IN THE

Supreme Court of Pennsylvania

MIDDLE DISTRICT

Docket No. 94 MAP 2012

In Re: Penn Treaty Network America Insurance Company in Rehabilitation

Appeal of: Michael F. Consedine,
Insurance Commissioner of the Commonwealth of Pennsylvania

On Appeal from the Order of the Commonwealth Court of Pennsylvania dated September 28, 2012, Docket No. 1 PEN 2009

BRIEF OF *AMICUS CURIAE* NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS IN SUPPORT OF APPELLANT

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TABLE OF CONTENTS

Page

I. STATEMENT OF JURISDICTION, *ETC.* 1

II. IDENTITY AND INTEREST OF *AMICUS CURIAE* 1

III. SUMMARY OF ARGUMENT 3

IV. ARGUMENT 5

A. The NAIC Receivership Models, upon which Pennsylvania's and other state receivership laws are based, were enacted to ensure policyholders in all states are uniformly protected in the event of insolvency. All states have enacted a version of these models, and the Commonwealth Court's decision could adversely affect the uniformity of state-based regulation of insurance. 5

B. The NAIC Receivership Models and the state laws based upon them give the rehabilitator the authority and discretion to determine if an insurer should be placed into rehabilitation or liquidation. 8

C. The Commissioner met his burden of proof and the Commonwealth Court erred when it did not accept the Commissioner's findings with respect to the deteriorating financial condition of the Insolvent Companies 14

D. The ultimate question in this case is whether future premium revenue for the Insolvent Companies can be increased to pay future claims. Increases in long-term care insurance premium rates are a matter of historical concern to the NAIC and state insurance regulators. 17

E. The Commissioner had reasonable cause to believe that the necessary rate increases could not be achieved, and that continued rehabilitation of the Insolvent Companies was therefore futile. 23

V. CONCLUSION 30

Exhibit "A"

Exhibit "B"

Exhibit "C"

Certificate of Compliance

Proof of Service

TABLE OF CITATIONS

Page(s)

CASES

Consedine v. Penn Treaty Network Am. Ins. Co.,
63 A.3d 368 (Pa. Commw. 2013) .... passim

Foster v. Mut. Fire, Marine & Inland Ins. Co.,
614 A.2d 1086 (Pa. 1992) 10, 11

In re Conservation of Alpine Ins. Co.,
741 N.E.2d 663 (Ill. App. 1st Dist. 2000) 13

Ins. Serv. Office v. Whaland,
378 A.2d 743 (N.H. 1977) 26

Kentucky Cen. Life Ins. Co. v. Stephens,
897 S.W.2d 583 (Ky. 1995) 11, 12

Koken v. Reliance Ins. Co.,
893 A.2d 70 (Pa. 2006) 6

Mass. Auto Rating Accident Prevention Bureau v. Comm'r of Ins.,
453 N.E.2d 381 (Mass. 1983) 26

Remco Ins. Co. v. State Ins. Dept.,
519 A.2d 633 (Del. 1986) 14

Young's Sales and Serv. v. Underground Storage Tank Indemnification Bd.,
6 MAP 2011, 2013 WL 2980609 (Pa. June 17, 2013) 11

STATUTES

40 Pa. C.S. § 221.18 (2012) 8

40 Pa. C.S. § 3801.304 (2012) 25

WIS. STAT. ANN. Ch. 645 (1967) 5, 6

OTHER AUTHORITIES

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Couch on Insurance 3d § 2:34 (2012) 24, 26, 27

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Carolyn Johnson, *How a Model Becomes a Law,* Contingencies, *March/April 1997* 6

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Joan Ogden, *Some Thoughts on Rate Stabilization*, Long-Term Care News, Society of Actuaries at 20 (December 2002)... 29

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U.S. GOV'T ACCOUNTABILITY OFFICE, GAO 08-712, OVERSIGHT OF LONG-TERM CARE INSURANCE 1 (2008)... 18

U.S. GOV'T ACCOUNTABILITY OFFICE, GAO 11-701, HEALTH INSURANCE PREMIUM RATES 5 (2011) 24

NAIC AUTHORITIES

NAIC, 2009 INSURANCE DEPARTMENT RESOURCES REPORT (2010) 25

NAIC Long-Term Care Insurance Regulation, Section 10 (1988)........................ 20

NAIC, Model Laws, Regulations and Guidelines: Guideline for Filing Rates for Individual Health Insurance Forms (1983) 25

NAIC Model Laws, Regulations and Guidelines: Insurer Receivership Model Act (2007)...6

NAIC, Model Laws, Regulations and Guidelines: Long-Term Care Insurance Model Regulation vol. IV (2010).. 21

NAIC, Model Laws, Regulations and Guidelines: Property and Casualty Model Rating Law (File and Use Version) (2009) 25

NAIC, Model Laws, Regulations and Guidelines: Property and Casualty Model Rating Law (Prior Approval Version) (2009) 25

NAIC Testimony before the U.S. House Committee on Energy and Commerce's Subcommittee on Oversight and Investigations regarding Long Term Care Insurance: Are Consumers Protected for the Long Term? Commr. Sean Dilweg (July 24, 2008) 25

NAIC Testimony before the U.S. House Committee on Energy and Commerce's Subcommittee on Oversight and Investigations regarding Long Term Care Insurance: Are Consumers Protected for the Long Term? Commr. Mike Kreidler (July 24, 2008) 28

NAT'L ASS'N OF INS. COMM'RS, FINANCIAL REGULATION STANDARDS AND ACCREDITATION PROGRAM (2013) 12, 13, 26

NAT'L ASS'N OF INS. COMM'RS, RECEIVER'S HANDBOOK FOR INSURANCE COMPANY INSOLVENCIES (2009) 12, 13, 26

NAT'L ASS'N OF INS. COMM'RS, STATE INSURANCE REGULATION 2 (2009) 18

Proc. of the Nat'l Ass'n of Ins. Comm'rs, 1946 vol. 1 25

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Proc. of the Nat'l Ass'n of Ins. Comm'rs, 1988 vol. 1 19-20

Proc. of the Nat'l Ass'n of Ins. Comm'rs, 1995 3rd Quarter, vol. 3 9

Proc. of the Nat'l Ass'n Ins. Comm'rs, 2000, 2nd Qtr. vol. 1 20

I. STATEMENT OF JURISDICTION, *ETC.*

The National Association of Insurance Commissioners (the "NAIC") submits its *amicus curiae* brief in support of Appellant Michael F. Consedine, Pennsylvania Insurance Commissioner and Statutory Rehabilitator (the "Commissioner") of Penn Treaty Network America Insurance Company in rehabilitation ("PTNA") and its subsidiary, American Network Insurance Company ("ANIC") (collectively, the "Insolvent Companies"). The NAIC adopts and incorporates by reference from the brief of the Commissioner the following: (1) Statement of Jurisdiction; (2) Order in Question; (3) Statement of the Scope of Review and the Standard of Review; (4) Statement of the Questions Involved; and (5) Statement of the Case.

II. IDENTITY AND INTEREST OF *AMICUS CURIAE*

The NAIC is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories. The Commissioner is the current Secretary-Treasurer of the NAIC and a member of its Executive Committee. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. The NAIC members, together with the central

resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

The NAIC's purpose is to provide its members with a national forum enabling them to work cooperatively on regulatory matters that transcend the boundaries of their own jurisdictions. Collectively, the state insurance commissioners work to develop model legislation, rules, regulations, white papers and actuarial guidelines that promote and establish uniform regulatory policy. Their overriding objectives are to protect consumers as well as to assist in maintaining the financial stability of the insurance industry.

The NAIC also has an interest in promoting the uniformity of insurance laws and regulations among the states. Pennsylvania's receivership law is based on model acts developed by the NAIC, and all states have adopted a version of these models. The Commonwealth Court's decision at issue on this appeal may affect the interpretation of the NAIC model acts as enacted in other states and challenges an insurance department's authority and ability to exercise its expertise in determining whether an insurer should be placed into rehabilitation or liquidation. The NAIC members are uniquely qualified and situated to assist this Court by presenting the regulatory and public policy concerns involved in this case.

Individually and collectively, the NAIC members and the state agencies over which they preside have a wealth of experience in the regulation of insurance.

Regulators have unique knowledge of and expertise in the insurance industry, and their expertise should be given the deference it deserves. The Commonwealth Court in this instance substituted its judgment for that of the Commissioner by requiring the Commissioner to submit a rehabilitation plan rather than approving his request to liquidate the Insolvent Companies.

The NAIC endorses the brief of the Commissioner and seeks to aid this Court by offering the legal position and public policy perspectives of the NAIC and its member states.

III. SUMMARY OF ARGUMENT

The NAIC believes the Commonwealth Court should have given deference to the Commissioner's position that the rehabilitation of the Insolvent Companies should have been terminated and a liquidation order entered because the Commissioner had reasonable cause to believe that further attempts to rehabilitate the Insolvent Companies would be futile.

This case is of national significance to the NAIC membership because the Commonwealth Court has effectively substituted its judgment for that of the Commissioner, and did not afford to the Commissioner the discretion intended under the NAIC model receivership acts upon which the Pennsylvania law is based. Specifically, the Commonwealth Court erred when it did not accept the Commissioner's findings with respect to the deteriorating financial condition of the

Insolvent Companies, and when it did not accept the Commissioner's reasonable belief that the premium rate increases necessary to cover future claims were too high to be achievable and thus continued rehabilitation was futile. While the Commissioner may have the burden of proof in showing a "reasonable cause to believe," it is not a heavy burden as claimed by the Commonwealth Court, and due consideration should be given to the Commissioner's expertise in the regulation of insurance. *Consedine v. Penn Treaty Network Am. Ins. Co.,* 63 A.3d 368, 457 (Pa. Commw. 2013).

The NAIC also disagrees with the Commonwealth Court's statement that "[t]his case presents a serious indictment of the existing system of rate regulation of long-term care insurance." *Id.* at 376. The NAIC and its member jurisdictions have made significant improvements to the regulation of long-term care insurance, particularly with respect to the oversight of premium rate increases. The Commonwealth Court has attempted to assume the authority of the Commissioner in this case, and it is imperative to the system of state regulation of insurance that this decision be overturned.

IV. ARGUMENT

A. The NAIC Receivership Models, upon which Pennsylvania's and other state receivership laws are based, were enacted to ensure policyholders in all states are uniformly protected in the event of insolvency. All states have enacted a version of these models, and the Commonwealth Court's decision could adversely affect the uniformity of state-based regulation of insurance.

Since the NAIC's formation in 1871 (at which time the Committee on Winding Up Insolvent Companies was formed), the NAIC has addressed issues regarding the treatment of insolvent or troubled insurers. Proc. of the Nat'l Ass'n of Ins. Comm'rs, 1871 vol. I at 18.[1] In 1936, the NAIC adopted the first of its various receivership model laws[2], the Uniform Rehabilitation, Reorganization, or Liquidation Act (the "1936 Model"). Proc. of the Nat'l Ass'n of Ins. of Comm'rs, 1936 vol. I at 33. The 1936 Model first created a uniform procedure so that all creditors, including policyholders and claimants residing in reciprocal states, were on an equal footing with those in the domiciliary state. *Id.* at 31-33.

In 1969, the NAIC adopted Wisconsin's Rehabilitation and Liquidation Act[3] as the NAIC model law (the "Wisconsin Model").[4] *See* Proc. of the Nat'l Ass'n of Ins. Comm'rs, 1969 vol. 1 at 168, 241 and 271. The Wisconsin statute and

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[1] The NAIC Proceedings are the official published minutes of the meetings of the NAIC.

[2] Collectively, the "NAIC Receivership Models."

[3] WIS. STAT. ANN. Ch. 645 (1967)

[4] The NAIC adopted the Wisconsin statute in its entirety and used the statute as its model law from December 1968 to December 1977. Proc. of the Nat'l Ass'n of Ins. Comm'rs, 1969 vol. 1 at 168, 241 and 271.

comments[5] were adopted in full by the NAIC, thereby providing great insight into the rationale for provisions of the model. The Pennsylvania receivership laws were based on the Wisconsin Model. *See Koken v. Reliance Ins. Co.*, 893 A.2d 70, 84 (Pa. 2006). The Wisconsin Model was the "blueprint for the Pennsylvania statute." *Id.*

The NAIC Receivership Models have evolved over time from a general statement of intent to protect unsecured creditors to a comprehensive statutory scheme to govern the rehabilitation or liquidation of an insolvent insurer. With every revision of the NAIC Receivership Models, each model has become more specific and detailed[6] in an effort to promote greater nationwide consistency and certainty in the course of a liquidation or rehabilitation. The NAIC Receivership Models are created and revised with input from the insurance commissioners and other interested parties.[7] Each version of the NAIC Receivership Models represents

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[5] "Following a relatively uncommon though not entirely unprecedented procedure, the Wisconsin legislature enacted S. 303 of 1967 as chapter 89, Laws of 1967, including in the bill and in the session laws not only the statutory language but also the comments of the Insurance Laws Revision Committee." *See* Wisconsin Model, Introductory Comment to WIS. STAT. ANN. Ch. 645 (1967).

[6] The 1936 Model was two pages; the current version of the NAIC model is 98 pages. *See* NAIC Model Laws, Regulations and Guidelines: Insurer Receivership Model Act vol. 3 pp. 555-1 to 555-98 (2007).

[7] *See generally* Carolyn Johnson, *How a Model Becomes a Law,* Contingencies, *March/April 1997,* at 33-35 (explaining process of creating and adopting NAIC model law involves participation by state regulators, consumers, and industry representatives; public hearings, public meetings, and written comments are considered in drafting process; model law drafting process may take months or years in order to reach consensus).

the collective wisdom and best practices of the state insurance commissioners. The 2005 version, the Insurer Receivership Model Act ("IRMA"), is the version of the model law in effect today. Recognizing the importance of protecting policyholders, all states have adopted a version of the NAIC models based, in part, on either IRMA or its predecessors. *See* Exhibit "A," NAIC Insurer Receivership Model Act State Page; *see also* Exhibit "B," NAIC Insurers Rehabilitation and Liquidation Model Act State Page.

Uniformity in the interpretation of the various state receivership laws and consistency in the application of these laws are important concerns to the NAIC. Enactment of a receivership scheme is an element of the NAIC Financial Regulation Standards and Accreditation Program. Accreditation is the process by which a program has been certified as fulfilling certain standards by a national professional association. In terms of insurance financial solvency regulation, accreditation is a certification given to a state insurance department by the NAIC once it has demonstrated it has met and continues to meet an assortment of legal, financial and organizational standards as determined by a committee of its peers. NAT'L ASS'N OF INS. COMM'RS, FINANCIAL REGULATION STANDARDS AND ACCREDITATION PROGRAM (2013).[8] As of this date, all 50 states, the District of

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[8] *Available at* http://www.naic.org/documents/committees_f_FRSA_pamphlet.pdf.

Columbia and Puerto Rico are accredited by the NAIC. As a requirement for accreditation for financial solvency regulation, each state must enact a receivership scheme similar to IRMA for the administration, by the insurance commissioner, of companies found to be insolvent.

The Commonwealth Court's decision in this case could affect the interpretation of the NAIC Receivership Models as they have been adopted by the states. Since most states have adopted some version of the NAIC Receivership Models, and since decisions of courts with similar or identical versions of the models can be persuasive authority in other jurisdictions, the outcome of this matter may affect receivership proceedings in other states.

B. The NAIC Receivership Models and the state laws based upon them give the rehabilitator the authority and discretion to determine if an insurer should be placed into rehabilitation or liquidation.

The Pennsylvania statute provides that whenever the rehabilitator has "reasonable cause to believe that further attempts to rehabilitate an insurer would substantially increase the risk of loss to creditors, policyholders, or the public, or would be futile, the rehabilitator may petition the Commonwealth Court for an order of liquidation." 40 Pa. C.S. § 221.18 (2012). The Commonwealth Court placed the "heavy burden" of proof on the Commissioner to show that any further attempts to rehabilitate the Insolvent Companies would be futile or increase the risk of loss, and characterized the Commissioner's futility argument as "the

proverbial house of cards." *Penn Treaty,* 63 A.3d at 457-58. Further, the Commonwealth Court did not defer to the Commissioner with respect to the decision to convert the rehabilitation into a liquidation, reasoning that "to apply deference to the job of factfinding would undermine this Court's responsibility to act upon the Rehabilitator's petition in a fair and neutral manner." *Id.* at 440 (citing the Commonwealth Court's own opinion in *Koken v. Legion Ins. Co.*, 831 A.2d 1196, 1229-30 (Pa. Commw. 2003), *aff'd sub nom. Koken v. Villanova Ins. Co.*, 878 A.2d 51 (2005)).

Contrary to the Commonwealth Court's assertion, the Commissioner needs only prove that he has a reasonable belief, which, as one commentator on the NAIC Receivership Models noted, "is not a difficult standard of proof." Proc. of the Nat'l Ass'n of Ins. Comm'rs 1995 3rd Quarter, vol. 3 at 609. The Wisconsin Model, upon which the Pennsylvania law is based, gives the rehabilitator broad powers under Section 645.33. The comments to the section specifically provide that "once appointed, the special deputy [receiver] should have great freedom of operation subject of course to protection of the public by an official bond, and by court and department supervision. But court supervision must be liberal and general, not strict or detailed." Proc. of the Nat'l Ass'n of Ins. Comm'rs, 1969 vol. 1 at 168, 241, 271 at Section 645.33.

Therefore, court control of the rehabilitation process shall be very liberal. Success may depend on the court's understanding of the imperative need for the rehabilitator to have broad discretion and the freedom to act quickly. The rehabilitator, not the court, must make the day-to-day decisions. *Id.* This Court should give due deference to the opinion of the Commissioner that continued rehabilitation of the Insolvent Companies would be futile. The correct standard to be applied by the Commonwealth Court to the Commissioner's determinations was abuse of discretion:

> [B]oth the Insurance Commissioner and the Commonwealth Court are obligated to interact in order to supervise, implement and regulate equitably the process engaged to rehabilitate an insolvent or financially hazardous insurer. As a result of these specific assignments, it is not the function of the courts to reassess the determinations of fact and public policy made by the Rehabilitator. **Rather, the involvement of the judicial process is limited to the safeguarding of the plan from any potential abuse of the Rehabilitator's discretion.**

Foster v. Mut. Fire, Marine & Inland Ins. Co., 614 A.2d 1086, 1091 (Pa. 1992) (emphasis added). This Court further stated:

> It has been established as an elementary principal of law that courts will not review the actions of governmental bodies or administrative tribunals involving acts of discretion *in the absence of bad faith, fraud, capricious action or abuse of power*....That the court might have a different opinion or judgment in regard to the action of the agency is not a sufficient ground for interference; *judicial* discretion may not be substituted for *administrative* discretion.

Id. at 1092 (quoting *Norfolk & W. R. Co. v. Pa. Pub. Util. Comm'n,* 413 A.2d 1037, 1047 (1980)). This deference to administrative discretion was recently confirmed by this Court. *See Young's Sales and Serv. v. Underground Storage Tank Indemnification Bd.,* 6 MAP 2011, 2013 WL 2980609 (Pa. June 17, 2013).

Other courts of states that have adopted the Wisconsin Model also recognize that the appropriate standard of review is one of abuse of discretion. For instance, the Kentucky Supreme Court reviewed a proceeding against a life insurer to convert a rehabilitation into a liquidation.[9] *Kentucky Cen. Life Ins. Co. v. Stephens,* 897 S.W.2d 583 (Ky. 1995). The Kentucky Supreme Court determined that administrative discretion was applicable to the determinations of the rehabilitator in such cases:

> [P]rior to the commencement of liquidation, there is a requirement of proof that rehabilitative efforts would substantially increase the risk of loss or be futile. Proof, as in this case, may take on several forms and a rehabilitator is granted authority to make judgments and take actions he believes to be in the public interest. The trial court's primary role is a supervisory one and the standard of the court's review of the rehabilitator's actions is one of abuse of discretion. **Under the special statutory proceedings, the Commissioner is granted administrative discretion in the context of the insolvency/delinquency proceedings and the burden of proof is upon those contesting the Commissioner's actions.**

[9] The proceeding was brought under Subtitle 33 of Chapter 304 of the Kentucky Revised Statutes, which is consistent with the Wisconsin Model.

Id. at 587-88 (emphasis added) (citing this Court's decision in *Mut. Fire, supra*). The court went on to find that where the Kentucky Commissioner of Insurance believed that further efforts to rehabilitate the insurance company would serve no useful purpose and that liquidation was desirable and necessary, only a strong showing to the contrary would have justified the trial court's refusal to follow the commissioner's recommendations. *Id.* at 588.

Upon entry of an order appointing an insurance commissioner as receiver, the receiver is vested with total control of the insurer. The rehabilitator is given a great deal of latitude in exercising his or her authority over the affairs of the insurer. NAT'L ASS'N OF INS. COMM'RS, RECEIVER'S HANDBOOK FOR INSURANCE COMPANY INSOLVENCIES at p. A (2009) (the "Receiver's Handbook").[10] The rehabilitator's actions may only be set aside if the supervising court finds that the receiver has abused his or her discretion. The standard of review in appealing a receivership order is whether the regulatory authority acted reasonably in an effort to protect policyholders, other creditors and the public. *Id.* "[S]tate appellate

[10] *See* Exhibit "C," Receiver's Handbook (selected excerpts). "These materials are designed and intended to provide a general overview of concepts, principles and procedures that the authors and editors believe may be of assistance to a receiver.... While these materials have been prepared at the request of the National Association of Insurance Commissioners, they do not reflect the formal position of that organization or of any individual or insurance regulatory authority in the states, districts or territories of the United States." Receiver's Handbook *Disclaimer*. Although it is not intended to be authoritative, the Receiver's Handbook provides the most current, complete information available on administering insurance company receiverships, and represents more than two years' of work compiling information from more than 50 authorities, including actuaries, accountants and consultants who regularly work on receiverships.

courts have refused to reverse an order of liquidation without a clear showing that the regulator abused his or her discretion. The reviewing court's primary focus is whether the regulator properly and reasonably acted to protect the policyholders and the public." *Id.* at 451.

Here, the Commonwealth Court found that the Commissioner had not proven futility in the rehabilitation of the Insolvent Companies, because "only with the filing of a [rehabilitation] plan, even in the most preliminary form, is it possible to track progress and establish the plan's viability or its futility.... Without a formal plan of rehabilitation, the Rehabilitator cannot make the case that a plan he never proposed or implemented is futile." *Penn Treaty,* 63 A.3d at 447. However, the Commonwealth Court was mistaken in its assertion that the Commissioner was required to attempt rehabilitation in order to prove futility. "A troubled company does not move systematically from one form of receivership to another, but rather, the regulator may choose to petition for the form of receivership appropriate to the circumstances at any given time." Receiver's Handbook at 3. The regulator is not required to attempt to rehabilitate the insurer as a prerequisite to seeking an order of liquidation. *Id.* at 450. *See also In re Conservation of Alpine Ins. Co.,* 741 N.E.2d 663 (Ill. App. 1st Dist. 2000) (decision whether to rehabilitate or liquidate not mandated by statute, but left to regulator's discretion based on circumstances);

Remco Ins. Co. v. State Ins. Dept., 519 A.2d 633 (Del. 1986) (regulator need not first pursue summary remedies).

Further, the Commonwealth Court ignored this Court's finding in *Legion* that there are extreme circumstances where futility might be established, even without the adoption of a formal plan of rehabilitation. The Commissioner determined that the Insolvent Companies' finances were in total disarray. *Penn Treaty*, 63 A.3d at 447. As discussed *infra*, the Commissioner met his burden of proof in showing that the finances of the Insolvent Companies were in complete disarray. The fact that the Commissioner did not first file a plan of rehabilitation did not contravene his reasonable conclusion that further efforts at rehabilitation would be futile.

C. The Commissioner met his burden of proof and the Commonwealth Court erred when it did not accept the Commissioner's findings with respect to the deteriorating financial condition of the Insolvent Companies.

The Commissioner's actuary (Milliman, Inc.) presented expert testimony that as of December 31, 2009, PTNA's statutory surplus was negative $2.1 billion and ANIC's statutory surplus was negative $137.0 million. *Penn Treaty,* 63 A.3d at 396-97. This resulted from increases to claim projections for PTNA of over $1 billion. *Id.* at 378. The expert for the Intervenors/Appellees (United Health Actuarial Services, Inc.) projected PTNA's statutory surplus to be negative $333 million and ANIC's surplus to be positive $600,000 as of December 31, 2009. *Id.*

The Commissioner's expert projected additional total premium rate increases needed for solvency at between 257-280% for PTNA and 221-244% for ANIC. *Id.* at 412. The expert for Intervenors/Appellees also projected a need for large rate increases. *Id.* at 416.[11]

For the Commonwealth Court, the central issue in determining whether the continued rehabilitation of the Insolvent Companies was futile was whether it accepted the Commissioner's argument that there was a drastic understatement of the Insolvent Companies' reserves. The Commonwealth Court found that the differences between the experts' actuarial projections reflect differences in the exercise of actuarial judgment, and not differences in data. *Id.* at 431. The Commonwealth Court explained the purpose of reserves in the context of rehabilitation:

> As noted, the claim reserve represents the amount needed to pay incurred claims until they end, which can be many years. The active life reserve represents a more ephemeral liability, i.e., what is estimated to be paid in the future on claims that may or may not develop. To estimate the reserve for future, but yet to be developed claims, the actuaries must conduct an inquiry that is broad in scope. They must estimate the number of policyholders, their mortality, their tendency to morbidity, inflation, deflation, investment earnings, premium volume and future rate increases over a 60–year period. It is a complicated process, and the results are uncertain because the factors

[11] The Commissioner also proposed to offer expert testimony from Vincent Bodnar, but the Commonwealth Court excluded Bodnar's testimony and his two reports. *Id.* at 395. The NAIC believes that Bodnar's testimony is important and enlightening, and should be considered by this Court.

> that go into the projections keep changing. **It is a high wire juggling act to predict what will happen during the period from December 31, 2009, to December 31, 2069, during which time a cure for cancer may be found or an asteroid may hit North America.**

Id. at 393-94 (emphasis added). The Commonwealth Court also commented on a recent discovery that has been shown to increase brain function in mice with Alzheimer's disease. "[T]he announcement of this breakthrough underscores the self-evident point that the future is uncertain and future developments may benefit the Companies." *Id.* at 460. Such statements indicate a belief by the Commonwealth Court that actuarial reserving may be an inexact science, and that there may be more than one reasonable actuarial opinion on the correct reserves for the Insolvent Companies.

Indeed, the Commonwealth Court never made a determination or conclusion of law that the Commissioner did not have reasonable cause to believe that the Insolvent Companies were in a deteriorating financial condition. Instead, the Commonwealth Court deemed these projections to be unreliable, *id.* at 458, and the testimony of the expert of Intervenors/Appellees to be "more compelling." *Id.* at 439. It further found as fact that the assumptions used by the Commissioner's expert were too pessimistic. *Id.* at 432. However, none of these statements equate to a finding that there was no reasonable cause to believe, which is the actual

standard of proof under the Pennsylvania statute and the NAIC Receivership Models.

The Commonwealth Court did a very thorough, detailed and exacting review of the expert testimony submitted in this case, and is to be commended for its efforts in this regard. However, judging solely from the length of the opinion, it is clear that the lower court went well beyond its role by denying the liquidation request and substituting its judgment for that of the Commissioner. The Commonwealth Court attempted to place itself into the shoes of the Commissioner, and did not simply determine whether the Commissioner's decision was an abuse of discretion, but rather questioned the decision of the Commissioner in page after page of *dicta*. The Commissioner acted well within the scope of his powers, and reached a reasoned decision with which the Commonwealth Court simply disagreed. The Commonwealth Court's mere disagreement does not mean that the Commissioner's decision should be ignored.

D. The ultimate question in this case is whether future premium revenue for the Insolvent Companies can be increased to pay future claims. Increases in long-term care insurance premium rates are a matter of historical concern to the NAIC and state insurance regulators.

The Commonwealth Court correctly recognized that the ultimate question in this proceeding is whether "future premium revenue can be increased at the pace needed to pay future claims." *Penn Treaty,* 63 A.3d. at 439. However, as shown

infra, the Commissioner had reasonable cause to believe that the necessary rate increases could not be achieved, and that continued rehabilitation of the Insolvent Companies was therefore futile. The Commonwealth Court was mistaken that "[t]his case presents a serious indictment of the existing system of rate regulation of long-term care insurance." *Id.* at 376.

Oversight of the long-term care insurance industry, including consumer protection standards for rate setting, is primarily the responsibility of the NAIC and the states. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO 08-712, OVERSIGHT OF LONG-TERM CARE INSURANCE 1 (2008). Members of Congress, state regulators and interested parties have raised concerns that increases in long-term care insurance premiums may leave some consumers without long-term care coverage just as they begin the need for such coverage. *Id.* at 2. The NAIC and its member jurisdictions have made significant improvements to the regulation of long-term care insurance, particularly with respect to the oversight of premium rate increases. The NAIC will provide this Court with a better understanding of state regulation of long-term care premium increases, and the steps taken to protect consumers from unreasonable rate increases.

"The fundamental reason for government regulation of insurance is to protect American consumers.... State regulation has proven that it effectively protects consumers and ensures that promises made by insurers are kept." NAT'L

ASS'N OF INS. COMM'RS, STATE INSURANCE REGULATION 2 (2009). State regulation of premium rate increases can be summarized as follows:

> The McCarran-Ferguson Act provides states with the authority to regulate the business of insurance, without interference from federal regulation, unless federal law specifically provides otherwise. Therefore, states are primarily responsible for overseeing private health insurance premium rates in the individual and group markets in their states. Through laws and regulations, states establish standards governing health insurance premium rates and define state insurance departments' authority to enforce these standards. In general, the standards are used to help ensure that premium rates are adequate, not excessive, reasonable in relation to the benefits provided, and not unfairly discriminatory.

U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-11-701, HEALTH INSURANCE PREMIUM RATES 5 (2011).

The NAIC adopted the Long-Term Care Insurance Model Act in 1987. Proc. of the Nat'l Ass'n of Ins. Comm'rs, 1987 vol. I at 11, 19, 655, 677-80, 700. The NAIC's earliest Long-Term Care Insurance Model Regulation was adopted in 1988. Proc. of the Nat'l Ass'n of Ins. Comm'rs, 1988 vol. I at 9, 20-21, 629-30, 652, 656-61. Since the adoption of these models, the NAIC, in collaboration with consumer advocates and the insurance industry, has amended the model act and regulation many times to address problems with products, including amendments with respect to the stability of premiums. *NAIC Testimony before the U.S. House Committee on Energy and Commerce's Subcommittee on Oversight and*

Investigations regarding Long Term Care Insurance: Are Consumers Protected for the Long Term? Commr. Sean Dilweg (July 24, 2008) ("Dilweg Testimony").[12]

The original model regulation required all individual long-term care insurance policies to meet a minimum 60 percent loss ratio. *See* NAIC Long-Term Care Insurance Regulation, Section 10 (1988) (at Proc. of the Nat'l Ass'n of Ins. Comm'rs, 1988 vol. I at 660). This meant that over the life of the policy, a minimum of 60 percent of the premium had to go towards the payment of claims. A maximum of 40 percent of the premium could be allocated to administrative costs and profit. However, it is important to note that this requirement, though a key consumer protection to ensure that a majority of the premium was being used for paying claims, did not address the potential underpricing of policies and the resultant premium increases. *See* Dilweg Testimony at 10.

In response to this problem, the NAIC amended the model regulation in 2000 to ensure greater premium stability. Proc. of the Nat'l Ass'n Ins. Comm'rs, 2000, 2nd Qtr. at 21-22, 162, 292-309. Section 20 eliminated the 60 percent minimum initial loss ratio requirement, and substituted an actuarial certification that must be filed with the initial premium rate filings, attesting that premiums will not increase over the life of the policy under moderately adverse conditions.

[12] In response to GAO report 08-712, *supra* at 18, several NAIC state insurance commissioners provided testimony before the House Committee on Energy and Commerce Subcommittee on Oversight and Investigations. Their testimony can be found on the NAIC webpage at http://www.naic.org/cipr_testimony_archive.htm#yr2008.

However, in the event that future premium increases become necessary and are filed with the insurance department, the original premium rates filed must now meet a 58 percent loss ratio, and the premium increases need to meet an 85 percent loss ratio. Furthermore, following each rate increase, the insurer must file its subsequent experience with the state insurance commissioner for three years. NAIC, Model Laws, Regulations and Guidelines: Long-Term Care Insurance Model Regulation vol. IV p. 641-32 (2010).[13] If the increase appears excessive, the commissioner may require the company to reduce premiums or take other measures, such as reducing its administrative costs, to ensure that premium increases that turn out to be unnecessary are returned to policyholders. *Id.* at 641-32, 641-33. *See also* Dilweg Testimony at 10–11.[14]

The 2000 amendments also put in place two additional levels of protection against premium increases. If premiums rise above a given level, based upon the age of the policyholder, for a majority of policyholders, the company is required to file a plan for improved administration and claims processing or to demonstrate that appropriate claims processing is in effect. Furthermore, if a commissioner believes that a rising rate spiral exists, he or she may require the company to offer policyholders affected by the premium increase an opportunity to replace their

[13] The 2010 Model regulation is the version currently in effect. There were no changes to Section 20 in the 2010 version.

[14] *See also* Selected Rate Setting Standard Added to NAIC's LTCI Model Regulation in 2000 from GAO-08-712, p. 16.

existing policies with comparable ones currently being sold, without underwriting. *Id.* at 641-34. This allows policyholders trapped in a rising rate spiral to switch to a more stable policy. Finally, as a last resort, if a commissioner determines that a company has persistently filed inadequate initial premium rates, the commissioner may ban the company from the long-term care insurance marketplace for up to five years, essentially putting the company out of business in the state. *Id.* at 641-35. *See also* Dilweg Testimony at 11.

These changes created a strong incentive for companies to price policies accurately upfront to avoid future increases and to encourage suitable sales of the products. In order to assist consumers in selecting a policy with premiums that do not drastically increase over time, insurers are required to disclose to prospective policyholders all prior rate increases for the past ten years. *See* Dilweg Testimony at 11–12.

The NAIC is continuing with its efforts to effectively regulate premium increases with respect to long-term care insurance. Over the past several years, the issue of addressing long-term care premium increases has been the topic of much discussion. On June 10-11, 2013, the NAIC held an Interim Meeting to work on addressing these increases. The focus of the meeting was two-fold: (1) addressing rate increases on older policies, including those sold prior to the 2000 amendments; and (2) looking at the regulatory framework to improve stability of rates for

policies going forward. Press Release, Nat'l Ass'n of Ins. Comm'rs, *State Insurance Regulators Work on Long Term Care Insurance* (June 11, 2013).[15]

E. The Commissioner had reasonable cause to believe that the necessary rate increases could not be achieved, and that continued rehabilitation of the Insolvent Companies was therefore futile.

The Commonwealth Court rejected the Commissioner's argument that the rate increases needed for the insolvent companies are too high to be achievable, and thus continued rehabilitation was futile. *Penn Treaty,* 63 A.3d at 450. Instead, it credited the testimony of the expert for the Intervenor/Appellees that the rate increases which are necessary for the Insolvent Companies "while high, are reasonable based on his experience." *Id.* The Commonwealth Court further found that the Commissioner's "case for liquidation is based upon the premise that states will refuse to carry out their statutory obligations to approve actuarially justified rate increases." *Id.* Finally, the Commonwealth Court intimated that states that do not raise rates will receive a proportionally lower distribution in the case of liquidation:

> On the other hand, if there were a liquidation, state regulators need to be aware that their state's inadequate rates will be considered. For example, estate distributions may be made in inverse proportion to the state's contribution to the insolvency. **The farther the state's approved rate deviates from what is actuarially justified, the less that state's guaranty fund should expect by way of distribution from the estate in the event of liquidation, absent extenuating circumstances.**

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[15] *Available at* http://www.naic.org/Releases/2013_docs/state_insurance_regulators_work_long_term_care_insurance.htm.

Id. at 460 (emphasis added).

The Commonwealth Court is attempting to assume the traditional discretionary power and authority of state insurance commissioners with respect to ratemaking. Ratemaking is generally not a judicial function, but is left to the discretion of state insurance commissioners, who are in the best position to determine the reasonableness of rates. 1 Lee R. Russ & Thomas F. Segalla, *Couch on Insurance* 3d § 2:34 (2012). The Commonwealth Court cannot substitute its judgment for that of the Commissioner, and it must recognize the complexity of the ratemaking function and give due weight to the experience and expertise of the Commissioner. In the present case, the Commissioner had reasonable cause to believe that the necessary rate increases could not be achieved, and that continued rehabilitation of the Insolvent Companies was therefore futile.

The 2000 amendments to the NAIC Long-Term Care Insurance Model Regulation (which addressed premium rate increases) are not effective with respect to policies issued prior to state adoption of the amendments. However, states have in place standards to help ensure that premium rates are adequate, not excessive, reasonable in relation to the benefits provided, and not unfairly discriminatory. *See* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO 11-701, HEALTH INSURANCE PREMIUM RATES 5 (2011). As early as 1946, the NAIC developed model laws on rate regulation of the property and casualty industry. The models provided that rates

shall not be "excessive, inadequate, or unfairly discriminatory." Proc. of the Nat'l Ass'n of Ins. Comm'rs 1946, vol. 1 at 396, 397-422. Over the years, the NAIC has adopted various versions of these models and additional models regulating rate review of other insurance lines.[16] In 1980, the NAIC adopted extensive guidelines, including actuarial standards, for filing rates of individual health insurance forms. I Proc. of the Nat'l Ass'n of Ins. Comm'rs, 1980 vol. 1at 38, 416-25. Pennsylvania's statute for health insurance rate filing is consistent with this standard. *See* 40 Pa. C.S. § 3801.304 (2012).

The regulatory review and approval of insurance filings is within the province of dedicated professional personnel in each state insurance department, who are trained to apply the specific product requirements set forth in statute and administrative regulation.[17] These professionals also have the expertise to identify and evaluate potential areas of ambiguity within a particular filing. This ability is developed through experience in reviewing and comparing countless insurance policies and understanding market trends. Moreover, courts have long recognized

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[16] *See, e.g.* NAIC Model Laws, Regulations and Guidelines: Property and Casualty Model Rating Law (File and Use Version), p. 1775-1 (2009); NAIC Model Laws, Regulations and Guidelines: Property and Casualty Model Rate and Policy Form Law Guideline, p. 1776-1 (2010); NAIC Model Laws, Regulations and Guidelines: Property and Casualty Model Rating Law (Prior Approval Version), p. 1780-1 (2009); NAIC Model Laws, Regulations and Guidelines: Guidelines for Filing of Rates for Individual Health Insurance Forms, p. 134-1 (1983).

[17] Illustrative of the workload and complexity inherent in the rate filing review and approval function is the fact that insurance departments across the country employed almost 1,200 individuals to support the actuarial and analytical aspects of form review and approval in 2009. NAIC, 2009 INSURANCE DEPARTMENT RESOURCES REPORT (2010).

and deferred to the discretion of state insurance commissioners to analyze and regulate insurance rates. "Due to its complexity. . . rate-making is left to the discretion of the insurance commissioner who is a specialist in the field and upon whose expertise we must rely." *Ins. Serv. Office v. Whaland*, 378 A.2d 743, 746 (N.H. 1977) (citing *Travelers Indem. Co. v. Williams*, 190 So.2d 27, 29 (Fla. Dist. Ct. App. 1966); *Md. Fire U.W. v. Ins. Comm'r*, 272 A.2d 24, 28 (Md. 1971)). *See also Mass. Auto Rating Accident Prevention Bureau v. Comm'r of Ins.*, 453 N.E.2d 381, 385 (Mass. 1983) (finding courts give "due weight to the Commissioner's experience, technical competence, and specialized knowledge as well as the discretionary authority vested in the Commissioner by the Legislature").

It is generally understood that in a receivership proceeding, rate increases made a part of a rehabilitation plan will require state insurance department approval. *See* Receiver's Handbook at 9. Courts are prohibited from imposing rates different than those approved by the commissioner. *Couch on Insurance* 3d § 2:34. The Commonwealth Court cannot substitute its judgment for that of the Commissioner, or for the state insurance commissioners of other states in which policies of the Insolvent Companies have been issued. Furthermore, it must recognize the complexity of the ratemaking function and give due weight to the experience and expertise of the state insurance commissioners. *Id.*

The Commonwealth Court here clearly erred when it presumed that states have statutory obligations to approve rate increases that are justified solely on actuarial grounds. *Penn Treaty,* 63 A.3d at 450. This is true even in the case of the rehabilitation of an insolvent insurance company. While courts have the duty to see that rates established by a commissioner are adequate, just, reasonable and nondiscriminatory, a reviewing court will not disturb a rate schedule unless the commissioner acted unreasonably. *Couch on Insurance* 3d § 2:34. Therefore, the central question remaining to be answered was whether the Commissioner had reasonable cause to believe that the necessary rate increases could not be achieved, and that continued rehabilitation of the Insolvent Companies was futile.

During the 1990s, a number of long-term care insurance companies submitted large rate increase filings to certain states based on the need to fund increased future claims costs. The rate increase filings created a difficult balancing act for state regulators, who needed to ensure that insurance companies have sufficient funds to make future payments and to protect policyholders who may be on fixed incomes and may not be able to afford rate increases. Gorman Actuarial, Inc., *Results of the Long-Term Care Insurance Survey* (June 30, 2009).[18] Rate increases concern state insurance regulators and consumer advocates because they

[18] *Available at* http://www.mass.gov/ocabr/docs/doi/consumer/healthlists/ltcare-survey.pdf. While the Gorman Survey was never offered into evidence in the underlying case, it nevertheless is considered to be a reliable source of information by the Massachusetts Division of Insurance, which posts the document on its website.

threaten purchasers' ability to continue paying for coverage and erode confidence in the industry. Rate increases may cause consumers to drop policies in which they have invested substantial resources, often at an age when they need the policy the most and can least afford an increase. The Lewin Group, *Long-Term Care Insurance: An Assessment of States' Capacity to Review and Regulate Rates* (Washington, D.C.: Feb. 2002).[19] The NAIC is very familiar with the issue of premium rate increases for long-term care insurance:

> The majority of consumer complaints my office receives about long-term care insurance are about the double-digit rate increase they receive on products they purchased in the late '80s and early to mid '90s. Consumers who receive these double-digit rate increases every few years do not understand how the rate increases could be justified. Unfortunately, many can no longer afford the premiums.... When faced with repeat double-digit increases, they do not want to hear how rates must be sufficient to ensure the ongoing financial viability of the company.

NAIC Testimony before the U.S. House Committee on Energy and Commerce's Subcommittee on Oversight and Investigations regarding Long Term Care Insurance: Are Consumers Protected for the Long Term? Commr. Mike Kreidler (July 24, 2008).[20]

Insurance regulators dislike long-term care premium rate increases that affect seniors, because they are vulnerable and may not be able to cope with rate

[19] *Available at* http://assets.aarp.org/rgcenter/il/2002_02_ltc.pdf.

[20] *Available at* *http://www.naic.org/documents/testimony_0807_kreidler.pdf.*

increases. Joan Ogden, *Some Thoughts on Rate Stabilization*, Long-Term Care News, Society of Actuaries at 20 (December 2002).[21] Protection of the policyholders in their states is the utmost priority for state insurance commissioners. They must consider multiple factors when deciding on the appropriate future rate levels, and not just the actuarial justification submitted in the rate increase filing. *See* Larry Pfannerstill, *Conflicting Perspectives on LTC Rate Increases*, Long-Term Care News, Society of Actuaries at 12 (May 2009). This is a greater consideration in those cases where the company has been granted a rate increase in the past. *Id.* As noted by the Commonwealth Court, the Insolvent Companies received multiple rate increases in the past. *Penn Treaty,* 63 A.3d at 385. Finally, even though the proposed rate increases for the Insolvent Companies would not be subject to the rules of the 2000 amendments to the NAIC Long-Term Care Insurance Model Regulation, it is also prudent to examine the provisions to the extent that regulators might refer to them in reviewing a rate filing. Allen Schmitz, *Long-Term Care Insurance Rate Increase Considerations,* Long-Term Care News, Society of Actuaries at 5 (December 2003).

The Commissioner had reasonable cause to believe that the necessary rate increases could not be achieved, and that continued rehabilitation of the Insolvent Companies was therefore futile. The Commissioner's expert testified that the

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[21] All Society of Actuaries publications are a*vailable at* http://www.soa.org/.

needed rate increases exceeded the level that state insurance regulators have approved in the past. *Penn Treaty,* 63 A.3d at 449-50. Because the Commonwealth Court did not accept the Commissioner's projected claim costs, it further stated that it did not accept the premium rate increases the Commissioner's expert said were needed to cover future claims. *Id.* at 450. However, the Commonwealth Court only considered whether the premium rate increases were actuarially justified, but did not consider other important issues for the proposed rate filing. Such consideration is necessary for the protection of policyholders, which is the highest priority for state insurance commissioners. Specifically, there is ample evidence that state insurance regulators are very concerned with long-term care rate increases as applied to elderly populations.

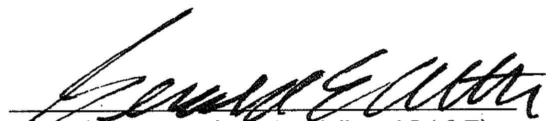
The Commonwealth Court should not have substituted its judgment for that of the Commissioner or the state insurance commissioners for those states in which policies of the Insolvent Companies have been issued, and it failed to recognize the complexity of the ratemaking function and give due weight to the experience and expertise of the Commissioner in this matter.

V. <u>CONCLUSION</u>

Throughout its decision, the Commonwealth Court played the role of the Commissioner, substituting its judgment for that of the insurance expert. The Commonwealth Court never addressed the issue of whether the Commissioner had

reasonable cause to believe rehabilitation would be futile, instead reaching its own conclusions regarding the rehabilitation. The Commissioner presented ample evidence and proved he had reasonable cause to believe continued rehabilitation would be futile. Despite this evidence, the Commonwealth Court denied the request for a liquidation order. The Commonwealth Court did not give due deference to the Commissioner's experience and expertise. Moreover, since all states have laws similar to Pennsylvania's regarding receiverships and numerous states have similar laws regarding rate regulation, the Commonwealth Court decision, if allowed to stand, could adversely affect state-based insurance regulation.

Respectfully submitted,



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