. at 424. The Trial Court, which ultimately utilized a strict construction of the statute, held that “a policy that insures against some expenses incurred through illness of the insured is health insurance.” (L.F. 31). It concluded, therefore, that the meager New Base Plan satisfied the statutory requirement.

The Trial Court’s reasoning exposes the fallaciousness of its ruling. It claimed, on the one hand, that it could envision a policy that would not constitute “health insurance” within the meaning of the statute, such as a policy with a million dollar deductible or one that only covered expenses arising from a common cold. (A 6). However, such policies would satisfy the obtuse standard ultimately adopted by the Trial Court: such policies would insure against “some expenses” and would therefore literally constitute “health insurance” within the very interpretation it adopted. (A 5).

The Trial Court's retraction of its preliminary injunction position that "legislature contemplated such health-insurance as employers commonly provide" (A 14) was, to understate matters, a stunning development from the Retirees' perspective.

The Retirees could not help but notice that the Trial Court's August 4, 2006 Memorandum Opinion was an exercise in harshly strict construction, as it employed only a dictionary to discern the meaning of the Retiree Health Insurance Statute. (A 5). It is possible that the Trial Court, contemplating the gravity of its ultimate decision in a significant case, grew concerned that it would be accused of engaging in "judicial activism" if it rendered a final judgment consistent with its preliminary injunction. See generally, Gary Toohey, In The Crosshairs: Missouri's Judicial System In The Balance, pp 24 - 26, Precedent (Fall 2007). Unfortunately, although the phrase "judicial activist" is little more than a cliché, it has been used to brand and harass Missouri judges. Such "judicial abuse" often is unwarranted. Richard A. Posner, The Meaning Of Judicial Self-Restraint, 59 Ind.L.J.1 (1983). That unfairness seems particularly poignant when the phrase would be used to pillory a judge saddled with the task of interpreting an unspecific statute passed by the legislative branch. *Id.*, p.5 (citing federal antitrust laws as an example of vague statute that courts have been constrained to flesh out).

Article II, § 1 of the Missouri Constitution mandates the separation of powers of the three branches of Missouri government. Under this tripartite system, so highly dependent on the powers and restraints arising from the checks and balances inherent therein, "[i]t is emphatically the province and duty of the judicial department to say what the law is." Marbury v. Madison, 5 U.S.137, 177 (1803). Certainly, legal scholars

engage in robust debate concerning the extent of the judiciary's power to dictate law to its coordinate branches. However, it seems absurd to accuse a court of engaging in improper judicial activism when it supplies reasonable meaning to a vague statute that the legislature had every opportunity to have crafted with greater specificity.

Regardless of what actually caused the Trial Court's drastic change in its analysis of the requirements of the statute, the Missouri General Assembly could not possibly have intended that the Department would satisfy the mandate created thereby via the adoption of a wholly unreasonable health benefits plan for the Retirees. Correlatively, Retirees suggest that the Missouri General Assembly did not intend the statute to permit the Department to foist on the Retirees a level of benefits so meager as to be the worst package that any of the seven (7) testifying experts could identify.

In contravention of sound principles of statutory construction, the Trial Court effectively set the bar so low as to give the Department license to completely eviscerate the Retirees' right to reasonable coverage. This Court should conclude, based upon applicable principles of statutory construction, that some reasonable and meaningful level of health insurance coverage was intended by the legislature's mandate. And the only way to ascertain whether the New Base Plan provides reasonable coverage is to compare what it affords to what exists in the marketplace. That comparison was thoroughly made before the Trial Court. The record evidence overwhelmingly established that the New Base Plan's provisions are so meager that they have no commercial analog. Thus, the New Base Plan violates the Retiree's statutory rights.

However, the Department points to isolated features of the New Base Plan that it

contends prevents it from being “illusory”. Department Brief, p. 21. However, the fact that the New Base Plan may have a few isolated features that have precedent in the market does not rescue it from its status overall as a uniquely deficient plan with no known equal in the marketplace. Tellingly, the Department’s expert, Richard Frank, explained that a plan’s individual annual deductible, maximum out-of-pocket expense, and in-network coinsurance percentage are the important factors in determining its quality. (Tr. 251-52). Thus, it is the awful synergy worked by the combination of such meager features in the New Base Plan that cause it to be so harmful to the Retirees.

Perhaps the absence of any meaningful effort by the Department to defend the New Base Plan's benefits package reflects a consciousness that the record renders such an undertaking impossible.⁹ Regardless of the Department's motivation, it is apparent that it seeks to uphold the Trial Court's judgment through misdirection.

⁹ The Department points out that the Retirees’ own expert testified at trial that whether coverage is “adequate” can only be determined by reference to a particular participant. Department Brief, p. 33. But Ms. Carpenter clearly testified that she was unfamiliar with any health benefits plan that affords a level of benefits as meager as that provided by the New Base Plan. (Tr. 42) And, the Trial Court observed that Ms. Carpenter was confused as to what she was being asked at that point. (Tr. 42). The Department also points out that the base option was described at trial by Ms. Carpenter as comprehensive medical coverage. (Tr. 61) But, in using this phrase she was describing only the range of charges that it would cover -- “physician charges,...inpatient hospital, outpatient,...diagnostic and

The Department seeks to excuse the abject meagerness of the New Base Plan by directing the Court's attention to its robust "Buy-Up" Plan, extolling the fact that a Retiree need pay a "mere \$251 monthly premium"¹⁰ out of his or her own funds to enjoy the privilege of participating in a health benefits plan with satisfactory benefits. Proudly, the Department proclaims that this "Buy-Up option provides the Retirees with the identical comprehensive medical coverage which the current active police officers have." Department Brief, p. 7. But, the Department omits to mention that it provides this satisfactory package of health benefits to its active officers without requiring them to pay any portion of the premium.¹¹ Saliently, the Department shoulders a statutory obligation

x-ray, prescription drug charges – not the benefits levels applicable to such charges. (Tr. 43-44). Certainly, a fair reading of Ms. Carpenter's trial testimony reveals that she emphatically and convincingly opined that the benefits afforded by the New Base Plan are so deficient as to be unprecedented.

¹⁰ Department Brief, p. 24. Apparently the Department lacks an understanding of the inability of many of its Retirees to pay an extra \$241 per month for health insurance. *See e.g.*, testimony of William Gooden. P.I. Tr., p. 24. Certainly, it is common knowledge that many Retirees survive on fixed incomes, and it should be apparent that they are a population whose members are ill-equipped to spend an extra couple hundred of dollars per month.

¹¹ *See* Department's May 5, 2006 letter to Retirees: "We are recommending the continuation of the current medical plan....for Active Employees...and the Department

to provide free health insurance coverage for its active officers that is virtually identical to that which it bears under the Retiree Health Insurance Statute:

8. The board of police commissioners:

(1) Shall provide or contract for life insurance coverage and for insurance benefits providing health, medical and disability coverage or officers and employees of the department.

§84.160.8 (1), R.S.Mo. (*See App.*, p. 30).

Thus, on the one hand, the Department abides by its statutory obligation to afford its active officers free, reasonable health insurance coverage, while concurrently it seeks to shirk its identical statutory obligation to its retired officers. This stark inconsistency in the Department's respect for its statutory obligations to its active officers and its retired officers is unlawful and deplorable. Moreover, although the Department argues now that it need not comply with the April 30, 2002 liability judgment in the Lane Lawsuit, it communicated a different message to the Retirees in a letter it issued just three days after that decision:

Dear Retiree:

As you may be aware, a class action suit was brought....asking the Court to clarify the meaning of language in our state statutes pertaining to health insurance for retirees.

The Board has been notified by the Court that the language in the statute mandates that the Board provides some basic type of insurance without cost to the retiree. Based on this response from the Court, I am canceling the \$53.50 per month contribution that you have been paying.

Sincerely,

continuing to pay for 100% of the cost....” (Supp. L.F., p. 6).

Colonel Joseph Mokwa
Chief of Police

Supp. L.F., p. 21.

Despite its representation to the Retirees that it would comply with the judgment in the Lane Lawsuit, the Department now argues the Retiree Health Insurance Statute “is silent as to who pays the premium for the coverage of the retirees,” suggesting that the absence of explicit language specifying who bears the brunt of the cost indicates the legislature could not have intended to impose the obligation on the Department.

Department Brief, p. 25. This position is contrary to the plain meaning of the statute.¹²

As the Lane Court ruled, the statutory obligation of the Department to “provide health...insurance coverage for retired officers” means that it must ensure that its Retirees “receive – not merely have ‘access to’ – at least some basic health insurance policy.” (A 28). And, the Trial Court ruled that Judge Wilson’s ruling is entitled to “*stare decisis* respect.” (A 4).

Inasmuch as the Trial Court determined it would respect Judge Wilson’s ruling, it did not engage in an analysis of whether the Department lawfully could refuse to pay the entire cost of the Retirees’ health insurance coverage. But the plain meaning of the statutory language dictates that the Department must bear all the cost. *See Welch v. Eastwind Care Center*, 890 S.W. 2d 395, 397 (Mo. App. W.D. 1995) (the word “shall” denotes a mandate to act); *Hoffman v. Martin*, 119 S.W. 2d 1027, 1029 (Mo. App. W.D.

¹² To this limited extent, the Retiree Health Insurance Statute is unambiguous: it manifestly directs the Department to shoulder the entirety of the premium.

1938) (“provide” means to furnish, or supply for use). Thus, the plain meaning of the language in the Retiree Health Insurance Statute directs that the Department is obligated to pay all the premiums charged for the health insurance it procures; otherwise, it would not be doing everything necessary to actually “supply” the Retirees with coverage.

Moreover, the Department does not really analyze the plain meaning of the words used in the Retiree Health Insurance Statute’s language. Rather, it rushes to bootstrap itself into a convenient position in which the adequacy of the coverage it affords is measured against the Buy-Up Plan, and not against the statutorily mandated New Base Plan. The Retirees observe that the Department has contended throughout this litigation that the meagerness of the proposed Base Plan must be considered in light of the fact that it is provided at no charge. This argument is without merit and the analysis that produces it is circular and confusing. The Lane Judgment determined that the Retiree Health Insurance Statute *requires* the Department to provide health insurance at no charge to the Retirees. That ruling constitutes persuasive authority and is based on a sound and logical construction of the statute.

Thus, despite the fact that the Department’s five experts could not identify even one health insurance plan providing as meager benefits as the New Base Plan, the Department urges that the bar should be lowered because this plan is provided for free. The circularity of the Department’s argument is obvious: because the Department complies with the statute’s mandate to provide free health insurance to retirees, the insurance it provides should be held to a lower standard in determining whether the statute has been satisfied. However, the fact that the Retirees do not pay for the New

Base Plan¹³ is irrelevant to the determination of whether the Department satisfies the legislature's evident intent that the insurance the Department provides be reasonable. As part of this circular effort, the Department contends that the Retiree Health Insurance Statute is ambiguous as to whether the Department must shoulder the premium alone. Department Brief, p. 14.¹⁴ The Department then also cites §§ 169.590 and 376.421, R.S.Mo., in an effort to convince this Court that it must resort to statutory construction to resolve the meaning of the phrase "provide health...insurance coverage...." But § 169.590 does not require school districts to afford health insurance coverage to their retirees. Rather, it simply directs that, if a district provides health insurance coverage to its active

¹³ Other than through their years of service which thereby constitutes the consideration they must provide to receive this statutory entitlement.

¹⁴ The Department does not assert this explicitly, but because it references other statutes in cobbling together its contention, it necessarily is suggesting the statute is ambiguous, thereby justifying an exercise in statutory construction. The Department itself acknowledges that resort to principles of statutory construction is improper absent the presence of ambiguous language. Department Brief, p. 19. Notably, the Department pled in the Trial Court that the Retiree Health Insurance Statute is "vague". Amended Answer, Affirmative Defense #6 (L.F. 25). Retirees obviously believe the Department's payment obligation is unambiguously imposed on it by the plain language of the Retiree Health Insurance Statute, but they nevertheless will concisely address the Department's statutory construction argument.

employees, it must enable its retirees to participate in the plan, albeit at their cost. Furthermore, the fact that the legislature felt it necessary to specify that the retirees must pay the premium if they elect to participate actually suggests that, absent such specification, the language in § 169.590.1 referencing a district that “provides group health insurance”, would mandate that such a district absorb the cost. So, consideration of § 169.590.1 actually supports the Retirees’ position that the Department must pay the full premium for the coverage it provides pursuant to the Retiree Health Insurance Statute.

Section 376.421.1(1)(b) offers no guidance whatsoever. This statute specifies the possible alternatives in terms of allocating the cost of group insurance; it is fully consistent with another statute, such as the Retiree Health Insurance Statute, dictating which of the alternatives must be followed.

The Department further contends that it is impermissible to read a commercial reasonableness standard into the statute because its language is “clear and unambiguous.” Department Brief, p. 19.¹⁵ But the Department itself applies principles of statutory construction in seeking to convince this Court that the Retiree Health Insurance Statute affords the Department unreviewable discretion in determining the quality and scope of the Retirees’ health benefits. Department Brief, p. 26. Therefore, the Department’s

¹⁵ The Department asserted in the Trial Court that this statute is so ambiguous that it is violative of due process. (L.F., p. 25). Obviously, that position conflicts with its stated position on appeal. See also, note 14, supra.

construct would permit it to impose on the Retirees a plan with a \$100,000 individual annual deductible, a result that would be absurd and clearly antithetical to the statute's remedial purpose. In fact, the Department itself acknowledges that settled Missouri law permits a Court to imply terms and meaning into a statute if necessary. Department Brief, p. 20 (citing *State ex rel. D.M. v. Hoester*, 681 S.W. 2d 449, 452 (Mo. banc 1984), and other cases to similar effect).

The Department also contends that the absence of evidence in the record as to whether the Missouri Department of Insurance approved the insurance policy incorporating the provisions of the New Base Plan somehow creates an obstacle to the Retirees' appeal. Department Brief, p. 21, n.3. That is not true. First, it is obvious that policies of insurance issued in Missouri are somewhat frequently determined to be ambiguous by the courts. Thus, the fact that the Department of Insurance may have approved a policy incorporating the benefits scheme of the New Base Plan is immaterial to this Court's determination as to whether that plan comports with the Retiree Health Insurance Statute.

Moreover, if the Department wished to make the Department's possible approval of a policy an issue in this case, it was obligated to plead that affirmatively. *Holdener v. Fieser*, 971 S.W. 2d 946, 950 (Mo. App. E.D. 1998); *Detling v. Edelbrock*, 671 S.W. 2d 265, 271 (Mo. banc 1984). It did not do that. Finally, the record is silent as to whether a policy incorporating the New Base Plan ever was submitted to the Department of Insurance for approval.

The Department also cites *St. Louis Police Officers' Ass'n v. Board of Police Commissioners*, 846 S.W. 2d 732 (Mo. App. E.D. 1992) for the proposition that § 84.160, RSMo, grants to the Department unreviewable *carte blanche* to determine the levels of benefits it will afford to its employees and retirees. The Department's interpretation of this case not only is incorrect, it ignores that its effect is to squarely endorse the statutory construction urged by Retirees.

In *St. Louis Police Officers' Ass'n*, this Court rejected the Department's interpretation of what level of salary continuation coverage benefits it must afford to its officers. 846 S.W. 2d at 737-38. To the extent that this Court addressed the quantum of salary continuation coverage that the Department must supply under this mandate, the Court reasoned that it is relevant to consider what is normal in the marketplace. Thus, the Court considered what typical "insurance policies provide for, and employers generally pay...." *Id.* at 738.

The Court indicated its approval of such an analysis because it determined that the statutory phrase "salary continuation coverage" was "ambiguous". *Id.* at 737. Ironically, then, *St. Louis Police Officers' Ass'n* provides firm precedent for the Retirees' position that the statute in question mandates a quality and scope of benefits that is normal when compared with what employers typically provide in the marketplace.

The Department also implies that the Retirees failed to clearly establish at trial their right to injunctive relief. Department Brief, p. 11. Retirees, generally speaking, do not dispute the principles of equitable law recited by the Department. However, the overwhelming weight of the evidence in the Record compels the conclusion that they

clearly were entitled to injunctive relief to prevent the Department from violating their statutory rights. *See Smith v. Western Elec. Co.*, 643 S.W. 2d 10, 13 (Mo. App. E.D. 1982) (injunctive relief lies “to prevent the doing of any legal wrong whatever, whenever in the opinion of the court an adequate remedy cannot be afforded by an action for damages”). *See also Clevenger v. McAfee*, 237 Mo. App. 1077, 170 S.W. 2d 424, 427 (Mo. App. W.D. 1943).

Sound public policy suggests this Court should construe the Retiree Health Insurance Statute to require something more than any policy of health insurance, no matter how meager. This legislation, although bereft of detail, necessarily implies some reasonableness requirement, and this Court should enforce that implicit, but unavoidable, standard. Such a construction prevents the mischief and harm caused the Retirees by the New Base Plan, and avoids application of the statute in a manner that produces an absurd result.

This Court should look to the “problem in society” that the General Assembly manifestly sought to remedy and conclude that the statute requires the Department to provide the Retirees with adequate and reasonable health insurance. *State ex rel Casey’s General Stores, Inc. v. City of West Plains*, 9 S.W.3d 712, 717 (Mo. App. S.D. 1999) (a court should examine “problem in society” in determining legislative intent). *See also State ex rel Rhodes v. Crouch*, 621 S.W.2d 47, 49 (Mo. banc 1981) (statute should be given meaning in light of its objectives); *State ex inf. Dalton v. Miles Laboratories*, 282 S.W.2d 564, 574, 365 Mo. 350 (Mo. banc 1955) (holding that remedial statutes “must be construed with a view to suppression of the mischief to be remedied.”).

If the Court declines to interpret the statute to imply a reasonableness standard, the Department invariably will view its ruling as an invitation to even more grossly degrade the Retirees' benefits. Because the Retiree Health Insurance Statute does not specify a level or particular array of health insurance benefits, this Court must supply some structure to the law because that is the only way to effectuate the remedial purpose of the provision.

In fact, the purpose of eliciting the overwhelming majority of the evidence in the record in this case was to enable the Trial Court to determine whether the New Base Plan possibly could satisfy the test adopted by the Trial Court in its preliminary injunction order: whether the scope and level of benefits were at least commensurate with "the most modest plans that employers commonly offer." (A 16). Absent implication of a reasonableness standard into this provision, it is possible that the "deductible of \$1,000,000" that the Trial Court hypothesized in its Final Judgment would actually satisfy the Department's obligations. (A 6). Plainly, reasonableness is required by the statute.

The evidence at the trial on the merits was consistent with the preliminary injunction hearing evidence to the effect that the quality and scope of the New Base Plan's benefits would be poorer than any other known health insurance plan. Despite the fact that the evidence adduced at the trial on the merits reinforced the conclusion that the proposed plan failed to meet the standard implicitly contained in the statute, the Trial Court recanted its previous interpretation of the Retiree Health Insurance Statute,

reversed its prior preliminary injunction holding and held that the Department's New Base Plan was lawful. (A 1-8).

Thus, in the face of the uniformity of evidence throughout the proceeding below establishing the woefulness of the New Base Plan, the Trial Court, without any explanation, reversed its initial interpretation of this statute and that the New Base Plan satisfies the statute. (A 2-8). In its Memorandum Opinion, the Trial Court articulated an entirely different test than the one it employed when it issued its preliminary injunction. Specifically, the Trial Court purported to rely on the plain and ordinary dictionary definition of "health insurance", as "insurance against expenses incurred through the illness of the insured." (A 5). The Trial Court indicated it was taking judicial notice that most all insurance policies insure against "some" medical expenses and grafted this modifier onto the dictionary definition. Consequently, its August 4, 2006 Memorandum Opinion articulated the purported test as follows: "a policy that insures against some expenses incurred through illness of the insured is health insurance". (A 5).

Based on this test, the Trial Court found that the New Base Plan insures against some expenses and therefore constituted "health insurance" within the meaning of the statute. The Trial Court purported to acknowledge that some policies could be "bad enough" to violate the statute (such as one with a million dollar deductible), but concluded that the New Base Plan is not so grossly deficient to be "bad enough" to violate the statute. (A 6). However, without implying a reasonableness standard into the statute, whereby expert evidence would inform a court as to whether a particular array of benefits is what might be found in a modest plan commonly afforded by employers, a

problematic and unacceptable void is left in the law: there simply is no workable standard to gauge whether a particular level of benefits satisfies the statute, and the Department as well as any reviewing court is thereby free to arbitrarily conclude what level of benefits suffices.

And although the Trial Court denied this, the “test” that it ultimately employed could be applied to uphold a plan that covers only the expenses incurred in caring for the common cold. That is because the dictionary defines “some”, which is the operative modifier identified by the Trial Court, as “being at least one”. Webster’s Ninth New Collegiate Dictionary (9th ed.)(1989).

Thus, applying the definitional interpretation the Trial Court finally adopted yields a test that merely inquires: “does the proposed policy insure against [at least one] expense that retirees might incur as a consequence of illness.” (A 5-6). It therefore is readily apparent that the Trial Court’s interpretation of the statute leads to absurd results and must be rejected.

The Retiree Health Insurance Statute is, unfortunately, ambiguous. Therefore, to discern its full meaning, statutory interpretation based on its plain language alone yields an unreasonable result that would sorely disappoint the legislature. *See United Pharmaceutical, supra*, 208 S.W. 3d at 910-12. Hence, this Court must interpret the statute’s mandate to “provide health insurance” in a reasonable manner that ensures that the protection envisioned by the legislature gives fair value to the Retirees.

Retirees respectfully submit that the Trial Court’s Final Judgment was the product of misapplication of applicable law, was legally erroneous and contrary to the

overwhelming weight of the evidence. The Trial Court’s errors caused the entry of a final judgment that manifestly prejudices the rights of the Retirees under the Retiree Health Insurance Statute.¹⁶

II. THE TRIAL COURT ERRED IN RULING THAT THE DEPARTMENT’S ACTIONS IN DRAMATICALLY REDUCING THE HEALTH INSURANCE BENEFITS THAT IT IS REQUIRED TO PROVIDE TO RETIREES DID NOT CONSTITUTE A VIOLATION OF RETIREES’ SUBSTANTIVE DUE PROCESS RIGHTS UNDER THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT, BECAUSE THE DEPARTMENT’S ACTIONS CONSTITUTED “TRULY IRRATIONAL” STATE ACTION IN VIOLATION OF THE RETIREE HEALTH INSURANCE STATUTE.

The uncontroverted evidence adduced at trial demonstrated that the Department made a unilateral determination to do whatever was necessary to substantially reduce its cost of compliance with the Retiree Health Insurance Statute. In so doing, it acted out of purely financial motive, with no consideration of the scope or quality of the benefits that

¹⁶ The Trial Court also erred in finding that “in the case at bar, the benefits found in the Board’s contemplated policy are modest when compared with those commonly found in health insurance policies that employers provide. Indeed, in some respects the benefits compare quite poorly.” (A 6). To the extent this finding suggests the proposed plan is just “modest”, and not awful, it lacks support in the record. The evidence at the preliminary injunction hearing and the trial on the merits showed that not one plan that any party can identify incorporates features as collectively meager as the New Base Plan. Indeed, virtually every component of the New Base Plan is unique in its minimalism.

would be provided to its Retirees. In acting so cavalierly, the Department engaged in “truly irrational” state action that severely eviscerated the Retirees’ statutory entitlement to health insurance. The Department’s unthinking conduct violated their substantive due process rights protected by Art. I, §10 of the Missouri Constitution and the due process clause of the Fourteenth Amendment to the United States Constitution.

The crafting of the New Base Plan began when Major Nocchiero initiated an inexplicable effort to reduce the cost of providing health insurance for the Retirees to that paid for insuring the Department’s active-duty officers. (Sup.Tr. 14, p.42-44; Sup.Tr. 29-30; Sup.Tr. 55). His thoughtless edict necessarily resulted in a gross degradation of the Retirees’ health benefits plan.

In achieving its solely cost-driven goal, the Department literally gave no consideration to the serious impairment of the quality of the health benefits that the Retirees would suffer. (Sup.Tr. 14, p.44; Sup.Tr. 99-89). Despite the significance of the reduction in Retiree benefits, this decision was not even considered by the Department’s Benefits Committee. (Sup.Tr. 30; Sup.Tr. 80-82; Tr. 139-140). The Department merely consulted its current provider and directed it to design a policy at the particular price point set by the present cost of the plan for actives. No effort was made by the Department to obtain quotes from other health insurance providers or to shop around to determine whether it could obtain a more mainstream package of benefits at an affordable cost. (Tr. 141-142).

The Department’s conscious disregard for the consequences of its draconian action, particularly given its obligations as a consequence of the Lane Lawsuit and the

mandate of the Retiree Health Insurance Statute, was “truly irrational.” *Furlong Companies, Inc. v. City of Kansas City*, 189 S.W.3d 157, 170-71 (Mo. banc 2006). *See also, Thorning v. Hollister School District*, 11 Cal. App. 4th 1598, 1610, 15 Cal. Repr. 91 (Cal. App. 6th Dist. 1992) (deprivation of health benefit entitlement is a violation of due process); *Duncan v. Retired Public Employees of Alaska, Inc.*, 71 P.3d 882, 888 (AK 2003) (practical considerations of rising health insurance costs do not justify constitutional violation). Notably, the Department does not dispute the Retirees’ description of the cavalier process that it followed in determining to foist the New Base Plan on the Retirees. *See* Retirees’ Brief, pp. 10-12, 32-33. Rather, the Department argues that its “dual option plan clearly and carefully follows the guidance set forth in The Honorable Timothy Wilson’s interlocutory order of April 30, 2002....” Department Brief, p. 28. Retirees believe this bald assertion is rank nonsense.

Judge Wilson ruled in unmistakable terms that the Retiree Health Insurance Statute requires the Department to, at a minimum, sponsor a health benefits plan that, if not superlative, is at least reasonable: “Hypothetically, if a law required that Smith ‘provide an automobile’ to Jones, Smith is not obligated to furnish Jones a Mercedes or a Cadillac. A Honda Civic would suffice.” (A 28). The experts who provided testimony below uniformly opined that they were unaware of any health benefits plan as meager from an overall benefits perspective as the New Base Plan. There are, in contrast, many Honda Civics on the road; they may not be luxury motor cars, but they undoubtedly are reasonable means of transportation. For the Department to contend that it has sought to

comply with Judge Wilson's ruling in fashioning the New Base Plan strikes the Retirees as disingenuous.

Retirees respectfully suggest that the Department's callous decision to impose a health benefits plan on the Retirees that is poorer in quality than any its own experts could identify, without engaging in any effort to explore alternatives, was not supported by rational thought. Therefore the New Base Plan has violated their substantive due process rights. *Furlong, supra*, 189 S.W. 3d at 170-71.

CONCLUSION

The Trial Court erred in concluding that Department's proposed Base Plan satisfies the Retiree Health Insurance Statute's mandate to "provide...health insurance coverage...." Although this statute contains no explicit standard by which to gauge the Department's compliance therewith, sound, sensible construction of this law dictates the conclusion that the Department must afford some reasonable level of coverage to its Retirees. Thus, compliance must be determined by evaluating the New Base Plan in light of the range of group plans that employers commonly offer to their employees.

The New Base Plan is so meager that its aggregate benefits level settles out far below the range of benefit plans actually provided by group sponsors. The Trial Court's refusal to interpret the Retiree Health Insurance Statute so as to include a reasonableness standard constitutes a reversible error of law that unduly prejudiced the Retirees' statutory rights. Further, to the extent that the Trial Court found that the New Base Plan

simply is modest, and not unreasonable, the finding plainly is contrary to the overwhelming weight of evidence in the record.

Finally, the manner in which this decision was made by the Department demonstrates the utter irrationality of its actions. This Court should conclude that the Department's imposition of the New Base Plan violated the Retirees' substantive due process rights under Art. I, §10 of the Missouri Constitution and the Fourteenth Amendment to the United States Constitution.

For the foregoing reasons, this Court should reverse the judgment of the Trial Court and remand this case to the Trial Court for further disposition consistent with this Court's opinion.

Respectfully submitted,

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CERTIFICATE OF SERVICE

The undersigned certifies that a true and correct copy of the foregoing brief, and a computer diskette containing the foregoing brief, were hand-delivered this _____ day of January, 2008 to: Patricia Hageman, City Counselor, 314 City Hall, St. Louis, MO 63103.

CERTIFICATE OF COMPLIANCE

I, Elkin L. Kistner, certify that the foregoing brief complies with the limitations contained in Missouri Supreme Court Rule 84.06(b) and, according to the word count function on Microsoft Word 2003 on which it was prepared, contained 11,436 words, exclusive of the cover, the Certificate of Service, this Certificate of Compliance, the signature block and the Appendix.

The undersigned further certifies that the version of this brief filed on computer diskette complies with Missouri Supreme Court Rule 84.06(h) because it has been scanned for viruses and it is virus-free.

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