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STATEMENT OF CORPORATE RELATIONSHIPS

United Policyholders is a non-profit corporation with no parent company and no subsidiary or affiliate.

PRELIMINARY STATEMENT

This is a motion for leave to file an amicus brief in support of the Petitioners-Appellants' appeal from a decision and order of the Appellate Division, First Department, dated October 22, 2002, in which the Petitioners-Appellants requests for (1) declaratory judgment pursuant to Section 3001 of the Civil Practice Law and Rules (hereinafter "C.P.L.R."), declaring that recent amendments to the Regulations of the Superintendent of Insurance governing no fault insurance (11 N.Y.C.R.R. § 65, hereinafter "the challenged regulations" or "the promulgated revision")[1] are illegal, null and void; and (2) judgment pursuant to Article 78 of the C.P.L.R. annulling these recent amendments were denied. The orders appealed from should be reversed on the law and on the facts.

STATEMENT OF INTEREST OF *AMICUS*

United Policyholders was founded in 1991 as a non-profit organization dedicated to educating the public on insurance issues and consumer rights. The organization is tax-exempt under Internal Revenue Code § 501(c)(3). United Policyholders is funded by donations and grants from individuals, businesses and foundations.

In addition to serving as a resource on insurance claims for disaster victims and commercial insureds, United Policyholders actively monitors legal and marketplace developments affecting the interests of all policyholders. United Policyholders receives frequent invitations to testify at legislative and other public hearings, and to participate in regulatory proceedings on rate and policy issues.

A diverse range of policyholders throughout the United States communicate on a regular basis with United Policyholders, which allows us to provide important and topical information to

[1] Full Citation: N.Y. Comp. Codes R. & Regs. tit. 11, § 65, hereinafter 11 N.Y.C.R.R. § 65

courts throughout the country via the submission of *amicus curiae* briefs in cases involving insurance principles that are likely to impact large segments of the public.

United Policyholders' *amicus* brief was cited in the U.S. Supreme Court's opinion in Humana v. Forsyth, 525 U.S. 299 (1999), and our arguments were adopted by the California Supreme Court in Vandenberg v. Sup.Ct., 21 Cal.4th 815 (1999). United Policyholders has filed *amicus* briefs on behalf of policyholders in over ninety cases throughout the United States.

QUESTIONS PRESENTED

A. Constitutional Questions

1. Does the Respondents' balancing of no-fault claimants' statutory right to uncontested prompt payments, against the Respondents' desire to reduce insurance fraud, make new policy without the delegated power to do so in violation of the separation of powers principles articulated in Boreali v. Axelrod?[2]

The Appellate Division held that the regulatory promulgation did not constitute legislative policy-making but was merely implementing the no-fault law, and that such rules did not exceed the Superintendent's authority. (Slip Op., p. 20; Appellants' Appendix ("A."), 51.)

2. The challenged regulations shorten the period for filing a no-fault insurance notice of claim to 30 days and a proof of claim to 45 days after medical treatment – deadlines that many automobile accident victims will fail to meet – and delegate to insurance companies the authority to set the standards for determining when a late filing can be excused. In the Courts below, the Petitioners-Appellants (hereinafter "Appellants") challenged this as an improper delegation of rulemaking power and a failure to publish rules in violation of Article IV, Section 8 of the State Constitution (N.Y. Const. art. IV, § 8) and the State Administrative Procedure Act (hereinafter

[2] 71 N.Y.2d 1, 517 N.E.2d 1350, 523 N.Y.S. 464 (1987).

"A.P.A."). Therefore, this appeal necessarily and directly presents the following constitutional question:

Does the delegation to insurers of the power to establish, without publication or filing with the Department of State, general standards to be applied in excusing late filings of no-fault notices of claims and proof of claims, violate N.Y. Const. art. IV, § 8, which provides that no rule or regulation will be effective until it is filed in the Department of State?

The Court below determined that there was no improper delegation and implicitly and necessarily determined that the standards in question are not "rules or regulations" within the meaning of the Constitution.

B. Non-Constitutional Questions

This appeal also presents the following non-constitutional questions:

3. Do the challenged regulations, by shortening the period for filing a no-fault insurance notice of claim to 30 days and for filing the proof of claim to 45 days, among other measures, contravene Section 5103 of the Insurance Law Article 51 (Ins. Law § 5103) and violate the legislative intent to provide prompt, sure availability of no-fault benefits?

The Appellate Division determined that the regulatory promulgation did not violate the provisions or legislative intent of Insurance Law Article 51.

4. Did the Respondents violate rulemaking requirements of the State Administrative Procedure Act ("A.P.A.") by: a) failing to analyze and respond to reasonable alternatives suggested in public comment on the challenged regulations to mitigate adverse effects of the rule; b) failing to provide a "best estimate" of the costs of the challenged regulations; and c) improperly delegating rulemaking functions to automobile insurers?

The Appellate Division did not address the first two issues specifically, making only a general finding of compliance with the A.P.A. (Slip Op., p. 23; A. 54)

5. Do the challenged regulations violate Section 5106 of the Insurance Law (Ins. Law § 5106) by eliminating the compound interest payable on overdue no-fault claims and allowing by regulation only simple interest?

The Court below determined that this provision did not violate Section 5106.

6. Do the challenged regulations contravene the provisions of Section 5106 of the Insurance Law by permitting the disallowance of a no-fault claimant's attorneys' fee in all cases where the claimant recovers less than the full amount of its claim?

The court below determined that such a regulatory provision did not violate Section 5106.

7. Do the challenged regulations violate Section 5102 of the Insurance Law (Ins. Law § 5102) by restricting assignment of certain types of health expenses?

The Court below held that the regulations do not violate Insurance Law Article 51 notwithstanding the prohibition on assignment.

8. Do the challenged regulations improperly expand the scope of no-fault arbitrators' authority in contravention of Section 5106 of the Insurance Law?

The Court below held there was no improper expansion of arbitrator authority.

PROCEDURAL HISTORY

This is a Motion for Leave to file an Amicus Brief in support of the Appeal brought by the Appellants upon the filing of a Notice of Appeal on November 21, 2002. The Appellants took the instant appeal on Constitutional grounds pursuant to C.P.L.R. 5601(b), from a Decision and Order of the Appellate Division, First Department (Williams, P.J., Nardelli, Andrias, Marlow, JJ.), dated and entered October 22, 2002.

Appellants contend that a question involving the construction of the Constitution of the State is directly and necessarily involved in the instant appeal and that important questions of

law of statewide importance are presented on this appeal, and that the Order appealed from contradicts precedent of this Court. See Servido v. Superintendent of Ins., 53 NY2d 1041, 425 N.E.2d 886, 442 N.Y.S.2d 498 (1981), reversing on the dissenting opinion, 77 A.D.2d 70 (App. Div. 1980).

Said Decision and Order of the Court below is a final Order for purposes of this Court's jurisdiction because it disposes of all of the claims of the Appellants within the meaning of C.P.L.R. 5602(a) and Article IV, Section 2 of the State Constitution (N.Y. Const., art. IV, § 2).

The instant proceeding is a combined Article 78/Declaratory Judgment Proceeding initiated in Supreme Court, New York County on August 28, 2001, that sought, inter alia, 1) declaratory judgment pursuant to C.P.L.R. 3001 declaring certain amendments to the regulations governing no-fault insurance are illegal, null and void. See 11 N.Y.C.R.R. § 65 (hereinafter "Regulation 68" or the "Challenged Regulations"); and 2) judgment pursuant to C.P.L.R. Article 78 annulling said regulations.

The Supreme Court, New York County (Wetzel, J.) denied the Petition on February 19, 2002 and Appellants filed a Notice of Appeal on February 20, 2002. The Appellate Division affirmed the judgment of the Supreme Court on October 22, 2002 and Notice of Entry of the Appellate Division Order was served on the Appellants by overnight courier on October 22, 2002. See C.P.L.R. 2103[b].

APPELLATE JURISDICTION

This Court has jurisdiction to hear the within appeal pursuant to C.P.L.R. 5601(b) on Constitutional grounds and pursuant to C.P.L.R. 5602(b), because the Decision and Order of the Appellate Division finally disposes of the action within the meaning of C.P.L.R. 5602(a) and N.Y. Const., art. IV, § 2.

FACTS

In this proceeding, Appellants contended that the State Insurance Department ("Department") has illegally promulgated proposed regulations governing no-fault insurance. See Ins. Law, art. 51. The challenged regulations repeal the current version of 11 N.Y.C.R.R. § 65 and substitute a revised § 65. The challenged regulations, inter alia:

> (a) Create a 30-day notice of claim precondition to the availability of no-fault insurance benefits under Article 51 of the Insurance Law. An injured automobile accident victim who misses this deadline now may lose all no-fault benefits for the accident, including health care and lost wages.

(Record Before the Court ("R.") 2849, 2877; 11 N.Y.C.R.R. §§ 65-1.1, -2.4; A. 359, 387);

> (b) Requires the filing of a proof of claim within 45 days after initial medical treatment; a no-fault claimant who misses this deadline may lose coverage for medical care

(R. 2849, 2877; 11 N.Y.C.R.R. §§ 65-1.1, -2.4; A. 359, 387); and

> (c) Delegate to insurance companies the power to set the standards for determining when claimants may be excused from missing those deadlines

(R. 2883, 11 N.Y.C.R.R. § 65-3.5; A. 393).

ARGUMENT

POINT I

THE DECISION BELOW SETS HARMFUL PRECEDENT REGARDING THE POWERS OF AGENCIES AND THE RIGHTS OF HONEST POLICYHOLDERS AND HONEST ACCIDENT VICTIMS

At stake in this case are the rights of honest policyholders and honest accident victims, who are being unfairly penalized for criminal acts that they have not committed. This penalty, moreover, is being fashioned by a State agency that has no power to do so. United Policyholders is deeply concerned at the precedent that would be set by the Appellate Division's decision. In effect, the agency is being allowed to do nearly anything it chooses, without the proper

delegation of authority to do so, simply by pointing to the existence of criminal elements in society.

No one disputes that certain people are committing insurance fraud in the no-fault automobile insurance system. That fraud, however, is primarily the action of organized crime. The record in this case is replete with accounts of specific, organized criminal rings that are perpetrating fraud, mostly in the Boroughs of Brooklyn, Queens and the Bronx in New York City, although some fraudulent activity is carried on outside the City as well. There is no evidence whatsoever that doctors throughout the State are dishonest swindlers, or that automobile accident victims are, simply by reason of becoming accident victims, inherently dishonest. In fact, nearly all automobile accident victims are simply ordinary people who got hurt in a car crash, and the vast majority of doctors and other providers, similarly are participating in the no-fault system simply to receive honest compensation for health care and other services honestly rendered.

In this case, unfortunately, the State Insurance Department has used fraud as justification to make drastic changes to the rights of all accident victims and their providers. No matter what arguments the public has raised about the agency's authority to do so or the inherent unfairness of the rules or the major gaps in rule-making analysis, the response of the agency is simply to point to fraud. That is not a good enough answer to the important questions raised in this case.

Fraud is a crime that should be punished, but there are many ways to approach the problem. The petitioners in this case made a series of good faith proposals to address the problem of fraud and to modify the agency's proposed no-fault rules to make them reasonable. The State Insurance Department, unfortunately, seems to be irrationally fixated on certain numbers of days for filing periods, without any meaningful analysis to justify those specific

deadlines and without any willingness to consider even the slightest modification of them. The State Administrative Procedure Act emphasizes the importance of considering alternative approaches to achieve the goal without placing undue burdens on the public, and requires the agency to explain why it rejects alternatives. This agency failed, blatantly, to do that, and the lower courts were in error to allow it. For the court to sanction the failure to analyze and consider alternatives to ensure that measures to curb criminal conduct do not harm innocent people would set a very bad precedent.

Similarly, it would set a very bad precedent to allow the Superintendent of Insurance to engage in legislative activity simply because the Legislature has not chosen to take the kind of action that the Insurance Department wants. The setting of a notice of claim deadline designed to preclude all no-fault benefits for no reason other than the fact that the person missed an extremely short filing deadline is entirely outside the agency's authority. Unfortunately, the Appellate Division confused the terms "notice of claim" and "notice of treatment" when it mistakenly assumed that the Legislature's rejection of a 1997 bill regarding a proposed 30-day notice of treatment deadline meant that it had determined that the agency had the authority to adopt a 30-day notice of claim. (A. 52) The bill set a notice of treatment deadline, and failure to meet it would have resulted in a reduction in health care benefits. The Appellate Division does not in fact know whether the Legislature rejected that bill six years ago because it (a) found the proposed 30-day deadline to be too harsh; (b) wanted the Insurance Department to set notice of treatment deadlines, (c) did not find it fair for the patient's benefits to be curtailed because a doctor failed to meet such a short deadline, or (d) had some other disagreement with the bill's approach. But more importantly, this 1997 bill did not address in any way the issue of who should set a deadline for notice of claim. If that bill had passed, failure to meet its notice of

treatment deadline would not have resulted in a complete denial of all no-fault benefits (both healthcare and wage loss) associated with the accident. In other words, that old bill is not "on point" regarding the question in the instant case of whether or not the Legislature delegated authority to the agency to preclude benefits.

Finally, the decision below would set very harmful precedent regarding the relationship between government agencies and the private sector with regard to rule-making. The new notice of claim and proof of claim provisions will deny benefits to no-fault accident victims who fail to meet the deadlines, and then require those injured people to demonstrate "clear and reasonable justification" for the failure to file on time. They must provide this demonstration, however, in accordance with standards that they are not entitled to see. Section 65-3.5(l) of the revised Regulation 68 authorizes each insurer to establish their own individual "standards for review of its determinations that applicants have provided late notice of claim or late proof of claim." (R. 2883). The standards are unpublished, and are set not by the agency but by the insurance carriers, who clearly have a financial interest in denying claims, especially if the injured person is a passenger or pedestrian rather than the policyholder. Any involvement of the private sector in governmental functions must be subject to the strictest of scrutiny, and this level of involvement far exceeds the bounds of propriety and legality.

The Appellants correctly argued below that these standards for excusing late filings must be duly promulgated by the agency itself, not the private sector, and published as regulations. They noted that these standards directly affect entitlement to no-fault benefits and are of wide ranging general applicability, and in the context of the extremely short deadlines set by these rules, the excuse standards are – undeniably -- a critical part of the regulatory scheme. Indeed, the Respondents themselves argued below that the excuse standards were a mitigating factor that

they had adopted as one alternative in their revised rule-making. Article IV of the New York State Constitution states, "[n]o rule or regulation made by any state department . . . shall be effective until it is filed in the office of the department of state." (N.Y. Const. art. IV, § 8). Under the challenged regulations, however, these standards will not be duly promulgated or even published, which clearly violates Article IV of the Constitution. For the purpose of brevity, the Amicus adopts the legal arguments on this point contained in the Brief of the Appellants. Rules promulgated by agencies must be must be promulgated under the A.P.A. and publicly available, and allowing this kind of delegation of rule-making authority would establish an extremely dangerous precedent, blurring the lines between government and the private sector and denying the public access to the text of rules that affect their rights.

POINT II

RESPONDENTS EXCEEDED THEIR AUTHORITY UNDER THE NO FAULT LAW AND VIOLATED THE STATE ADMINISTRATIVE PROCEDURE ACT

A. Respondents Have No Authority to Impose New Conditions on the Availability of No-Fault Benefits

For the purpose of brevity, the Amicus adopts the arguments contained in the Appellants' Brief regarding the fact that the Legislature has not delegated authority to the State Insurance Department to establish new conditions restricting no-fault benefits. The Amicus would simply add that, given that the No-Fault Law was designed to replace common law rights, the Court should interpret its delegation to the State Insurance Department very strictly. The Legislature clearly engaged in a careful balancing of interests that should not be changed unilaterally by the State Insurance Department, especially as drastically as this set of rules changes it.

The decision below essentially gives the agency carte blanche to set any deadline that it chooses for Notice of Claim, and without even providing any meaningful justification for its

choice. This Court should consider that these rules shorten the Notice of Claim deadline not by one-fourth or one-third but by two-thirds. What is the barrier? How far can the Insurance Department go? Could it have shortened the Notice of Claim deadline by four-fifths, down to just 18 days? Again, the Amicus urges this Court to consider the impact of these rules on honest policyholders and automobile accident victims, who may not immediately recognize that they have an injury, or may be elderly and have trouble taking initiative on their own behalf, or may feel reluctant to contact their insurance carrier without first getting legal advice, or may wrongly assume that the other car's insurance policy is supposed to cover the accident. Such delays are not criminal behavior, but ordinary human behavior that can be resolved in a reasonable amount of time, but not within an unreasonably short amount of time. Such people should not be penalized.

It is particularly disturbing that this agency feels that it can simply step in and make policy in the absence of Legislative action. The agency clearly is making policy – it has determined that the goal of curbing fraud can and should be met by severely curtailing the rights of all automobile accident victims in the state, recognizing that some innocent people will be denied their rightful benefits and forced to fight to get them back. Even Justice Wetzel acknowledged that:

> Petitioners highlight the dicta in Judge Gangel-Jacob's decision suggesting that these New Regulations will have far-reaching effects and directly impact everyone involved in the No-Fault system. No one can refute that prognostication. Indeed, it is axiomatic that with any statute of limitations, the shorter the period the more likely there will be time-barred claimants.

R. 15; A. 66 (emphasis added). This is, undeniably, a major policy shift. Nothing in the No Fault Law suggests that honest claimants should be held to standards so strict that many of them will

be denied benefits and forced to litigate or arbitrate to get them back. Indeed, one of the purposes of the No Fault Law was to reduce the need for litigation.

It is not this Court's fault, nor the fault of policyholders and accident victims, that the State Insurance Department has failed to convince the Legislature that it should adopt such drastic measures in the name of curbing fraud. If the Department indeed has evidence that fraud is so widespread that drastic measures are needed, and if the Department has analysis that demonstrates the reasonableness of its approach, it should have placed this evidence before the Legislature and made its case to them for legislation. Surely the agency is not without lobbying ability. Indeed, these rules were first proposed in 1999, and the decision of Justice Gangel-Jacob certainly suggested that the agency did not have the authority to take such drastic action.

It would set very dangerous precedent to allow this agency to expand its own regulatory powers, unilaterally, to replace the Legislature's legislative powers. It cannot simply "enact" those policy changes through use of rule-making. See Boreali v. Axelrod, 71 N.Y.2d 1, 517 N.E.2d 1350, 523 N.Y.S. 464 (1987), particularly where, as here, there is no delegation of power to do so.

B. This Court Should Require Agencies to Meet Their Duty Under the A.P.A. to Analyze and Respond to Reasonable Alternatives, Provide a Full Cost Analysis, and Avoid Illegal Delegations of Rulemaking Authority

Members of the public, including policyholders and accident victims, depend upon government to abide by proper rule-making procedures, and to promulgate rules that are designed to achieve their goals without placing unreasonable and unfair burdens on honest members of the public. This is why the Legislature has placed such importance on the agency's duty to consider alternatives to its proposed rules in order to "avoid undue deleterious economic effects or overly burdensome impacts of the rules upon persons . . . directly or indirectly affected by it." A.P.A. § 202-a(1). Section 202-a(3)(g) requires the agency to provide a

Statement on Alternatives, including why any significant alternatives were not incorporated into the rule. A.P.A. § 202-a(3)(g). Section 202(5)(b) requires the agency to respond to alternatives raised by the public; specifically, requires the agency to provide "a summary *and an analysis* of the issues raised and significant alternatives suggested by any such comments" and "a statement of the reasons why any significant alternatives were not incorporated into the rule." A.P.A. § (5)(b)(i)-(ii) (emphasis added).

The Appellants in this proceeding suggested, obviously in good faith, a large number of alternative approaches to achieve the goal of reducing fraud while protecting the rights of honest claimants with regard to notice of claim, proof of claim for health expenses, standards for examinations under oath, and the issue of fee schedule disputes. The agency, however, rejected these alternatives without explaining its reasons.

For the purpose of brevity, the Amicus adopts the arguments related to the A.P.A. that are contained in the Appellants' Brief. It would, however, like to emphasize the harmful precedent set by the decision below.

Either the Legislature's mandate is law or it is not. Either the agency is required to respond to alternatives or it is not. The fact that this promulgation was omnibus – an entire rule-making scheme rather than a selective and small set of amendments – does not take the agency off the hook for compliance with the A.P.A.. It cannot argue that its response to one alternative regarding proof of claim for wages, for example, is sufficient, or that its illegal delegation of rule-making authority to insurers to set standards for missed deadlines is sufficient. It must explain why it failed to respond to such reasonable alternatives as, for example, analyzing the real world time it takes to file no-fault proofs of claim before setting a new deadline or analyzing

the no-fault claims filed more than 30 days after the accident to determine the factors that delay filing of claims. See R. 240, 248; A. 299, 307.

Similarly, this Court should not allow the agency to shirk its duty under the A.P.A. to assess the financial impact of its rules on regulated persons, including claimants and their providers. A.P.A. § 202-a(3)(c) requires that the RIS contain a "statement detailing the projected costs of the rule," including the costs for implementation of and compliance with the rule. The Legislature specifically amended this provision 1990 to require that the cost statement disclose the information and methodology on which the costs are based and, where a full cost estimate cannot be given, the agency must nevertheless provide a "best estimate."[3] That Legislative action is strong indication that the Legislature did not want agencies to get away with avoiding their duty to provide cost estimates. The Legislature clearly wanted agencies to come to grips with the real world economic impact of their rule-makings.

Nevertheless, neither the RIS nor the RFA provide the "estimate of the annual cost of complying with the rule" or even the "estimate of the number of small businesses . . . to which the rule will apply," required by A.P.A. § 202-b(2)(a) and (c). The Amicus adopts the arguments in the Appellants' Brief on this matter but would like to emphasize that the costs of compliance with these rules should take into consideration the fact that honest claimants and their providers will be denied no-fault benefits, even though they are not guilty of fraud and will be forced to undergo legal action through arbitration or court to attempt to regain them. The agency also must admit that it cannot guarantee that their attempt to regain benefits will be successful, especially since it cannot vouch for the fairness of excuse standards that it will not propose, or subject to public comment under the A.P.A.

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[3]Law of 1990, Ch. 850, § 12. See A.P.A., § 202-a(3)(c)(iv).