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IN THE COMMONWEALTH COURT OF PENNSYLVANIA

Re: Penn Treaty Network America Insurance Company in Rehabilitation	DOCKET NO. 1 PEN 2009
In Re: American Network Insurance Company in Rehabilitation	DOCKET NO. 1 ANI 2009

JOINT OPPOSITION BY BROADBILL AND PTAC TO THE HEALTH INSURERS' "REPLY" MEMORANDUM OF LAW

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ARGUMENT[1]

While this Court approved, as a technical matter, the Health Insurers' motion to submit a "reply" brief on August 8, 2016, the Court should nevertheless disregard the arguments made in that brief because the Health Insurers (i) have no standing to be heard on the MOU at all, much less a second time; (ii) raise new arguments in their proposed brief, which is in fact a surreply rather than a reply; and (iii) had many opportunities to develop their own evidence and test the facts adduced by the parties to the MOU about tax issues that have been hotly litigated before this Court for a year and a half. But even if considered, the Health Insurers' reply brief adds nothing of substance to its prior objection and the MOU should be approved in all respects.

I. THIS COURT'S JUNE 19, 2015 ORDER LIMITS THE HEALTH INSURERS' STANDING IN THIS PROCEEDING.

This Court's June 19, 2015 Order granted the Health Insurers "limited intervention" to participate in proceedings "related to the Second Amended Plan (or future modifications thereof), and any petitions for liquidation."[2] Objecting to the MOU is beyond the scope of that limited intervention Order. Indeed, the Health Insurers appear to accept this undeniable fact, recognizing that "settlements are not plans of reorganization" and admitting that no rehabilitation plan is "being pursued."[3] And the Health Insurers never sought—nor did the Court ever grant—a subsequent order expanding the Health Insurers' limited right to intervene beyond that "discrete controversy."[4]

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1 "Motion" refers to the Application for Leave to File a Reply Memorandum in Further Support of Objection to the Application for Settlement Approval. "Surreply" refers to Exhibit A to the Motion. Otherwise, this objection adopts the naming conventions of PTAC and Broadbill's July 26, 2016 Reply Brief.

2 June 19, 2015 Stipulation and Order of Intervention.

3 Obj. at 7, 13, 23.

4 Pa.R.A.P. 3775(c)(2) ("Limited intervention. When the applicant's interest involves a *discrete controversy* relating to the administration of the insurer's business or estate, the Court may grant the applicant limited intervention to participate as a party in the discrete controversy.").

Moreover, the Health Insurers do not explain how approving the MOU would harm them directly, which the Pennsylvania Supreme Court has held is a threshold question for establishing standing.[5] Unless adversely affected by the matter at issue, an entity is not aggrieved and thus "has no standing to obtain a judicial resolution of that challenge."[6] This standard is even more stringent in the Rehabilitation context, where under Pennsylvania Rule of Appellate Procedure 3775(c), a party must have "[a]n interest which may be directly affected ***and*** which is not adequately represented by existing parties, ***and*** as to which petitioners may be bound by the action of the agency in the proceeding."[7] *Crosby Valve* is instructive, where the Commonwealth Court affirmed an order denying a motion to intervene to challenge a transaction to which the proposed intervenor was not a party.[8]

This Court should note that in the over fifty pages of briefing that they have filed, the Health Insurers confine themselves to a single conclusory footnote, without any detail or evidentiary support, suggesting that they "will bear the burden of the assessments from the state insurance guaranty associations."[9] By that challenged logic, every taxpayer has standing in any matter involving the state or federal treasury. More importantly, the Guaranty Associations—which have their own counsel—never objected to the MOU. As the proposed intervenor in *Crosby Valve*, the Health Insurers should not be heard from—again.[10]

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5 *Johnson v. Am. Standard*, 607 Pa. 492, 516 (2010) (a party must be "aggrieved in order to possess standing").

6 *Hospital & Health System Ass'n of Penn. v. Dep't of Public Welfare*, 585 Pa. 106, 115 (2007).

7 *Crosby Valve, LLC v. Dep't of Ins.*, 131 A.3d 1087, 1097–98 (Pa. Commw. Ct. 2016) (affirming denial of intervention request because approval of the proposed transaction would not result in per se injury to the petitioners) (emphasis in original) (citing 1 Pa. Code § 35.28(a)(2)).

8 *Id.*

9 Obj. 12 n.3.

10 *Crosby Valve*, 131 A.3d at 1097–98 .

Nor can the Health Insurers' objection and briefing be considered an "amicus" to the Guaranty Associations' position, since the Guaranty Associations do not object to the MOU. At most, the interests of the Health Insurers (if any) in this proceeding are derivative of those of the Guaranty Associations. As such, the Health Insurers are bound by the decision of their principal.[11]

II. THE HEALTH INSURERS' SURREPLY IMPROPERLY RAISES NEW ARGUMENTS.

Even apart from the standing problem, the Health Insurers' surreply improperly raises new arguments,[12] which Pennsylvania Rule of Appellate Procedure 2113—under which the Health Insurers bring the Motion—does not permit.[13] The Health Insurers cannot credibly assert that they could not have raised earlier the arguments they make for the first time now.[14] Instead, they assert as an unproven conclusion that the surreply is "necessary to address arguments raised by" the MOU parties without explaining why.[15] There is no reason at all—and the Health Insurers offer none—why the following arguments that they now raise could not have been asserted in the opposition to the MOU:

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[11] In contrast to the Health Insurers, Broadbill has standing because (i) it is a party to the MOU and (ii) it is responding jointly with the PTAC and Woznicki intervenors, who have broader standing to participate.

[12] *See* Pa.R.A.P. 2133, Official Note ("The scope of the reply brief is limited, however, in that such brief may only address matters raised by appellee and not previously addressed in the appellant's brief.").

[13] *Commonwealth v. Fahy*, 558 Pa. 313, 322 n.8 (1999) (citing 16 STANDARD PENNSYLVANIA PRACTICE 2d § 89.5).

[14] *See Fahy*, 558 Pa. 313, 322 n.8 (The Supreme Court of Pennsylvania "cannot condone" reserving arguments "in an attempt to curtail or preclude" response thereto).

[15] Mot. at 1.

- PTAC has no right to take a worthless stock deduction;[16]
- the Tax Sharing Agreement provides that subsidiaries determine their tax payments as if they were not members of the consolidated group;[17]
- tax positions available to PTAC would not harm the Estate; and [18]
- mediation sessions "cannot be the basis on which" settlement is approved.[19]

Litigation in this Court has been focused on tax issues and the CNOLs for more than a year and a half. All of the arguments about using the CNOLs and their ownership have been before this Court for a long time. Indeed, PTAC and Broadbill both filed formal comments outlining their positions, and further previewed them for the Health Insurers at the depositions of Patrick Cantilo and Lori Jones.

III. THE HEALTH INSURERS HAD AMPLE OPPORTUNITY TO DEVELOP THEIR OWN EVIDENCE AND TEST THE EVIDENCE OF THE PARTIES TO THE MOU BEFORE DISCOVERY CLOSED.

Patrick Cantilo testified before this Court for two days in July 2015. Document discovery closed several months after that, on September 15, 2015.[20] Then, between December 2015 and February 2016, the parties deposed Mr. Cantilo, Ms. Jones, and Mr. Fairbanks. At all three depositions, the Health Insurers had an opportunity to—and did—cross-examine each witnesses on any issue, including tax.

The claim that the Health Insurers could not question Mr. Cantilo at the Phase I hearing is unavailing because—while no party cross-examined then—their counsel, John Lavelle, questioned him in a deposition for nearly 6 hours, over 3 days, and 220 pages ***after Mr. Cantilo***

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[16] Surreply at 10–11. In fact, the Objection argues the opposite. *See* Obj. at 11 ("[D]econsolidation would leave PTAC in a position where it would still be able to take its worthless stock deduction.").

[17] Surreply at 13.

[18] *Id.* at 13–16.

[19] *Id.* at 7–8.

[20] *See* July 30, 2015 Scheduling Order.

had testified in Phase I. The Health Insurers had more than ample opportunity to test Mr. Cantilo's previous testimony. Mr. Lavelle also had as much time as he wanted to question Ms. Jones, which he did on December 23, 2015 (for 65 pages). The Health Insurers never requested more time with either witness. After that, Don Abrams, Mr. Lavelle's partner and a tax specialist, deposed Mr. Fairbanks (PTAC's and Broadbill's tax expert) for about two hours—a time allotment to which the Health Insurers agreed with the Commissioner's counsel.[21] While the Health Insurers sought to depose Mr. Fairbanks again, rather than waste resources, the Court proposed a videoconference among the tax specialists at O'Melveny and Morgan Lewis to better understand each side's respective positions. That videoconference took place on February 25, 2016.[22] The Health Insurers did not mention Mr. Fairbanks again until now.

Importantly, the Health Insurers alone are responsible for their decision not to proffer an expert (or even fact) witness on tax questions, or on any other question for that matter. That Mr. Cantilo, Ms. Jones, or Mr. Fairbanks did not provide testimony to support the Health Insurers' theories does not mean that the record "cannot support" granting the MOU. As the record shows, the Health Insurers were able to test the evidence that the parties to the MOU proffered. There is nothing the Health Insurers know now that they did not know when they filed their objection to the MOU (or when they decided not to put on an affirmative case).

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[21] The Court permitted five hours of questioning to be divided among the questioners at their own discretion.

[22] *See* Ex. 19 (February 25, 2016 e-mail from John Lavelle) ("Please be advised that the continued deposition of Mr. Fairbanks noticed for this Friday, February 26 has been postponed pursuant to the Court's direction at a telephonic conference on Monday February 22 with counsel for the Health Insurers, Broadbill, PTAC, and the Rehabilitator. We will notify you if and when Mr. Fairbanks' continued deposition is rescheduled.")

IV. IN ADDITION TO BEING IMPROPER, THE HEALTH INSURERS' BRIEF AVOIDS ADDRESSING THE PARTIES' PRINCIPAL ARGUMENTS.

Aside from its standing and procedural deficiencies, the Health Insurers' brief either sidesteps or simply ignores PTAC's and Broadbill's main substantive arguments. These critical arguments are that (i) the Health Insurers' proposal cannot be effectuated; (ii) other cases have authorized settlement payments in similar insurance rehabilitations; and (iii) the Estate risks having to pay hundreds of millions of dollars in taxes if the Health Insurers are wrong. The Health Insurers' silence and elision regarding these issues confirms that they offer no good reason for the Court to deny approval of the MOU.

A. The Health Insurers do not contest that their proposal cannot be effectuated.

The Health Insurers simply do not contest the argument that their proposed alternative cannot be effectuated. While the Health Insurers acknowledge that the Rehabilitator "exercises the rights of [PTNA's] board of directors,"[23] they do not say what authority would grant her powers that PTNA's board does not possess.[24] The Health Insurers' alternative plan—which hinges on breaking consolidation by issuing more shares—thus simply cannot be put into effect.[25] Moreover, the Health Insurers do not dispute that issuing more shares without PTAC's express approval would (i) constitute a fraudulent transfer, (ii) expose the Estate to liability for conversion and breach of fiduciary duties, and (iii) result in prolonged litigation before this Court and possibly the IRS.[26]

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[23] Surreply at 18.

[24] *See* Reply at 14; Ex. 20 (April 13, 2016 PTNA by-laws). An undated version was accidentally attached to the PTAC Intervenors' Reply brief as Exhibit 18.

[25] *See* Surreply at 18.

[26] *See* Reply at 14–15.

B. The Health Insurers do not address that courts have authorized similar settlement payments in insurance rehabilitations.

The Health Insurers do not refute that under Pennsylvania law the settlement payment to PTAC for accessing the CNOLs constitutes first-priority administrative expenses, which include "the actual and necessary costs of ***preserving . . . the assets of the insurer***."[27] Here, the settlement is necessary to prevent a huge tax bill that could catastrophically impair the Estate's ability to pay claimants. In fact, other courts—including the Commonwealth Court of Pennsylvania—have recognized the value that CNOLs can provide an estate in similar circumstances, and to secure the use of such tax attributes afforded administrative priority to much larger payments.[28] Rather than address this issue head-on, the Health Insurers' offer up a circular argument and also engage in misdirection.

First, the Health Insurers claim that the proposed payment "is only an administrative expense if the Court approves the settlement."[29] But that assumes the conclusion. Because the question is ***whether*** the Court should approve the settlement, asserting that the payment would be administrative on approval is no reason to deny approval—unless one already assumes that administrative priority would be bad. And there is no independent reason to assume that.

Second, the Health Insurers have nothing to say about court-approved settlements in similar circumstances (*i.e.*, *Reliance* and *Ambac*). Instead, the Health Insurers throw up the *non sequitur* that "the standard adopted in *Jevic* was adopted on the basis of who received payment, not why."[30] But if that were true, Pennsylvania's statutory distribution scheme would not prioritize certain ***types*** of claims (such as, administrative or personal injury) over ***who*** made the

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[27] Reply at 11.

[28] *See id.* at 12–13.

[29] Surreply at 5.

[30] Obj. at 4–5; Reply at 11–13.

claims (such as, the federal government or employees).[31] So the Health Insurers' *Jevic* discussion, in addition to failing to address the *Reliance* and *Ambac* examples, is incorrect.

C. The Health Insurers do not consider—or even mention—the risk that if they are wrong the Estate will have to pay hundreds of millions of dollars in taxes.

The Health Insurers remain silent about the real risk that their WSD and deconsolidation theories are wrong.[32] Indeed, the Health Insurers' brief contains additional reasons to conclude that their deconsolidation theory is wrong.[33] In any event, they offer no fact testimony or expert opinion to suggest that they are right, and there is nothing else in the record that would support their position and theory.

First, if PTAC were to take a WSD, the tax year of the PTAC consolidated group would end at midnight of the deconsolidation date, not—as the Health Insurers claim—on the first day of the following year.[34] This would result in PTNA and ANIC losing access to the CNOLs—as Ms. Jones and Mr. Fairbanks opined—thus likely subjecting the Estate to hundreds of millions of dollars in avoidable taxes.[35] That, in turn, would dramatically reduce the assets available to service policyholder claims.

Second, it is easy to see the IRS disagreeing with the Health Insurers' definition of "worthless" because they arbitrarily rely on one of ***several*** possible tests of worthlessness under Treasury regulations.[36] As Mr. Fairbanks testified, it is impossible to speculate how the IRS

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31 *See* 40 P.S. § 221.44.

32 *See* Reply at 15–17.

33 *See* Surreply at 5.

34 *See* Treas. Reg. §§ 1.1502-75 & -76; Surreply at 15.

35 Ex. 21 (Jones Tr.) 122:21–24 ("Q: So I'm not very good at math, but what we're looking at is approximately $280 million in this example, right? A: Approximately."); Ex. 3 (Fairbanks Report) ¶ 30 ("I understand that there are between $800 to $900 million of CNOLs, or more, with a tax-effected value of over $280 to $315 million, that will be eliminated pursuant to the Plan.").

36 *See* Surreply at 14–15.

would ultimately determine a litigated controversy.[37] The Health Insurers simply disregard the risk that they are wrong and offer no certainty for their claim that a WSD "would have no negative consequences on the Companies."[38]

Rather than provide reassurance, the Health Insurers' reliance on *In re Prudential Lines* should heighten the Court's concern.[39] The Second Circuit decided that case ***seventeen years*** before the IRS established the Unified Loss Rules on September 17, 2008.[40] If the Health Insurers' dated assumptions about the effect of deconsolidation are incorrect, the mistake could cost the Estate hundreds of millions of dollars in tax claims.[41] There is an easy way to insure against that risk—approve the MOU.

Finally, the Health Insurers fail to address the fact that their proposed deconsolidation (even if it could be effectuated) exposes the Estate to significant adverse tax consequences that do not exist under the MOU. For example, under the Health Insurers' tax strategy, if the PLR is denied the result will be a disaster for the Estate because much of the CNOLs that could shield income will have been allocated to PTAC and not the Estate. In contrast, the settlement provides the Estate up to all of the CNOLs if the PLR is denied.

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[37] Ex. 22 (Fairbanks Tr.) 127:1–8 ("Q: Is there anything in the Codification of Economic Substance that would prevent PTAC from taking a worthless stock deduction in this case? . . . A: Again, I'm not going to speculate on what the IRS would ever do in a controversy matter.").

[38] Surreply at 15.

[39] 928 F.2d 565 (2d Cir. 1991).

[40] *See* Internal Revenue Bulletin: 2008-44, *Unified Rule for Loss on Subsidiary Stock* (Nov. 3, 2008), *available at* https://www.irs.gov/irb/2008-44_IRB/ar07.html.

[41] *See* Reply at 16.

CONCLUSION

For the foregoing reasons, the Court should approve the MOU, and disregard the Health Insurers' objection and surreply.

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Respectfully submitted,

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