[J-73A&B-2014]]
IN THE SUPREME COURT OF PENNSYLVANIA
MIDDLE DISTRICT

IN RE: PENN TREATY NETWORK AMERICA INSURANCE COMPANY IN REHABILITATION	: No. 94 MAP 2012 : : Appeal from the Judgment of the : Commonwealth Court entered on : September 28, 2012 at No. 1 PEN 2009
APPEAL OF: TERESA D. MILLER, INSURANCE COMMISSIONER OF THE COMMONWEALTH OF PENNSYLVANIA	: : ARGUED: September 10, 2014 : :
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CONCURRING AND DISSENTING OPINION

MADAME JUSTICE TODD **DECIDED: July 20, 2015**

I join the Majority in rejecting the Commonwealth Court's interpretation of 40 P.S. § 221.18(a) ("Section 518(a)") which required that, in order to convert the rehabilitation process of an insolvent insurer into a liquidation of that company, the Pennsylvania Insurance Commissioner ("Commissioner") must "prove, as a matter of fact, that [the] insolvent insurer's immediate financial circumstances are in such disarray that they are completely unsalvageable," or that the Commissioner must "adopt a rehabilitation plan, and, then, have its implementation fail." Consedine v. Penn Treaty Network, 63 A.3d 368, 447, 458 (Pa. Cmwlth. 2012). Section 518(a) places no such exacting obligations

on the Commissioner, but, instead, all that its express language requires for the Commissioner to obtain an order of liquidation from the Commonwealth Court is that the Commissioner show that he or she possesses "reasonable cause to believe that further attempts to rehabilitate [the] insurer would substantially increase the risk of loss to creditors, policy and certificate holders, or the public, or would be futile." 40 P.S. § 221.18. This statutory requirement of "reasonable cause" is a considerably lesser burden of evidentiary proof for the Commissioner to meet than the standard applied by the Commonwealth Court in this matter, which, in essence, required the Commissioner to show, factually, that rehabilitation of the insurance companies involved in this appeal — Penn Treaty and American National Insurance Company ("ANIC"), hereinafter referred to as "Companies"[1] — was impossible.

Therefore, I agree with the Majority that, under Section 518, the Commonwealth Court must apply an abuse of discretion standard when reviewing the Commissioner's administrative decision to convert a rehabilitation proceeding to a liquidation. Such a standard is in accord with our Court's prior admonishment that a reviewing court should exercise "great deference" to decisions of the Commissioner made while acting in his or her capacity as rehabilitator of an insolvent insurer, due to the Commissioner's unique professional expertise in regulation and oversight of the insurance industry. Foster v. Mutual Fire, 614 A.2d 1086, 1093 (Pa. 1992). Consequently, judicial review in this instance is "limited to the determination of whether there has been a manifest and flagrant abuse of discretion or a purely arbitrary execution of the agency's duties or functions." Blumenschein v. Housing Authority of Pittsburgh, 109 A.2d 331, 335 (Pa. 1954). The fact "[t]hat 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

[1] ANIC is a wholly owned subsidiary of Penn Treaty.

may not be substituted for *administrative* discretion." Id. (emphasis original); Foster, 614 A.2d at 1092; Bowman v. D.E.R., 700 A.2d 427, 428 (Pa. 1997); see also Couch on Insurance, § 5.23 (acknowledging that, while courts have a role in controlling the insurance commissioner's exercise of his or her powers, a court "may not, however, use its supervisory role as a means of substituting its judgment for that of the commissioner.").

However, the Majority goes on to affirm the Commonwealth Court's order denying the Commissioner's liquidation petition, agreeing with the lower court's implication that the Commissioner lacked candor and abused the rehabilitation process. The Majority does so, even though the Commonwealth Court's decision was based on its *de novo* review of the evidence, and its findings that the Commissioner "treated the rehabilitation as a conservatorship to give him time to prepare for liquidation," and that the Commissioner did not make "an earnest effort to correct the condition that caused the Companies' financial difficulties: the pricing structure for the OldCo . . . policies . . . but, rather, looked for reasons to be excused from that duty." Consedine, 63 A.3d at 447, 458. By contrast, application of the proper abuse of discretion standard leads me to conclude, as I discuss below, that the record supports the Commissioner's conclusion that liquidation was warranted because he had reasonable cause to believe that continued efforts at rehabilitation were futile, and also that continuing with the rehabilitation process would substantially increase the risk of loss to policyholders.[2] I

[2] While, in response to my expression, see Majority Opinion at 9 n.8, the majority correctly notes that, under Section 518(a), the Commonwealth Court has original jurisdiction over a petition to convert a rehabilitation proceeding to a liquidation, this does not mean that the Commonwealth Court, in ruling on such a petition, sits as if it were a trial court making findings of fact in the first instance as to whether the Commissioner possessed reasonable cause to liquidate the insolvent insurer. To the contrary, and as the majority seemingly concedes, that court must apply a deferential abuse of discretion standard, which requires it to function as a reviewing court, and, as (continued…)

must, therefore, respectfully dissent from that portion of the Majority's decision which affirms the Commonwealth Court's overturning of the Commissioner's determination that liquidation of these Companies was the appropriate course of action.

The record in this matter reflects that the Pennsylvania Insurance Department ("Department") has been actively and continuously engaged in addressing these Companies' ongoing financial difficulties since 2001 — a period of time spanning the tenures of four separate commissioners. These Companies sold "long-term care" policies[3] in all fifty states during the 1990s.[4] Prior to 2002, Penn Treaty sold lucrative,

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such, its role is limited to determining whether the Commissioner abused his or her discretion in finding that reasonable cause existed to convert the rehabilitation of the insolvent insurance company to a liquidation. See Majority Opinion at 8; see also Foster, 614 A.2d at 1091 (observing that, in conducting discretionary review of the Commissioner's decisions made during the conduct of the rehabilitation process, "it is not the function of the courts to reassess the determinations of fact and public policy made by the Rehabilitator"). If the evidence relied on by the Commissioner supports the findings on which his or her administrative decision is based, as, in my view, it does here, then the Commissioner has not committed an abuse of discretion, and his or her decision should be upheld by the Commonwealth Court. Federal Kemper v. Pa. Dept. of Ins., 600 A.2d 244, 248 (Pa. Cmwlth. 1991). Thus, the majority's acquiescence in the Commonwealth Court's "reject[ion]" of evidence and its "finding[s]" based thereon, Majority Opinion at 9 n.8, is, from my perspective, inconsistent with the abuse of discretion standard which it agrees is applicable. See also Amicus Brief of National Association of Insurance Commissioners at 17 (expressing the view that the Commonwealth Court exceeded its proper role because it "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").

[3] These policies provided benefits to the policyholder in the event that he or she required skilled nursing services, intermediate care, custodial care or home health care due to chronic illness or disability, whether such services were provided in the policyholder's home or at an external facility. Commissioner's Preliminary Report and Rehabilitation Plan, 4/6/09, at 6. A typical policy, though providing lifetime benefits, and guaranteed to be renewable so long as the policyholder paid the premiums, was priced at only about 50% of what was needed to support such benefits. N.T. Hearing, 2/1/11, at 182-83.

but badly underwritten, policies known as "OldCo" policies. After 2002, both PennTreaty and ANIC began selling long term care policies which were more soundly underwritten than the OldCo policies — referred to for purposes of these proceedings as "NewCo" policies. The Department's 2001 involvement was necessitated because the serious financial drain created by payouts under the OldCo policies caused the Companies to cease writing any new policies, but, nevertheless, saw their statutorily mandated capital reserves drained to below 150% by the mounting payouts under the OldCo policies. This resulted in the Companies being placed into a "regulatory action" classification which obliged them to work with the Commissioner — then Diane Koken — to develop and implement a corrective action plan to rehabilitate them. N.T. Hearing, 1/31/11, at 92-93.[5] At that time, the Companies enlisted the services of an actuarial consulting firm — Milliman — to prepare the corrective plan and assist in its execution. Id. at 93.

Milliman did actuarial projections as to the shortfall the Companies faced as a result of future claims under the OldCo polices and computed the amount of rate increases which would be needed to rehabilitate the Companies.[6] Based upon these

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[4] Although ANIC sold only NewCo policies, because it is a wholly owned subsidiary of Penn Treaty, the financial situations of both are inextricably intertwined, and the actual managerial and administrative functions of ANIC are performed by the management of Penn Treaty. Milliman Surplus Projection Report, 10/15/09, at 8; Milliman Preliminary Report, 4/2/09, at 8; Signal Hill Report (Appendix to Preliminary Rehabilitation Plan), 4/6/09, at 45-46.

[5] The Commissioner also contemplated liquidating the Companies at that time. N.T. Hearing, 2/2/11, at 33.

[6] Such actuarial projections involved predicting the amount of revenue which would be generated by premiums from existing and new policies, as well as investment earnings and expenses, and, additionally, predicting the amount which would have to be paid out in claims made under policies based on "morbidity," i.e., the health of the policyholder (continued…)

projections, the Companies and Milliman devised a plan to bolster the Companies' capital reserves by $125 million, which depended on the Companies' acquisition of reinsurance — for an annual fee of $12 million — as well as obtaining rate increases for the OldCo policies from insurance regulatory agencies in each of the states where it had sold them. Id. at 93-94,122; N.T. Hearing, 2/16/11, at 78-79. Such further rate increases were needed, even though, in 2001, the Companies had already asked for, and received, authorization from these same state regulators for rate increases on the OldCo policies, because of the growing number, and dollar value, of actual and projected claims being made under those policies. N.T. Hearing, 1/31/11, at 122, 124-25. The Companies received from regulators 92% of the amounts they had requested in the 2001 round of rate increases. Id. at 122.

The Companies' corrective plan was approved by the Commissioner in February 2002. N.T. Hearing, 1/31/11, at 93. Thereafter, the Companies, with the supervision and involvement of the Commissioner, undertook additional efforts to secure rate increases on the OldCo policies from almost all of the state regulatory bodies with jurisdiction over them. The first such rate increase requested pursuant to the implementation of the corrective plan was in 2003 for 16%, and the Companies received approval from 80% of the state regulators. Id. at 125-26. However, regulatory agencies expressed discomfort at having to grant this second round of rate increases, given the size and magnitude of the first round of rate increases they had granted only a short time before. Id. at 127.

Milliman continued to perform analyses of the claims payouts under the OldCo policies from 2003-2005, and determined that the rate increases which had been

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making a claim, which influences the duration and total cost of the benefits paid out under the claim. N.T. Hearing, 1/31/11, at 111, 170, 189.

approved were insufficient to cover the losses caused by those payouts; accordingly, Milliman recommended additional rate increases be pursued. Id. at 127-28. The Companies' management approved this course of action and sought a 22% rate increase in late 2005 from those states which had denied the 2003 rate increases. Commissioner's Preliminary Report and Rehabilitation Plan, 4/6/09, at 21. 66% of these requested increases were ultimately approved. Id. Once more, however, the revenue from these increases was insufficient to cover the worsening claims situation created by the OldCo policies. N.T. Hearing, 1/31/11, at 130.

Further actuarial analysis of the payouts under the OldCo policies led to the Companies requesting a 37% rate increase from state regulators in 2006, of which only 54% were granted by 2009. Commissioner's Preliminary Report and Rehabilitation Plan, 4/6/09, at 21. Resistance by state regulators to these successive rate increase requests had, by then, grown to the point where some regulators either refused the requests outright, or granted much lower amounts than requested. N.T. Hearing, 1/31/11, at 138. In *toto*, according to the Commissioner's data, the Companies were granted only $80.3 million of the approximately $128.02 million in rate increases they sought during the time period 2003-2009 — a success rate of 63%. FBR Analysis, September 2008, (Plaintiff's Exhibit P-0007), at 43.

In addition to the continuing financial stress on the Companies due to claim payouts under the OldCo policies, a new problem arose during 2006 and 2007 when the volume of reserve capital needed to pay current and future claims began to approach the limits covered by their reinsurer. Eventually, in 2008, the Companies fell $12 million short of the credit needed from the reinsurer to maintain the level of capital reserves called for in the corrective action plan, and the reinsurer refused to increase the amount of credit it was providing to the Companies. N.T. Hearing, 1/31/11, at 154-55.

Ultimately, in December 2008, the Companies terminated the reinsurance agreement and reabsorbed approximately $113 million in outstanding liability, which the reinsurer had previously covered via letters of credit. Commissioner's Preliminary Report and Rehabilitation Plan, 4/6/09, at 15. At this point, the Companies were projecting a year-end "negative surplus" in the range of $125 million.[7] N.T. Hearing, 1/31/11, at 168.

The additional financial stress created by the pending loss of reinsurance caused the board of directors of Penn Treaty to conclude that the Companies would be insolvent as of January 1, 2009, and prompted managerial representatives to approach the Commissioner — then Joel Ario — in the latter part of 2008 to prepare to enter rehabilitation. N.T. Hearing, 1/31/11, at 182. During preliminary discussions held at that time between representatives of the Companies and deputy commissioners from the Department, the Companies' representatives reported to the deputy commissioners that they were facing a shortfall because of the loss of reinsurance of approximately $100 million. N.T. Hearing, 2/2/11, at 35. Based on these representations, the Commissioner and his staff believed, then, that this reported deficiency, while "extraordinary" in its amount, could possibly be addressed by a combination of rate increases and reductions in agents' commissions. Id. at 35, 39, 51. The Commissioner's staff undertook extensive preparations to begin the rehabilitation process, a substantial portion of which was devoted to retaining the Companies' employees so that, when the Commissioner assumed managerial control of the Companies, their core business would continue. Id. at 42-44.

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[7] An insurer's negative surplus is the amount by which its reported liabilities exceeds its assets. See, e.g., Jay Greene, State Orders Health Plus Insurance To Find Financial Partner, Crain's Detroit Business, March, 15, 2015, *available at* http://www.crainsdetroit.com/print/article/20150315/NEWS/303159976/state-orders-healthplus-insurance-to-find-financial-partner.

In January 2009, the Commissioner, with the consent of the management of the Companies, filed a petition for rehabilitation, which was granted by the Commonwealth Court on January 6, 2009. The order of the Commonwealth Court directed the Commissioner, as statutory rehabilitator, to, *inter alia*, file a "preliminary" plan of rehabilitation by April 6, 2009. Commonwealth Court Order, 1/6/09, at 5. Commissioner Ario was designated the rehabilitator and his Deputy Commissioner — Joseph DiMemmo — who had been involved with monitoring these Companies since shortly after they had been required to take corrective action in 2001, was given primary responsibility for overseeing the rehabilitation process. N.T. Hearing, 2/2/11, at 50. Thereafter, Deputy Commissioner DiMemmo formed a rehabilitation implementation committee with the managerial staff of the Companies, which included the Companies' CFO, Mark Cloutier, and Robert Robinson, an insurance professional who had successful experience managing the rehabilitation of an insolvent insurer and who was designated by the Commissioner to be the Chief Rehabilitation Officer of the Companies, handling their day to day operation during rehabilitation. N.T. Hearing, 2/2/11, at 91-93; 2/3/11, at 180, 184. Subsequently, this committee met on a weekly basis to assess the status of the rehabilitation process and to consider the feasibility of pursuing various rehabilitation options. N.T. Hearing, 2/2/11, at 99.

The Commissioner chose Milliman to perform the actuarial analyses required for the preparation of the interim rehabilitation plan — inasmuch as he had specifically retained Milliman to provide these types of services during rehabilitation, as Milliman had considerable experience with the Companies' unique financial situation, and as it had developed a claims reserve model which considered the Companies assets and liabilities. N.T. Hearing, 2/2/11, at 70-75. Milliman — using the available financial statements provided by the Companies which, by then, showed a negative surplus for

the Companies of $223 million at the end of 2008, and relying on its claims reserve model, which valued future claims costs based on the amount of claims paid by the Companies from 1993-2006 — prepared projections estimating when the Companies' surpluses could be brought back to a positive level, and, also, when those surpluses could be brought back to the level at which enhanced regulatory oversight by the Department would no longer be necessary. Milliman Report, 4/2/09, at 1, 16. Milliman based its projections on varying levels of assumed reductions in the Companies' operating expenses, i.e., claims administration costs, commissions, etc., coupled with immediate aggregate rate increases on all OldCo policies and NewCo policies ranging from 17.3% to a maximum of 42.3%. Under the most optimistic of Milliman's projections, if, on January 1, 2010, operating expenses were reduced by $20 million and rate increases of 42.3% on all policies were implemented, then the Companies' surplus would turn positive in 2013 and they would be free of regulatory oversight in 2015. Lesser levels of expense reductions and rate increases resulted in the dates of solvency, and freedom from Department supervision, being pushed back correspondingly. Milliman estimated that a minimum rate increase of greater than 27.3% was needed on the OldCo policies, alone, or the Companies would never escape negative surplus status. Milliman Preliminary Rehabilitation Report, 4/2/09, at 10.

In preparing his Preliminary Rehabilitation Report for the Commonwealth Court, the Commissioner also considered a study prepared by a consultant — Signal Hill Capital Company — he had retained to evaluate possible alternative financing arrangements available to the Companies, such as: raising additional capital from third parties, obtaining other re-insurance, and selling all or part of the Companies. The Commissioner noted in his preliminary report that Signal Hill had determined that none of those options was feasible at the time due to the Companies' weakened financial

position, and that the most viable means of rehabilitating the Companies was through rate increases on the OldCo policies and reduction of the Companies' operating expenses. Commissioner's Preliminary Report and Rehabilitation Plan, 4/6/09, at 47. Based on Milliman's and Signal Hill's determinations that rate increases were necessary for rehabilitation, the Commissioner indicated in his preliminary report that, in developing his final plan of rehabilitation, he was giving consideration to "how rate increases could be quickly and effectively authorized and implemented." Id. at 50.

Critically, the Commissioner also noted that, at the time of the preliminary report, he had not yet completed a liquidation analysis, which would include a state by state review of the availability of guaranty association coverage[8] in the event the Companies were liquidated. Id. at 47. The Commissioner stated in the report that "it appears that in liquidation, [Penn Treaty] will not be able to pay policyholder claims in full, and coverage available from state GA's [sic] are limited by statute in most states and therefore will not cover the entirety of many policyholder claims, especially for those policyholders with unlimited, lifetime benefits." Id. However, the Commissioner made no definitive

[8] Guaranty associations ("GAs") are statutorily created non-profit entities in each of the 50 states and the District of Columbia. They are comprised of insurance companies doing business in the jurisdiction, each of which pays a tax or assessment to the association based on the volume of business the insurer conducts in the jurisdiction. The GAs protect policyholders when their insurer becomes insolvent or is liquidated by guaranteeing, assuming, or reinsuring each policyholder's benefits up to the limits mandated by statute in its jurisdiction, or it transfers those policies to a solvent insurer which becomes obligated to do the same. In exchange, the GAs receive the premium payments under the policies and, as subrogees of the policyholders, may assert claims against the insolvent insurer's estate for distribution of its assets. See Couch on Insurance, §§ 6.27-28, 6.30. Thirty-six states, including Pennsylvania, have statutory limits of $300,000 for long-term care insurance, 7 states have limits in excess of $300,000, with New Jersey having no limits, and only 6 states have less than $300,000 in coverage limits. *Amicus* Brief of Pennsylvania National Life and Health Guarantee Association and National Organization of Life and Health Guarantee Associations at 18-19.

conclusion in this regard, noting only that "[f]urther analysis of these issues is underway." Id. at 48. Although the Commissioner proposed in this preliminary report that any final plan of rehabilitation would be filed by October 2, 2009, he further stated in the preliminary report that he would make a final determination, once the liquidation analysis was complete, as to whether he would continue to pursue rehabilitation. Id. at 53. The Commissioner additionally cautioned that, should "continued rehabilitation of the Companies . . . substantially increase the risk of loss to policyholders, creditors or the public, the rehabilitation plan could be modified or converted to a liquidation." Id. at 50.

In preparing the final rehabilitation plan, Milliman, at the direction of the Commissioner, compiled new long-term surplus projections for the Companies. As part of this process, Milliman re-analyzed claims payouts being made under the Companies' long-term care policies to determine the level of claim reserves the Companies would need to maintain to cover such claims. It was Milliman's observation that, since 2006, its claims reserve model, which predicted the amount of claims which would need to be paid in a given time period under the policies, had underestimated the value of the claims actually paid by $20 million. N.T. Hearing, 2/16/11, at 117-20, 141. Milliman performed a study of the problem and concluded that its model failed to account for "increasing severity in claim costs" caused by greater use of higher cost nursing homes, rather than assisted living facilities, and a higher number of claimants receiving lifetime benefits because they were living longer. Milliman Actual Experience Analysis (Trial Exhibit P-0920), 4/28/08, at 2-3. Also, Milliman's study showed that its claims reserve model had previously projected higher savings as the result of anticipated "morbidity

improvement" among policyholders which did not actually materialize.[9] N.T. Hearing, 2/17/11, at 32.

As a result of this study, Milliman adjusted its claims reserve model. N.T. Hearing 2/16/11, at 145-46. Beginning in May 2009, in conjunction with the rehabilitation team, Milliman used its upgraded model to perform additional future projections of claims reserves based on the actual dollar amount of claims the Companies paid during the last calendar quarter of 2008 and the first two calendar quarters of 2009. N.T. Hearing, 2/4/11, at 93. In performing this analysis, Milliman found that the value by which actual claims the Companies paid exceeded projected claims increased steadily and significantly during this time period, with actual claims exceeding projected claims by 9% at the end of 2008, 12% in the first quarter of 2009, and 15% in the second quarter of 2009. According to this trend, Milliman estimated that payouts to claimants would be 24% higher than anticipated during the third quarter of 2009. Id. at 94. This cost-escalation trend, which triggered the concomitant need to bolster the Companies' capital reserves to cover the increased payouts, caused great consternation among the members of the rehabilitation team. N.T. Hearing, 2/4/11, 97-98.

Because of his concern over the deteriorating claims reserve situation, Chief Rehabilitation Officer Robinson approached Deputy Commissioner DiMemmo to convey his concerns, and he recommended that an independent auditing firm be retained to review Milliman's work and verify it. Id. at 98. DiMemmo concurred with the recommendation, and the accounting firm of Ernst and Young was engaged for this

[9] As morbidity affects the likelihood that any given policyholder will be in active claim status in a given year, morbidity improvements such as advancements in healthcare and changes in lifestyle reduce the propensity for a policyholder to file a claim. N.T. Hearing, 2/16/11, at 120-22; Milliman Surplus Projections Report, 10/15/09, at 10.

task. Ernst and Young thereafter became a participant in the rehabilitation process, evaluated Milliman's projections, and ultimately found no fault with them. Id. at 100-102, 199-200.

Based on its analysis of the Companies' actual claims experience with the long-term care policies as of June 30, 2009, Milliman prepared a full evaluation of what the Companies' actual financial condition would be at the end of 2009, and what it was likely to be a decade later in the year 2020, which took into account the necessary amount of reserves both Companies were obliged to maintain to cover all claims, present and future. Milliman prepared two estimates — one aggressive and one conservative — each based on assumptions about the Companies' ability to achieve cost containment, such as claims reductions due to a brain fitness program being implemented by the Companies for policyholders, expected annual morbidity improvements, and rate increases. Both estimates presumed that the Companies would cease paying commissions to their agents as of January 1, 2010. Milliman Surplus Projections Report, 10/15/09, at 9-12.

In the first estimate, using more aggressive assumptions about cost reduction, wellness and morbidity improvements, and the assumption that the Companies could achieve successful rate increases of 60% on the OldCo policies and 70% on the NewCo policies by 2013,[10] Milliman projected that, as of December 2009, Penn Treaty's negative surplus would stand at slightly more than $1.3 billion and ANIC's negative surplus at $45 million. Milliman Surplus Projections Report, 10/15/09, at 9, 15. Even with those levels of rate increases, Penn Treaty's negative surplus was projected to

[10] These projected rate increases were based on estimates from management of the Companies as to the upper range of attainable rate increases if the Companies were to remain in rehabilitation and continue to file for rate increases on a state by state basis. Milliman Surplus Projections Report, 10/15/09, at 31.

exceed $2 billion by 2020, and it would exhaust all of its assets by 2025. Similarly, by 2020, ANIC's negative surplus was projected to exceed $57 million, and its assets would be completely depleted by 2042. Id.

In the second estimate, using the more conservative assumptions, the financial position of the Companies worsened. Under those assumptions, if aggregate rate increases of 35% for Penn Treaty and 45% for ANIC were granted by 2013, Penn Treaty's negative surplus would stand at over $2.1 billion in 2009, grow to 3.4 billion by 2020, and completely consume all of its assets by 2021; whereas, ANIC's negative surplus would be $130 million in 2009, swell to $209 million by 2020, and drain the company completely by 2032. Id.

Milliman further found that, to achieve the goal of the Companies attaining solvency and exiting rehabilitation by 2025, they would need rate increases on their long-term care policies considerably in excess of these levels. Under the more aggressive assumptions outlined above, Penn Treaty would have to receive *total* rate increases by June 2010 of 180% on the OldCo policies, and ANIC would have to receive total rate increases of 104% on the NewCo policies. Using the above-referenced more conservative assumptions, by June 2010 Penn Treaty would need to obtain total rate increases of 232% on the OldCo policies, and ANIC would require total rate increases of 203% on the NewCo policies. Even if the goal to exit rehabilitation was delayed until 2050, substantial rate increases would still be required by June 2010 for them to become solvent, in the total range of 160-203% for Penn Treaty on the OldCo policies, and 82-165% for ANIC on the NewCo policies, again using the same upper and lower aggressiveness assumptions. Milliman Surplus Projections Report, 10/15/09, at 16.

Milliman's findings regarding the considerable size of the Companies' projected negative surpluses and needed rate increases were communicated by Chief Rehabilitation Officer Robinson to Deputy Commissioner DiMemmo prior to a weekly meeting of the rehabilitation committee in late August 2009. N.T. Hearing, 2/2/11, at 136-38; (Plaintiff's Exhibit P-0530). At the hearing held in this matter, DiMemmo recalled being shocked by the enormity of the numbers when they were relayed to him, as, in his view, the amount of the projected negative surpluses and required rate increases for a return to solvency had "changed everything," such that rehabilitation was no longer viable. N.T. Hearing, 2/2/11, at 138. This was contrary to the opinion he had been previously relaying to the Commissioner based on Milliman's older 1993-2006 claims projection reports. Id. DiMemmo noted that he had never, in his experience as Deputy Insurance Commissioner, seen any long-term care insurance carrier receive rate increases of 200% during a rehabilitation process. Id. at 122-23. DiMemmo further opined that seeking rate increases of this size would be further complicated by the fact that the Department would have to approach the same state regulators who had previously been reluctant to grant the prior requested increases, discussed *supra*, which had been considerably smaller. Id. at 123.

Robinson concurred with DiMemmo's assessment that, given the historical experience involving regulators' approval of such increases, there was a low probability of this level of rate increase being granted, even though such increases might be actuarially justified. N.T. Hearing, 2/4/11, at 185-86. Importantly, Robinson noted that, even if such increases were granted by regulators, it would harm those policyholders not able to afford the increases and, consequently, likely cause them to reduce their benefit levels or drop the policies altogether, thereby losing their coverage. Robinson

opined that for the Department to seek rate increases which would likely result in such an outcome was "not functioning in the best interest of the policyholders." Id. at 187.

In September 2009, DiMemmo, Robinson, and the other members of the rehabilitation committee met twice with Commissioner Ario. At the first meeting on September 14, the Commissioner requested a breakdown by state of the rate increases that would be needed. N.T. Hearing, 2/4/11, at 189. Because of the severity of the projected negative surpluses, and the enormity of the needed rate increases for solvency, Commissioner Ario accepted the unanimous recommendation of the rehabilitation committee that they should move, on a preliminary basis, toward liquidation. N.T. Hearing, 2/11/11, at 34. Commissioner Ario, however, also requested that the committee consider whether there was any possible way to avoid liquidation and asked that they report back to him on any viable options. Id. at 35. The committee reviewed available options and, two weeks later on September 28, 2009, met with Commissioner Ario and again recommended unanimously that a liquidation petition should be filed. Id. at 36. Commissioner Ario agreed that, based on the projections, this was the best course of action, noting in his testimony at the hearing below that "[n]obody ever offered me, either internally or externally, any solution that would get by . . . a negative balance of this dimension for a company of this size." Id. at 35.

Based on this new information indicating the depth of the insolvency of the Companies, the Commissioner concluded that liquidation, which would trigger access by policyholders to guaranty coverage, would be in the best interests of those policyholders. In the estimation of the Commissioner, GA coverage would fully cover the majority of policyholders, and for those whose benefits exceeded the statutory limits of guaranty coverage, they would still receive "substantially more complete payment of their claims." Amended Petition for Liquidation, 10/23/09, at 9. The Commissioner

further determined that continued rehabilitation would result in a pernicious claims' preference — namely, that policyholders with claims coming due first would be paid their full level of benefits since the insurer still had assets to pay them, but, later in the rehabilitation process, policyholders would receive less as the assets of the insurer were depleted. Id. at 9-10. Accordingly, having concluded that continued rehabilitation of the Companies would be futile, given the magnitude of the rate increases needed to achieve solvency, and, also, that the interests of the policyholders would be better served by immediate liquidation, the Commissioner sought termination of the rehabilitation process and entry of an order of liquidation.

In my view, the Commissioner did not abuse his discretion in electing to cease rehabilitation efforts and pursue liquidation under these circumstances. Foster, supra. First, and foremost, the evidence of record supports the conclusion that the Commissioner had reasonable cause to believe that continued rehabilitation of these Companies would be futile under the circumstances. 40 P.S. § 221.18(a). By the time Commissioner Ario made the decision to liquidate these Companies in October 2009, the Department had already worked with them for nearly a decade in attempting to rectify the serious financial problems created by the badly underwritten OldCo policies; thus, the Commissioner was keenly aware of the Companies' lack of success in obtaining considerably more modest rate increases from state regulators. Nevertheless, the record reflects that, when the Companies entered rehabilitation, the Commissioner, based on the information presented to him then about the Companies' financial status — which indicated that the Companies could possibly be returned to profitability through obtaining rate increases on all OldCo and NewCo policies ranging from 17.3% to 42.3% by 2013 — was willing to consider pursuing that degree of rate increase. The record also supports the Commissioner's determination that, once this

information proved to be inaccurate and the true status of the Companies' inability to pay future claims was revealed, i.e., that, in order for the Companies to achieve solvency within a reasonable length of time — a decade and a half — they would have to, by the *following June*, be granted approval by state regulatory bodies for a range of rate increases on all OldCo policies of at least 180%, and possibly as high as 232%, and be granted approval for rate increases on the NewCo policies of at least 104% and as much as 203%, the prospect of obtaining such massive increases was dim.

The Department's well-documented previous experience with these particular Companies being denied far lesser increases by regulatory bodies in the past indicated that the rate increases of this level would likely not be granted by these same bodies during a continued rehabilitation process. Indeed, at the time the Commissioner filed his liquidation petition, the broad experience of his actuarial consultant, Milliman, indicated that rate increases on long-term care policies, as a general matter, were becoming more difficult to attain from state regulators, and, in Milliman's view, as the age of policyholders making claims under these policies increased over time, regulatory approval would only become progressively more difficult. N.T. Hearing, 2/24/11, at 10. Moreover, and importantly, as developed in the testimony at the hearing in this matter discussed *supra*, large rate increases would also likely result in many policyholders reducing their levels of coverage, or worse, dropping the coverage they had already paid for, at a time in their lives when they were most in need of such coverage. (Certainly, the prospect of such deleterious consequences was a compelling reason why state regulators were unlikely to grant such precipitous increases, given their fundamental responsibility to regulate the insurance marketplace and protect policyholders.) Hence, from my perspective, the Commissioner's conclusion that continuing with the rehabilitation process would be futile, since the rate increases which

were essential for the Companies to return to solvency within a reasonable time frame were not likely to be achieved, was well-supported.

The record also supports the conclusion that the Commissioner had reasonable cause to believe that continued rehabilitation of these Companies would create a substantially increased risk of loss to policyholders in the form of reduced benefits. The Commissioner's liquidation analysis indicated that, if the Companies continued in rehabilitation without receiving the steep rate increases needed to make them solvent, then the assets of the Companies would be gradually depleted. This would result in a situation where current claimants would receive the full amount of benefits which they paid for, whereas future claimants would receive lesser amounts as the Companies' assets dwindled, and benefit levels payable under the policies would inevitably have to be capped in an effort to conserve the Companies' diminishing resources. N.T. Trial, 2/24/11, at 5-8.

The Commissioner found that the prospect of this disparate treatment of various groups of claimants could be avoided, however, by immediate liquidation of the Companies, as GAs in the home states of the various policyholders would then be responsible for paying benefits up to their state's mandated benefit levels. Although not all policyholders would be entitled to receive their full benefits through immediate liquidation, it was the Commissioner's considered judgment at the time he sought liquidation — which was informed by the most accurate data available to him regarding the financial status of the Companies — that it was the best of all the options available to him. At the time he filed his liquidation petition, the Commissioner estimated that liquidation would result in the majority of the Companies' policyholders receiving greater benefits through the GAs — 70 to 80% of the current benefit levels under their policies — than they would receive if the Companies continued in rehabilitation, which the

Commissioner noted would, because of the large size of the projected negative surpluses, ultimately result in less of the policyholders' benefits being covered by guaranty coverage. N.T. Trial, 2/3/11, at 65-67, 70; Commissioner's Brief at 44. Thus, in my view, the Commissioner's liquidation decision was supportable on this basis as well, since it sought to diminish the harm to the individual policyholders caused by these Companies' insolvency.

Although the Commissioner admitted, at the time he filed his preliminary rehabilitation plan, that there were limits to GA coverage, he also informed the lower court in his preliminary rehabilitation report that he was continuing to analyze the issue of whether resort to such coverage would, ultimately, be in the best interests of all policyholders. The Commissioner also noted that he was specifically reserving final judgment on this issue until the necessary analysis of this question was complete. Upon completion of that analysis, and based upon it, the Commissioner reached the conclusion that GA benefits, though lesser, were still more than what the policyholders would achieve if the Companies were permitted to continue to steadily deplete their assets and cut benefits throughout the protracted rehabilitation process, which the Commissioner determined would ultimately be futile.

Critically, and contrary to the conclusion of the majority and the suggestion of the Commonwealth Court, in my view, this record does not reflect any lack of candor by the Commissioner to the tribunal, but, rather, supports the conclusion that the Commissioner, after conveying his initial impressions to the lower court, based upon the information furnished to him by the Companies to that point in time, thereafter undertook a more comprehensive and deliberative evaluation which led him to his ultimate conclusion that resort to guaranty coverage would minimize prospective losses to policyholders. Furthermore, I do not find the evidence of record supports the

Commonwealth Court's conclusion that the Commissioner somehow misused the rehabilitation process merely to bide time to prepare for liquidation.[11] As outlined above, the evidence of record supports the conclusion that the Commissioner initially acceded to the Companies' desire to pursue rehabilitation, and he was, during the preliminary phase of the rehabilitation process, working towards that goal. Indeed, the Commissioner hired a seasoned insurance professional to run the Companies, who had prior experience in rehabilitating a faltering insurer, and the Commissioner worked with the Companies' own actuary to devise a plan to return the Companies to solvency. The Commissioner was, at that point, wholly relying on the Companies' disclosures about their financial status to guide his decision-making process. It was only after the Commissioner received an accurate depiction of the Companies' deficiencies in their ability to pay future claims from the professionals he had engaged — some of whom were the Companies' own managerial staff — that he elected to convert the rehabilitation process to a liquidation. I, therefore, discern no misuse of the rehabilitation process by the Commissioner based on this record.

In sum, while I agree with the Majority that Commissioner Ario's decision to liquidate these Companies was reviewable under a deferential abuse of discretion standard, I dissent from the Majority's affirmance of the Commonwealth Court's denial of the Commissioner's petition to liquidate the Companies, as, from my perspective, the Commonwealth Court failed to apply this standard and, instead, improperly substituted its own judgment for that of the Commissioner.

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[11] I note that the Commissioner is not statutorily obligated to pursue rehabilitation of an insolvent insurer at all if he or she deems the circumstances warrant an immediate liquidation to protect policyholders and creditors. 40 P.S. §§ 221.19-20.