IN THE COURT OF CHANCERY OF THE STATE OF DELAWARE

DELAWARE COMPENSATION RATING BUREAU, INC.,	)	
Petitioner-Appellant,	)	
v.	)	Consolidated C.A. No. 4318-VCL
INSURANCE COMMISSIONER OF THE STATE OF DELAWARE,	)	Delaware Compensation Rating Bureau, Inc. Filing No. 0807
Respondent-Appellee.	)	

MEMORANDUM OPINION AND ORDER

Submitted: April 16, 2009
Decided: July 24, 2009

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LAMB, Vice Chancellor.

This case involves a challenge to the Insurance Commissioner's interpretation of the 2007 amendments to the workers' compensation insurance laws. For the reasons discussed in this opinion, the court concludes that the Commissioner properly construed those amendments and, thus, affirms the Commissioner's orders.

I.

The Delaware Compensation Rating Bureau, Inc. (the "DCRB") appeals from two orders of the Insurance Commissioner of the State of Delaware (the "Commissioner").[1] The court has jurisdiction pursuant to 18 *Del. C.* § 2620, and is limited to consideration of the record established in the proceedings below.[2] The DCRB and the Commissioner are in dispute over the meaning and effect of certain recent amendments to Chapter 26 of the Delaware Insurance Code,[3] which specifically covers workers' compensation insurance.[4] In particular, the parties

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[1] Specifically, the DCRB appeals the Commissioner's November 25, 2008 Decision and Order Concerning Bureau Filing No. 0806 (the "November Order"), R. Ex. 20 at 1121-31, and the Commissioner's December 30, 2008 Decision and Order Concerning Bureau Filing No. 0807 (the "December Order"), R. Ex. 25 at 1153-54. The two appeals rest on identical issues of fact and law and have been consolidated.

[2] *See* 18 *Del. C.* § 328(g).

[3] Codified at Title 18 of the Delaware Code.

[4] The DCRB is the sole licensed "advisory organization" under Chapter 26 of the Delaware Insurance Code. *See* 18 *Del. C.* § 2607(a). As such, one of its primary roles is to assist the Commissioner by the preparation and submission to the Delaware Department of Insurance (the "Department") of a voluntary market loss cost rating plan, *see* 28 *Del. C.* § 2607(c), and residual market rates, *see* 18 *Del. C.* § 2618(a), based on data collected from all insurance carriers writing workers' compensation insurance in Delaware. All such carriers are required by law to be members of the DCRB. *See* 18 *Del. C.* § 2607(b).

fundamentally disagree about the proper construction of 18 *Del. C.* § 2609(d), recently added as part of a reform of the workers' compensation insurance system.

In an attempt to solve the problem of Delaware's high workers' compensation insurance costs relative to other states,[5] the 144th General Assembly enacted Senate Bill 1 on January 17, 2007. Among its provisions, Senate Bill 1 requires the adoption of medical cost containment measures designed to reduce medical expenses paid by insurers on injured workers' claims.[6]

Section 2 of Senate Bill 1 requires the DCRB to file a new voluntary market rating plan within 90 days of the adoption of a new health care payment system (as provided for in 19 *Del. C.* § 2322B(14)), and annually thereafter.[7] The same section requires each authorized insurer to make a rate filing pursuant to Section 2609 within 60 days of each such new rating plan becoming effective. Section 3 of Senate Bill 1 then amends Section 2609 of the Delaware Insurance Code by adding subsection (d), which reads:

> A filing made pursuant to this section should provide for a reduction in premium based upon any savings realized by insurers as a result of workers' compensation cost containment measures implemented pursuant to legislation adopted by the General Assembly.

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[5] Prior to the enactment of reform, Delaware workers' compensation insurance rates were the third highest in the nation. R. Ex. 4 at 47.

[6] 76 Del. Laws ch. 1 (2007) (Senate Bill 1, hereinafter "SB 1"), § 11, 12, also found at R. Ex. 5 at 61-66.

[7] Codified as the final paragraph of 18 *Del. C.* § 2607(c).

The medical cost caps required by Section 11 (and anticipated by Section 2) of Senate Bill 1 became effective on May 23, 2008.[8] As required by law, on July 15, 2008, the DCRB submitted Bureau Filing No. 0806, Workers' Compensation Residual Market Rate And Voluntary Market Loss Cost Filing ("Filing No. 0806"), with a future effective date of October 1, 2008.[9] Based on certain anticipated medical cost reductions as a result of the new medical payment system fee schedule, Filing No. 0806 proposed overall average reductions in both residual market rates and voluntary market loss costs of 11.57%, effective on a new, renewal, and outstanding basis for workers' compensation insurance policies as of 12:01 a.m., October 1, 2008.[10]

As part of its standard review, on August 8, 2008, AIS (one of the Department's independent actuarial consultants) sent a memorandum to the Commissioner with its independent analysis of Filing No. 0806.[11] In this memorandum, AIS advised that the DCRB had failed to include in its rate filing all of the cost savings that would be realized by carriers on injuries occurring prior to the October 1 effective date ("Pre-October Occurrences").

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[8] R. Ex. 20 at 1130. Pursuant to Senate Bill 1, medical savings under these provisions are to apply to treatment rendered as of that date, "regardless of the date of injury." SB 1 § 11. *See also* 12 Del. Reg. 67 (July 2008) ("The health care payment system shall apply to all services provided after the effective date of the health care payment system and regulations and regardless of the date of injury.").
[9] R. Ex. 6 at 82.
[10] *Id.*
[11] R. Ex. 10 at 963-68.

Also on August 8, 2008, the DCRB made its annual filing, Bureau Filing No. 0807, Workers' Compensation Residual Market Loss Cost Filing Proposed Effective December 1, 2008 (Selected Portions Effective June 1, 2009) ("Filing No. 0807").[12] Filing No. 0807 proposed a reduction in residual market rates of 8.64%, and voluntary market loss costs of 10.03%, to be effective on or after 12:01 a.m., December 1, 2008. These proposed reductions were independent of and in combination with the 11.57% reductions proposed in Filing No. 0806.

After meeting with the DCRB, on August 15, 2008, the Commissioner issued Decision And Order Regarding Filing No. 0806 (the "August Decision").[13] Based on AIS's August 8 memorandum, the Commissioner determined that the "Rating Bureau's filing may not reflect all savings realized by Senate Bill 1."[14] Nevertheless, "to ensure that policyholders see all of the savings that can be actuarially justified . . . as soon as possible," the Commissioner approved the overall rate reduction of 11.57%, effective 12:01 a.m., October 1, 2008.[15] Further, having determined that the DCRB had made insufficient efforts to determine cost savings to carriers based on all of the cost-saving provisions of Senate Bill 1 (in particular, the cost savings resulting from the application of the new health

[12] R. Ex. 9 at 153.
[13] R. Ex. 12 at 974-77.
[14] *Id.* at 976; *see also* R. Ex. 10 at 963, 967-68.
[15] R. Ex. 12 at 976.

payment system to Pre-October Occurrences, as identified by AIS's memorandum), the Commissioner directed submission of additional information and argument on the subject.

On September 15, 2008, the Commissioner received two supplemental submissions in response to his August 15th directive: (1) a letter from Daniel V. Folt, Esquire, outside legal counsel to the DCRB (the "Folt Letter"),[16] and (2) a memorandum from AIS (the "Second AIS Memorandum").[17]

The Folt Letter consisted of extensive briefing of the same legal arguments the DCRB presently maintains before the court, contending that the Commissioner lacked the authority to order the return to policyholders of the cost savings realized as a result of the application of the health payment system to Pre-October Occurrences. The Folt Letter did not, however, present evidence or argument to (1) quantify the cost savings in cases arising from Pre-October Occurrences, or (2) demonstrate that the inclusion of such savings in prospective premium rates would in any way render the rates "inadequate."[18]

By contrast, the Second AIS Memorandum specifically addressed the cost savings attributable to Pre-October Occurrences. AIS argued that Senate Bill 1 "does not limit the savings to be considered to only those claims occurring on

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[16] R. Ex. 15.
[17] R. Ex. 14.
[18] See 18 *Del. C.* § 2604(a)(2) for the statutory definition of "inadequate" rates.

October 1, 2008 and thereafter," but, instead, under the statutory scheme enacted by the General Assembly, "[t]he savings provisions of the legislation apply to all claims, irrespective of when those claims occurred."[19] The AIS advised:

> The amount of savings that insurers will realize on the outstanding portion of losses for claims with an occurrence date prior to October 1, 2008 is substantial. The outstanding medical losses at a given point in time are about twice the total of the combined indemnity plus medical losses incurred in a given year based upon information in the DCRB's 2007 filing and about three times the total of the combined indemnity plus medical losses incurred in a given year based upon information in the DCRB's 2008 filing. In addition, the DCRB has not taken into account the savings on claims between the effective date of the medical fee schedule of May 23, 2008 and the October 1, 2008 date used in the DCRB's filing. This adds about another 0.4 years of savings that the DCRB has not accounted for in its analysis. This indicates that at a minimum there are about 2 to 2½ years of savings on medical costs that the DCRB filing has not taken into account. Therefore, whatever the annual savings are to insurance companies on future claims as a result of SB 1, the savings to insurance companies on the outstanding portion of claims with earlier occurrence dates will be at least twice as much.[20]

In support of these conclusions, AIS supplied a detailed schedule comparing outstanding medical losses to combined annual medical plus indemnity losses over a 10-year period.[21] The Second AIS Memorandum also offered three ways the cost savings on Pre-October Occurrences could properly be recovered for employers.[22] Among those methods was to account for the savings in prospective premium

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[19] R. Ex. 14 at 1002.
[20] *Id.* at 1002-03.
[21] *See id.* at 1042-43.
[22] *See id.* at 1003-05.

rates, and to spread those premium reductions over a number of years in order to avoid undue rate fluctuations.[23]

On September 30, 2008, the DCRB responded to the Second AIS Memorandum.[24] The response, however, presented no evidence to quantify the cost savings attributable to Pre-October Occurrences. Nor did the DCRB attempt to refute the Second AIS Memorandum's assessment of the magnitude of those savings. Rather, it focused on qualitative questions regarding the basis for the AIS assessment.[25]

Having considered the various submissions of the DCRB and AIS, the Commissioner issued the November Order. In the November Order, the Commissioner determined that Filing No. 0806 failed to account for cost savings realized in cases arising from Pre-October Occurrences. The Commissioner noted

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[23] *See id.* at 1004.
[24] R. Ex. 16.
[25] *See id.* at 1096-97. Specifically, in addition to incorporating by reference its earlier legal arguments, the DCRB (1) challenged the inclusion by AIS of the time period from May 23, 2008 to October 1, 2008 in its savings analysis on the grounds that the health care payment system "was not accomplished on or as of May 23, 2008," (2) discussed health care practice guidelines, and (3) questioned the specific methods by which AIS proposed to enact the rate adjustments to reflect the savings. R. Ex. 16 at 1096-97; *see also* R. Ex. 20 at 1129-30. With regard to the DCRB's objections regarding savings resulting from the health care practice guidelines, the DCRB had earlier explained in Filing No. 0806 that it was "unable to establish what the legacy treatment protocol(s) may have been, and/or how the practice guidelines adopted under SB 1 would differ from past practice in terms of direct and/or indirect costs or savings." R. Ex. 6 at 84. On this basis, the Commissioner concluded in the November Order that as of the time of his decision, there was not sufficient empirical information to order premium reductions based upon cost-cutting provisions other than the fee schedules. R. Ex. 20 at 1121. Thus, the second objection contained in the DCRB's September 30th letter is not relevant to the instant appeal.

that although afforded an opportunity, the DCRB did not challenge the calculations of the Department's independent actuary, AIS.[26] Thus, the Commissioner found:

> [t]he only argument made by the Rating Bureau that would affect the Department actuary's [AIS's] calculations in any way–that the fee schedules did not take effect on May 23, 2008–is simply incorrect. The medical fee schedules were made applicable to any treatment occurring after May 23, 2008 in the order approving the fee schedules themselves. 12 Del. Reg. 67 (7/1/2008). Therefore, the only factual evidence before me on this issue is the evidence presented by the Department's actuary [AIS].[27]

Relying therefore on the unrebutted opinion of AIS, the Commissioner adopted "the most conservative estimate offered by the Department's actuary," and concluded that the cost savings in cases arising from Pre-October Occurrences totaled "23% of current Delaware premium value."[28] In order to avoid undue rate fluctuations, based on AIS's recommendation, the Commissioner directed the DCRB to apply these savings to prospective rates as a reduction of:

> 6% of 2008 rates in its annual filing currently pending with the Department,[29] a reduction in prospective rates of 6% of 2008 rates in its 2009 and 2010 filings with the Department required by 18 *Del. C.* § 2607(c), and a reduction of 5% of 2008 rates in its 2011 filing with the Department.[30]

In that ruling, the Commissioner also addressed each legal issue argued by the DCRB in its various submissions and concluded that each lacked merit.

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[26] R. Ex. 20 at 1129.
[27] *Id.* at 1129-30.
[28] *Id.* at 1130.
[29] This refers to Bureau Filing No. 0807.
[30] R. Ex. 20 at 1130.

Subsequently, on December 30, 2008, after a full hearing, the Commissioner issued the December Order. In that order, the Commissioner ordered that Filing No. 0807 "must be adjusted to comply with" the November Order, "which required an additional savings of 6% to be added to each of the Rate Reductions."[31] The Commissioner further ordered that the filing reflect an additional 1.1% reduction for each of the rate reductions, based upon savings recognized from use of the consumer price index for medical fees. Accordingly, the Commissioner directed the DCRB to resubmit Filing No. 0807 in a manner that reflects residual market rate level cost reductions of 15.74% and voluntary market loss cost reductions of 17.13%.[32] The DCRB only disputes 6% of those figures, which represents the cost savings in cases arising from Pre-October Occurrences.

On February 26, 2009, the court entered a stipulated proposed order resolving a motion to stay filed by the DCRB. Pursuant to the terms of that stay, the DCRB agreed to implement the entirety of the workers' compensation rate reductions set forth in the December Order, except for this year's 6% reduction representing cost savings in cases arising from Pre-October Occurrences. That 6% reduction is stayed pursuant to the court's order pending disposition of the instant appeals.

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[31] R. Ex. 25 at 1153.
[32] *Id.* at 1154.

II.

The standard of review on appeal from a decision of an administrative agency is well settled: the court must determine whether the ruling is (i) supported by substantial evidence and (ii) free from legal error.[33] In making the former determination, the court must affirm the agency's decision unless the agency has abused its discretion.[34] An abuse of discretion will not be found unless the record clearly indicates that the agency's decision was based on improper or inadequate grounds.[35]

An agency's conclusions of law are reviewed de novo "but with a deferential bent, which recognizes the expertise of the [agency] in adjudicating disputes in the field . . . ."[36] Notably, however, Delaware courts do not accord agency

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[33] *See Stoltz Mgmt. Co. v. Consumer Affairs Bd.*, 616 A.2d 1205, 1208 (Del. 1992). With respect to administrative findings of fact, the court's role is "limited to reviewing the record to determine whether the decision is supported by substantial evidence." *Deskis v. Cty. Council*, 2001 WL 1641338, at *4 (Del. Ch. Dec. 7, 2001). Where the agency's factual determination is supported by substantial evidence, the court will affirm the ruling. *See id.*; *see also Smyrna Police Empl. Ass'n v. Town of Smyrna*, 2007 WL 3145286, at *3 (Del. Ch. Oct. 17, 2007) (recognizing that factual determinations must be affirmed if they are "'supported by substantial evidence' in the administrative record"). The appellant bears the burden to show a lack of substantial evidence. *See Lehto v. Bd. of Educ.*, 2008 WL 821525, at *1 (Del. Super. Mar. 4, 2008) (citing *Bd. of Educ. v. Shockley*, 155 A.2d 323 (Del. 1959)), *aff'd*, 962 A.2d 222 (Del. 2008).

[34] *Id; c.f. Public Water Supply Co. v. DiPasquale*, 735 A.2d 378, 383 n.9 (Del. 1999) (interpreting "*Stoltz*'s pronouncement that 'absent an abuse of discretion, the decision of the agency must be affirmed' . . . as referring only to agency findings of fact that are supported by substantial evidence in the record before the agency and the application of those facts to settled principles of law").

[35] *See BCBSD, Inc. v. Denn*, 2008 WL 1838462, at *4 (Del. Super. Apr. 22, 2008).

[36] *Smyrna Police Empl. Ass'n*, 2007 WL 3145286, at *3 (citing *Bd. of Educ. v. Colonial Educ. Ass'n*, 1996 WL 104231, at *4 (Del Ch. 1996), *aff'd*, 685 A.2d 361 (Del. 1996)); *Bundy v. Corrado Bros.*, 1998 WL 283460, at *2 (Del. Super. Mar. 25, 1998) ("[T]his Court gives strong

interpretations of the statutes which they administer so-called *Chevron*[37] deference, as do federal courts in reviewing administrative decisions under the federal Administrative Procedures Act.[38]

The basic tenets of statutory construction are likewise well known: the court must endeavor to ascertain and give effect to the intent of the legislature.[39] "Where the language of the statute is unambiguous, no interpretation is required and the plain meaning of the words controls."[40] If the statute, however, is ambiguous, it "must be construed as a whole in a manner that avoids absurd results."[41] A statute

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consideration to an agency's interpretation of relevant statutes."); *Chrysler Corp. v. State*, 457 A.2d 345, 349 (Del. 1983) ("[W]eight is given to an administrative interpretation . . . when a statute is ambiguous and construction is required.").

[37] *Chevron, U.S.A., Inc. v. Nat. Resources Def. Council*, 467 U.S. 837 (1984).

[38] *See DiPasquale*, 735 A.2d at 383 (declining explicitly to adopt the *Chevron* standard "with respect to review of an agency's interpretation of statutory law"). The Delaware Supreme Court has repeatedly reaffirmed in this regard that "[s]tatutory interpretation is ultimately the responsibility of the courts. A reviewing court may accord due weight, but not defer, to an agency interpretation of a statute administered by it. A reviewing court will not defer to such an interpretation as correct merely because it is rational or not clearly erroneous." *Id.* at 382-83; *see also New Castle Cty. Dep't of Land Use v. Univ. of Del.*, 842 A.2d 1201, 1211 (Del. 2004) (quoting the language in *DiPasquale* above).

[39] *In re Adoption of Swanson*, 623 A.2d 1095, 1096 (Del. 1993) ("The basic rule of statutory construction [] requires a court to ascertain and give effect to the intent of the legislature."); *see also Rubick v. Sec. Instrument Corp.*, 766 A.2d 15, 19 (Del. 2000) (stating that the goal of statutory construction "is to ascertain and give effect to the intent of the legislature").

[40] *Ingram v. Thorpe*, 747 A.2d 545, 547 (Del. 2000) (citing *Spielberg v. State*, 558 A.2d 291 (Del. 1989)); *Rubick*, 766 A.2d at 18; *Fid. & Deposit Co. of Md. v. Dep't of Admin. Servs.*, 830 A.2d 1224, 1228 (Del. Ch. 2003); *see also Swanson*, 632 A.2d at 1096-97 ("If the statute as a whole is unambiguous and there is no reasonable doubt as to the meaning of the words used, the court's role is limited to an application of the literal meaning of those words. However, where . . . the Court is faced with a novel question of statutory construction, it must seek to ascertain and give effect to the intention of the General Assembly as expressed by the statute itself.").

[41] *Ingram*, 747 A.2d at 547.

is ambiguous if it "is reasonably susceptible of different conclusions or interpretations."[42]

III.

The central issue on appeal is whether the Commissioner erred in determining that Senate Bill 1 provides that cost savings associated with claims arising from Pre-October Occurrences are to be taken into account when setting prospective rates. The DCRB also questions whether the advisory organization rating plan is the appropriate and permissible place to take such savings into account, even assuming *arguendo* that it is proper for rates to be reduced to account for those savings. Lastly, the DCRB argues that if the court answers the first question in the affirmative, that Senate Bill 1 is unconstitutional pursuant to the Contract Clause[43] of the United States Constitution.[44]

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[42] *Coastal Barge Corp. v. Coastal Zone Indus. Control Bd.*, 492 A.2d 1242, 1246 (Del. 1985).
[43] U.S. CONST. art. I, § 10.
[44] The DCRB states in its opening brief its view of the questions presented to this court:

> 1. Did the Commissioner commit reversible error by ordering the DCRB to reduce loss costs and rates in its 2008, 2009, 2010, and 2011 filings by a total of 23% of 2008 premium value so as to incorporate medical cost savings associated with claims made prior to implementation of the Payment System, where: (a) SB 1 contains no language expressing an intent that its provisions apply retroactively; (b) Chapter 26 as amended by SB 1 (i) maintains a prospective ratemaking system under which the DCRB is to file annually a rating plan limited to prospective loss costs and (ii) does not impose on either the DCRB or individual insurers an obligation to reduce future insurance premiums by savings associated with the Payment System; and (c) the Commissioner has no authority under Chapter 26 to mandate that the DCRB reduce loss costs or rates by specified amounts?
> 2. Did the Delaware Insurance Commissioner commit reversible error by interpreting Senate Bill 1 of the 144th General Assembly to effectively mandate the refund of previously approved premium payments, where such an interpretation constitutes a

With regard to whether Senate Bill 1 provides that cost savings associated with claims arising from Pre-October Occurrences are to be taken into account when setting prospective rates, the court agrees with the Commissioner, that Senate Bill 1 unambiguously so provides. Section 3 of Senate Bill 1, codified at 18 *Del. C.* § 2609(d), provides: "[a] filing made pursuant to this section should provide for *a reduction in premium* based upon *any savings realized* by insurers as a result of workers' compensation cost containment measures implemented pursuant to legislation adopted by the General Assembly."[45] The court finds the statutory language here unambiguous that all savings realized, whether on pre-existing or later occurring claims, are to be used to reduce premiums for current employers.

Even if this were not clear, however, the statutory synopsis clarifies any ambiguity. It reads, in pertinent part: "Section 3 of this Act expresses the intent that *savings in costs actually realized* as a result of this legislation's health care cost containment provisions *will be reflected in prospective premiums* through the

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> substantial impairment of the contractual relationship between the insurance companies providing workers' compensation insurance in Delaware and their policyholders, thereby rendering Senate Bill 1 of the 144th General Assembly in violation of the Contracts Clause, Art. 1 § 10, of the United States Constitution?

Appellant's Opening Br. 13-14.

The court notes that among the questions the DCRB suggests are presented is not whether the Commissioner's findings of fact were supported by substantial evidence. The court nevertheless finds here that they were supported by substantial evidence, as detailed extensively above.

[45] Emphasis added.

rate filing process."[46] This serves as well as a rebuttal to the DCRB's primary argument that the legislature did not intend to disturb the purely prospective mechanism normally employed in making rates.[47] The General Assembly, both in the express language of the statute, and in the synopsis summarizing the statute's intent, made it clear that as between the insurers and the premium-payers, all savings from the health-cost containment provisions are to inure to the benefit of the premium-payers. For that to happen, the purely prospective nature of the traditional rate-making mechanism must give way for a short time, in order that cost savings on claims arising from pre-rate-change occurrences may be accounted for in the premium setting process.[48] Moreover, the court agrees with the Commissioner that:

> putting the clear language of the Act to one side, to allow insurers to enjoy a windfall recovery as a result of medical cost containment measures would do violence to the expressed intent of the legislature as reflected in the Synopsis of the Act and contemporaneous statements by those responsible for the Act's adoption.[49]

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[46] 76 Del. Laws ch. 1 (2007), at 30 (emphasis added).
[47] The DCRB characterizes the application of savings from pre-existing claims to future rates as retroactive ratemaking. Whether it is or not, it is clear from the language of the statute that it is the effect intended by the General Assembly.
[48] The DCRB argues that this is bad insurance regulatory policy, and in any event not actuarially sound. That may or may not be, and the court has neither the expertise nor the jurisdiction to consider that argument. Questions of policy are primarily for the General Assembly to consider, not for the courts. Moreover, while this court does not have the expertise to consider these arguments fully, the Department of Insurance and the Commissioner do, and have ultimately found them unpersuasive.
[49] R. Ex. 20 at 1125 (citing Synopsis of Section 3 of SB 1).

The court now turns to the DCRB's second argument. The gravamen of that argument is that even if Senate Bill 1 authorizes the application of savings on claims arising from Pre-October Occurrences to reduce prospective premiums, 18 *Del. C.* § 2609(d) (and all of Section 2609) applies to voluntary market insurer rate filings rather than advisory organization rating plan filings under 18 *Del. C.* § 2607, or advisory organization residual market rate filings under 18 *Del. C.* § 2618. The court agrees here with the Commissioner that:

> The [DCRB's] position would elevate form far above substance. The structure of SB 1 makes clear that the mechanism for allocating savings from medical cost containment measures is the adoption of a rating plan. The requirements that the rating plan be adopted within 90 days of the health care payment system [pursuant to 18 *Del. C.* § 2607(c)], and be followed by insurer filings within 60 days under Section 2609, are but two parts of the same process. For the [DCRB] to argue that it as an advisory organization (notably an advisory organization that is by definition, comprised of member insurers, [*see*] 18 *Del. C.* § 2607(b)) is not bound by SB 1 because rates are ultimately filed by its member insurers is a hyper-technical reading of the Act that would defeat its clear and stated purpose.[50]

The DCRB argues that because each insurer may not be identically situated with respect to its ability to realize the cost savings produced by Senate Bill 1, that

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[50] *Id.* at 1126 (citing *Mayor & Council of Wilmington v. Dukes*, 157 A.2d 789, 793-94 (Del. 1960) (holding that although the statute may have been inartfully drafted, the court would interpret that statute to give effect to the intent of the legislature)). The court agrees with the DCRB that the General Assembly's drafting of the statute could have been more artful in this regard. But, more importantly, the court agrees with the Commissioner that to give effect to the intent of the General Assembly, the better interpretation of the statute is the one adopted by the Commissioner–that the advisory organization is, when filing its rating plan, to include, in an actuarially appropriate manner, all savings resulting from SB 1.

including the cost savings in the rating plan rather than in each insurer's rate filing (as a wooden-literal reading of the Act would require) may result in insurer rates that are inadequate.[51] The Commissioner, however, fully recognized this risk, and also that the insurer rate filing process presented an opportunity for those insurers so situated to avoid being placed in the position of charging inadequate rates. The Commissioner stated:

> I recognize that requiring these savings to be reflected in the [DCRB's] annual rate filings carries the potential of requiring an individual insurer that did not fully recognize that amount of savings to nonetheless adjust its prospective rates. However, individual insurers have the opportunity in making their individual rate filings to argue for rates that diverge in some way from the [DCRB's] group filings, 18 *Del. C.* § 2609(a), and I expect that individual insurers for which this decision would result in such an outcome will make that argument.[52]

Thus, the true effect of placing the savings associated from claims arising out of Pre-October Occurrences in the rating plan rather than preserving it for the rate filing process is that, out of the many insurers licensed to sell workers'

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[51] This may potentially result from two differences. First, some insurers may have long-term service contracts with medical service providers, which contracts (and their cost structures) are explicitly preserved after the adoption of the new payment system. *See* SB 1 § 11(d) ("Upon adoption of the health care payment system, an employer and/or insurance carrier shall pay the lesser of the rate set forth by the payment system or the health care provider's actual charge. *If an employer or insurance carrier contracts with a provider for the purpose of providing services under this chapter, the rate negotiated in any such contract shall prevail.*") (emphasis added). Second, some insurers may have underwriting histories in Delaware which are very different from the mean. As a result, they may have fewer claims resulting from Pre-October Occurrences. For those insurers, the actual savings realized from the application of the payment system to such claims may be less than the savings anticipated by the AIS report.

[52] R. Ex. 20 at 1130.

compensation insurance in Delaware, the Commissioner will only need to take individualized consideration of those situated materially differently from the mean, rather than needing to consider the savings realized by every insurer individually during the rate filing process. The court finds this both sensible, and within the sound discretion of the Commissioner, and the court will not disturb that decision in order to enforce the hyper-technical reading of the statute urged by the DCRB.

Lastly, the court finds the DCRB's contention that Senate Bill 1, as construed by the Commissioner below (and now this court), violates the prohibition against the passing of laws by the states which "impair the Obligation of Contracts,"[53] without merit. The DCRB attempts to characterize the two orders of the Commissioner as resulting in an impermissible "substantial impairment" of the insurers' existing contracts.[54] This characterization is unsupported by either fact or law.[55] The Commissioner's orders providing for the additional prospective

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[53] U.S. CONST., art. I, § 10.

[54] *Energy Reserves Grp., Inc. v. Kan. Power and Light Co.*, 459 U.S. 400, 411 (1983) ("The threshold inquiry is 'whether the state law has, in fact, operated as a substantial impairment of a contractual relationship.'" (quoting *Allied Structural Steel Co. v. Spannaus*, 438 U.S. 234, 244 (1978)). The *Energy Reserves* Court also noted that "state regulation that restricts a party to gains it reasonably expected from the contract does not necessarily constitute a substantial impairment. In determining the extent of the impairment, we are to consider whether the industry the complaining party has entered has been regulated in the past." *Id.* (internal citations omitted).

[55] Moreover, even if *arguendo* the Commissioner's orders *did* constitute a substantial impairment of the insurer's existing contracts, the Court's holding in *Energy Reserves* would nevertheless permit that impairment in this case. The Court held that "[i]f the state regulation constitutes a substantial impairment, the State, in justification, must have a significant and legitimate public purpose behind the regulation, such as the remedying of a broad and general social or economic problem. Furthermore, since *Blaisdell*, the Court has indicated that the public purpose need not

rate reductions to account for cost savings arising out of claims from Pre-October Occurrences have no effect on pre-existing contracts.

Rather, the order only changes the rates that the insurers can charge in contracts going forward. Hypothetically, if an insurer were to have stopped providing workers' compensation insurance in Delaware on September 30, 2008, that insurer would be unaffected by the additional savings ordered by the Commissioner. Therefore, it cannot be said that the orders affect the rights of the insurers arising from their pre-amendment insurance contracts. Instead, the orders have the effect of requiring the insurers, in exchange for continuing to sell workers' compensation insurance in Delaware, to disgorge to present premium-payers the otherwise windfall profits they would realize as a result of the savings resulting from the cost saving measures (a result that strikes the court as entirely reasonable, particularly in a heavily regulated industry like insurance). This constitutes not an impairment of past contracts, but a condition to future contracting in a regulated industry which is characterized by conditions to contracting. The court, therefore, holds that the Commissioner's orders do not violate the Contract Clause of the United States Constitution.

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be addressed to an emergency or temporary situation. One legitimate state interest is the elimination of unforeseen windfall profits. The requirement of a legitimate public purpose guarantees that the State is exercising its police power, rather than providing a benefit to special interests." *Id.* at 411-12 (internal citations omitted).

IV.

For the reasons set forth above (together with those articulated in the Commissioner's well-reasoned November Order, which the court hereby fully adopts), the orders of the Commissioner below are AFFIRMED. IT IS SO ORDERED.