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IN THE COMMONWEALTH COURT OF PENNSYLVANIA

In 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

REPLY OF REHABILITATOR TERESA D. MILLER TO THE HEALTH INSURERS' RESPONSE REGARDING STANDARD OF REVIEW

I. INTRODUCTION

On July 20, 2015, the Pennsylvania Supreme Court held that the following standard of review applies to the Commonwealth Court's review of a petition to convert a rehabilitation to a liquidation proceeding under § 518 of Article V, 40 P.S. § 221.18(a):

> ***[W]e find that judicial review of a statutory rehabilitator's decision to seek conversion under Section 518(a) generally is to be undertaken with due deference to the rehabilitator and is governed by an abuse-of-discretion standard.*** … Thus, for purposes of Section 518(a), the Commonwealth Court ordinarily should confine its inquiry to whether the reasonable cause requirement of Section 518(a) was satisfied …, with due regard for the Commissioner's expertise in such arena.

In re Penn Treaty Network Am. Ins. Co., 119 A.3d 313, 322-23 (Pa. 2015) (emphasis added). That is the same standard that the Supreme Court has established for approval of a rehabilitation plan. *In re Mutual Fire, Inland, & Mar. Ins. Co.* ("*Mutual Fire II*"), 614 A.2d 1086, 1091-92 (Pa. 1992). Thus, it is now clear that the present rehabilitation plan—which includes the contemplated liquidation of PTNA as part of a business-division strategy—will be reviewed with deference to the Rehabilitator and is governed by an abuse-of-discretion standard. In their most recent brief addressing the standard of review,[1] the Health Insurers improperly seek to diminish that deference and to quarantine the abuse of discretion standard by suggesting that some other standard should apply to aspects of the Plan that raise "legal issues," or to the Rehabilitator's burden when presenting evidence. Those arguments are not tenable as a matter of law in light of *Penn Treaty* and *Mutual Fire II*. Abuse of discretion is the only standard that applies to the pending plan-approval petition. Nor do the Health Insurers have standing to develop the challenge they would raise.

[1] Both before, and now after, the Supreme Court's decision, the Health Insurers have suggested that portions of the Plan should be reviewed under a less deferential standard than abuse of discretion. See Surreply of Health Insurers Regarding Std. of Review, at 2-3 (filed Apr. 7, 2015). This position cannot survive the Supreme Court's admonition in *Penn Treaty* that review of a plan and conversion to liquidation requires "due deference to the rehabilitator and is governed by an abuse-of-discretion standard." 119 A.3d at 322.

II. ARGUMENT

A. None of the legal issues identified by the Health Insurers warrant review under a standard different than abuse of discretion.

The Health Insurers claim that certain "legal issues" require this Court's "plenary review," as if to suggest that a standard completely separate from abuse of discretion applies to those matters. Health Insurers' Br. at 2. That is not the case. In fact, their position would inject confusion into the abuse of discretion standard by conflating the concepts of a violation of law and the application of legal principles to the facts under a separate "legal issues" umbrella. *Id.*

The Health Insurers' suggested standard ignores the interconnected governing law. A violation of the law by the Commissioner would constitute an abuse of discretion, and it would be an abuse of discretion to proffer a rehabilitation plan that contravenes clear constitutional or statutory requirements. *Cashdollar v. State Horse Racing Comm'n*, 600 A.2d 646, 650 (Pa. Commw. Ct. 1991). But, in an area where the law is unsettled or where legal standards must be applied to the facts underlying a plan, *Penn Treaty* and *Mutual Fire II* instruct that "judicial review … should proceed subject to a more deferential overlay relative to the … Commissioner." *Penn Treaty*, 119 A.3d at 323. *See also Mutual Fire II*, 614 A.2d at 1092 (noting that, when reviewing a proposed plan, "'*judicial* discretion may not be substituted for *administrative* discretion'" (quoting *Norfolk & W. Ry. Co. v. Pa. Pub. Util Comm'n*, 413 A.2d 1037, 1047 (Pa. 1980)).

Moreover, when an issue entails application of law to factual decision-making, review under the abuse of discretion standard (with deference to the Rehabilitator) is proper under *Penn Treaty* and *Mutual Fire II*. That is precisely the case as to the four supposedly "legal" issues identified by the Health Insurers (*i.e.*, the construction of *Neblett v. Carpenter*, applicability of the best interests of the creditors test, payment of agent commissions, and payment of uncovered benefits).

1. The Health Insurers lack standing and, further, misinterpret *Neblett.*

a. The Health Insurers lack standing to raise the *Neblett* issue because they are not creditors of the Companies.

The Health Insurers claim that the United States Supreme Court's decision in *Neblett v. Carpenter*, 305 U.S. 297 (1938) broadly requires that creditors fare at least as well in rehabilitation as they would in liquidation. Even if that test applied as formulated by the Health Insurers—and it does not because it is only a due process concept that the Supreme Court applied to *policyholders*, not general creditors—the Health Insurers lack standing to raise it because ***they are not creditors of the Companies.*** Policyholders are, and guaranty associations in the future are expected to be, creditors of the Companies; the Health Insurers are not creditors and will not become creditors in the future. In fact, the Health Insurers suggested during the July hearing that they believe that liquidation of the Companies may be appropriate. *See* Plan Approval Hearing Tr. 228:15-229:1

(July 13, 2015). Their only "grievance" with the Plan is that they may ultimately fund some part of its benefits through guaranty association ("GA") assessments. However, participation in the GA system is essentially a state-mandated economic cost of doing business that the Health Insurers assumed by writing business in a particular state.

Being a participant in the state-mandated GA system is not sufficient to confer standing to raise the so-called *Neblett* argument. Each state requires GA membership—and, by extension, payment of GA assessments—as a condition of becoming an admitted insurer transacting business in the state. *See, e.g.*, 40 P.S. § 991.1704(a) ("All member insurers shall be and remain members of the [Pennsylvania GA] as a condition of their authority to transact insurance in this Commonwealth."). No insurer has any obligation to become admitted in any particular state. If the prospect of GA assessments is unduly onerous for a particular insurer, that insurer is free to make a business decision not to write coverage in a particular state, to limit its insurance offerings to product lines not covered by the GA system, or to operate only in states that have the lowest GA coverage limits (thereby reducing its exposure to GA assessments). Similarly, if GA assessments result in increased costs to member insurers, those insurers are free to build assessments into their cost of doing business, and to request approval

of premium rates that account for those assessments.[2] In other words, the prospect of GA assessments represents an economic calculus that an insurer voluntarily assumes when it decides, as a matter of business strategy, to write business in a particular state.

The Health Insurers—by attempting to claim creditor status under their formulation of *Neblett*—seek to convert that *economic* calculus into a *legal* right. It is not. By definition, under Article V a creditor is "a person having any claim, whether matured or unmatured, liquidated or unliquidated, secured or unsecured, absolute, fixed or contingent" against the insolvent insurer. 40 P.S. § 221.3. It is undisputed that neither PTNA nor ANIC owe a debt of any kind to the Health Insurers, and that the Health Insurers neither have nor will have any claim against the Companies. Simply put, the Health Insurers are not creditors under Article V. Their attempt to cast themselves as such for purposes of advancing their own business interests in this receivership should not be countenanced.[3]

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[2] In actuality, the Health Insurers will recoup much of any GA assessments they pay, as most states permit insurers to set off such assessments from their premium tax liability. *See, e.g.*, 40 P.S. § 991.1711(a) ("A member insurer may offset against its premium tax liability to this Commonwealth a proportionate part of the assessments described in section 1707 to the extent of twenty per centum (20%) of the amount of such assessment for each of the five (5) calendar years following the year in which such assessment was paid.").

[3] To the extent that the Health Insurers' possess any interest in the receivership, that interest is represented here by the National Organization of Life and Health Insurance Guaranty Associations ("NOLHGA"). NOLHGA, as the

The Health Insurers' argument distills to little more than a bald assertion that it is somehow unfair, inappropriate, or an unconstitutional "taking" of some sort to ask them to cover GA assessment costs that they knowingly and voluntarily agreed to assume as a condition of writing business in the affected states. That is not so. Even if *Neblett* stood for the proposition that the Health Insurers claim it does, only the Companies' true *creditor* —namely, the *policyholders* here—would benefit from it. The Health Insurers—who possess at most only an indirect *business interest* here—would not. The Rehabilitator and the Policyholders Committee represent the interests of policyholders here.

b. *Neblett* does not stand for the proposition that each and every creditor must, at an individual level, fair as well in rehabilitation as they would in liquidation.

Even if the Health Insurers qualified as creditors, *Neblett* does not hold that each and every creditor must individually fare better in rehabilitation than he or she would in liquidation. In *Neblett*, the plan at issue gave *policyholders* the choice to either accept a substitute policy with fewer benefits than their existing one or to opt

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entity that represents the interests of state guaranty associations, is statutorily permitted to intervene with full standing in receivership proceedings precisely for the purpose of representing the interests of the state GAs and by extension, member insurers in receivership proceedings. *See* 40 P.S. § 991.1706(*l*) (authorizing the Pennsylvania GA to intervene in any proceeding involving "an impaired or insolvent insurer"); *id.* § 1706(o) (authorizing the Pennsylvania GA to "join an organization of one or more other state associations of similar purposes [*i.e.*, NOLHGA], to further the purposes and administer the powers and duties of the association.").

out of the rehabilitation proceedings and accept a dividend equal to the amount that they would have received in liquidation. 305 U.S. at 305. The *policyholders* challenged the substitute policies, claiming that the lesser benefits violated their due process rights and constituted an impermissible impairment of contracts. *Id.* The Supreme Court, however, rejected that argument:

> This position is bottomed upon the theory that the *policy holders* are compelled to accept the new company as insurer on the terms set out in the rehabilitation agreement. As has been pointed out, they are not so compelled but are given the option of a liquidation which on this record appears as favorable to *them* as that which would result from the sale of the assets and pro rata distribution in solution of all resulting claims for breach of outstanding *policies*.

Id. (emphasis added).

In other words, the Supreme Court relied on the liquidation opt-out as evidence that policyholders were treated fairly, and that their due process and contractual rights were not unconstitutionally impaired. The court did not, however, impose an opt-out as a constitutional requirement or mandate that each individual policyholder must fare better in rehabilitation than in liquidation as a prerequisite to approval of a plan. Indeed, as this Court and others have observed:

> [W]e do not read *Neblett* as establishing "the broad principle that a rehabilitation plan is per se invalid unless every *policyholder* will fare as well in rehabilitation as in liquidation." Rather, the Supreme Court's focus in *Neblett* was on whether the rehabilitation plan at issue in that case was invalid. … [T]he Supreme Court was

> responding to a specific argument made by the appellants and was not purporting to establish a rule that a rehabilitation plan is per se invalid unless, similar to the plan at issue in *Neblett*, it permits *policyholders* to receive the liquidation value of their claims or the right to opt out of the plan.

In re Ambac Assur. Corp., 841 N.W.2d at 503-04 (Wis. Ct. App. 2013) (quoting this Court's decision in *Consedine v. Penn Treaty Network Am. Ins. Co.*, 63 A.3d 368, 453 (Pa. Commw. Ct. 2012)) (emphasis added).

That rationale is underscored by the very nature of the rehabilitation process. The Health Insurers treat *Neblett* as if it required a mathematical calculation. For each policyholder, they would have the Court calculate the dollar value of the policyholder's benefits in rehabilitation and value of his or her liquidation claim, place those amounts on opposite side of the balance, and approve the plan so long as the former equaled or outweighed the latter. But the Pennsylvania Supreme Court explicitly rejected that position in *Mutual Fire II* when it noted that "individual interests might have to be sacrificed or compromised in order to preserve the ultimate goal of [the rehabilitation] process." 614 A.2d at 1102. Moreover, the Health Insurers' position ignores the realities of the rehabilitation process. Rehabilitation is not the sterile process that such an analysis implies.

The rehabilitation process is inherently forward-looking and requires the Rehabilitator to apply her judgment about how best to protect policyholders over time. It is for precisely that reason that courts grant "great deference in favor of

the Insurance Commissioner" when developing a plan of rehabilitation. *Mutual Fire II*, 614 A.2d at 1093. *Neblett* does not disturb that deference. So long as the rehabilitation plan is "procedurally and substantively fair and equitable" to policyholders and other creditors, it should be approved. *Koken v. Fidelity Mut. Life Ins. Co.* ("*Fidelity Mutual III*"), 912 A.2d 410, 415 (Pa. Commw. Ct. 2006). The Court should reject the Health Insurers' suggestion that *Neblett* establishes any standard to the contrary.

2. The "best interests of the creditors" test as formulated by the Health Insurers does not apply in the receivership context, as the Rehabilitator is statutorily entrusted with protecting the interests of policyholders.

The Health Insurers further suggest (either under *Neblett* or some other due process principle) that a rehabilitation plan must be judged without deference to the Rehabilitator under a "best interests of the creditors" test, similar to that which applies when converting a reorganization to a liquidation proceeding under the federal Bankruptcy Code. *See In re Am. Cap. Equip. LLC*, 688 F.3d 145, 161 (3d Cir. 2012) (explaining that a court may grant a conversion if doing so furthers the creditors' best interests).

That argument overlooks the fundamental difference in purpose between bankruptcy proceedings and insurance receivership. Whereas bankruptcy proceedings are intended to preserve economic value for creditors, "the equitable purpose of rehabilitation and liquidation is to protect first of all consumers of

insurance," *i.e.*, the policyholders. *Grode v. Mutual Fire, Mar. & Inland Ins. Co.* ("*Mutual Fire I*"), 572 A.2d 798, 801 n.5 (Pa. Commw. Ct. 1990). It is for that reason that the General Assembly has entrusted the Insurance Commissioner, as rehabilitator, with the task of developing a rehabilitation plan, and that courts employ deference to the Rehabilitator's decision-making process. *Mutual Fire II*, 614 A.2d at 1091-92. Indeed, as acknowledged by the Supreme Court in this case, "'only a strong showing to the contrary [can] justif[y] the trial court's refusal to follow the recommendations of the administrative officers to whom the supervision of the insurance company was entrusted by the legislature.'" *Penn Treaty*, 119 A.3d at 322 (quoting *Ky. Cent. Life Ins. Co. v. Stephens*, 897 S.W.2d 583, 588 (Ky. 1995) and equating that standard with the one applied by *Mutual Fire II*). The General Assembly has committed the protection of policyholders to the discretion of the Rehabilitator—not other creditors or removed entities with purely business interests—subject to review for abuse of discretion. The Health Insurers' attempt to sidestep that discretion under the guise of the "best interests of the creditors test" is unfounded and should be rejected.

3. The remaining purported "legal issues" identified by the Health Insurers are likewise subject to deferential review.

Despite the Health Insurers' artful sleight of hand attempting to equate all matters of law and fact with a "legal issues" umbrella, each of the remaining issues identified by the Health Insurers present mixed questions of fact and law as to

which the Rehabilitator receives deference, but in respect of which the Health Insurers lack standing to complain.

First, payment of commissions to agents of ANIC is not a purely legal issue. The Plan provides for payment of such commissions because, as a company comprised entirely of self-sustaining policies, "commissions due … will be made by ANIC as a normal cost of its business." See Second Amended Plan, at 67. The propriety of paying such commissions is therefore tied to the Rehabilitator's determination that ANIC will be able to cover those expenses as part of its ordinary operating costs. In fact, the Rehabilitator previously sought summary judgment regarding her authority to suspend agent commissions, and a panel of this Court found that "an evidentiary record [was] required in order to resolve" that issue. *See* Order entered Nov. 12, 2009. The legitimacy of paying (or not paying) agent commissions is therefore a mixed question of fact and law subject to the Rehabilitator's discretion, and it entitled to deference under *Penn Treaty* and *Mutual Fire II.*

Second, payment of uncovered benefits likewise represents a question on which applicable law must be applied to the facts at issue. Identifying the methodology used to allocate assets to uncovered benefits and to determine whether a particular policy is non-self-sustaining (and therefore whether the policyholder is entitled to such benefits) are questions that require the exercise of

judgment based on the Companies' financial position. The Rehabilitator's determination on these issues may not be displaced absent an abuse of discretion.

Third, the Health Insurers state that "similarly situated creditors must be treated in the same fashion"—a principle which the Rehabilitator has advanced and with which she generally agrees. *See* Insurers' Br. Regarding Std. of Rev. at 4. But that principle applies to true creditors only, which the Health Insurers are not. Additionally, Article V commits the protection of policyholders to the discretion of the Rehabilitator, and her determination regarding how best to accomplish that end is "'entitled to great weight and careful consideration'" by the Court. *Penn Treaty*, 119 A.3d at 321 (quoting *In re Globe & Rutgers Fire Ins. Co.*, 266 N.Y.S. 29, 31 (N.Y. Sup. Ct. 1933)). Thus, the Rehabilitator's determination regarding how best to protect policyholders and other creditors is entitled to deference. So long as all similarly situated creditors are treated alike, there is no abuse of discretion. The Health Insurers' argument must be rejected to the extent that a lesser standard applies to that determination.

B. The Health Insurers seek to impose a higher evidentiary burden than the substantial evidence standard.

In her previous brief on the standard of review, the Rehabilitator acknowledged that the abuse of discretion standard applied by *Mutual Fire II*, *Norfolk*, and *Penn Treaty* "is similar to the substantial evidence standard under which appellate courts review administrative decisions." *See* Rehabilitators' Supp.

Br. Regarding Std. of Review (filed June 30, 2015). Under that standard, a Plan must be confirmed so long as it does not violate applicable law and is supported by "such relevant evidence as a reasonable mind might accept as adequate to support the conclusion[s]" reached by the Rehabilitator. *Civil Ser. Comm'n v. Poles*, 573 A.2d 1169, 598-99 (Pa. Commw. Ct. 1990). *See also Koken v. Fidelity Mut. Life Ins. Co.* ("*Fidelity Mutual I*"), 803 A.2d 807, 812 (Pa. Commw. Ct. 2002) (stating that substantial evidence standard applies to the rehabilitator's decision-making in the receivership context). Substantial evidence "is a lesser standard than the preponderance and clear and convincing standards": it is that evidence which, taken as true, is enough to support a conclusion. *Scott v. Unemployment Comp. Bd. of Rev.*, No. 1307 CD 2009, 2010 WL 9512696, at *2 (Pa. Commw. Ct. Feb. 16, 2010) (quoting *BMY v. Unemployment Comp. Bd. of Rev.*, 887 A.2d 804, 951 n.7 (Pa. Commw. Ct. 1986)).

The Health Insurers raise three issues on which they allege the Rehabilitator bears a substantial evidence burden. Two of those issues have no bearing on Plan approval, and on the third the Rehabilitator has already satisfied her burden under the substantial evidence/abuse of discretion standard.

First, the Health Insurers suggest that the Rehabilitator must "present substantial evidence to establish that the Plan satisfies the three-part test articulated by *Mutual Fire II*." *See* Health Insurers' Br. Regarding Std. of Rev. at 6, 10 (filed

Aug. 25, 2015). However, even if they had standing to raise it (and they do not), the *Mutual Fire II* test that they reference is a legal test to determine whether a contractual impairment is constitutional, not a factual requirement that all rehabilitation plans must satisfy.[4] Here, there is no contractual impairment because every policyholder has the right to place their policy with PTNA—and thereby receive exactly what they would have if both Companies were liquidated. As such, the "test" that the Health Insurers invoke does not apply. Again, so long as the Rehabilitator produces evidence that the plan is "procedurally and substantively fair and equitable" to all creditors, it must be approved. *Fidelity Mutual III*, 912 A.2d at 415. The Rehabilitator has done so here.

Second, the Health Insurers claim that the Rehabilitator must present substantial evidence of compliance with the Court's May 2012 Order. But the Health Insurers do not claim that the Rehabilitator has violated that Order, nor do the Pennsylvania Supreme Court's decisions in *Mutual Fire II* or *Penn Treaty* require that a party carry an affirmative burden to show compliance with a prior court order as a condition of plan approval. The only burden that applies under those cases is one to show abuse of discretion—and that burden rests with the

[4] *Mutual Fire II* sets forth both the test to determine whether a contractual impairment is valid and the standard of review (*i.e.*, abuse of discretion) applicable to a rehabilitation plan. Although *Mutual Fire II*'s test for impairment of contract does not apply here, that case nonetheless establishes the proper standard of review with regard to the pending Plan.

entity alleging the abuse. *Ario v. Fidelity Mutual Life Ins. Co.* ("*Fidelity Mutual IV*"), 935 A.2d 55, 62 (Pa. Commw. Ct. 2007). No party has produced the slightest hint of evidence of any abuse by the Rehabilitator. This issue therefore has no bearing on Plan approval.

Third, Health Insurers claim that the Rehabilitator must "present substantial evidence to demonstrate that the Plan can actually be implemented," notwithstanding their objections as to contingencies regarding licensing and tax issues. *See* Health Insurers' Br. Regarding Std. of Rev. at 10 (filed Aug. 25, 2015). In essence, the Health Insurers claim that the Rehabilitator must produce proof positive that each of those contingencies will be satisfied. *Id.* at 7-8. But neither the abuse of discretion nor the substantial evidence standard requires the Rehabilitator to eliminate all contingencies as a condition of Plan approval. Abuse of discretion and substantial evidence simply require evidence from which one could conclude that their fulfillment is possible. *See Poles*, 573 A.2d at 598-99 (describing substantial evidence as that which is "adequate to support the conclusion" at issue). Indeed, this is why Section 518 exists—to enable a receiver to respond to contingencies.

The Rehabilitator has not yet completed her case-in-chief, and it is therefore premature to judge the sufficiency of her case. Nonetheless, she has already

identified a good-faith basis to believe those contingencies will be fulfilled. As Special Deputy Rehabilitator Patrick Cantilo testified:

> I have had many discussions with the regulators and Guaranty Associations about this concept, and although no regulator is able to make any commitment before there's a final plan approved by this court, I'm hopeful that we can achieve that.

See Plan Approval Hearing Tr. 165:6-12 (July 13, 2015). Moreover, Mr. Cantilo further testified that "at least one state has said pretty unequivocally that they will" provide a limited license sufficient to allow transfer of policies between the Companies. *Id.* at 171:1-2. He further explained that, even if the licensing contingencies identified by the Health Insurers are not fulfilled, they can otherwise be addressed through a voluntary GA trigger, by placing policies in the affected states with ANIC, or by revising the Plan. *Id.* at 167:9-168:23. That testimony, together with the balance of the Rehabilitator's case once presented, is more than sufficient to satisfy the abuse of discretion standard for plan approval under *Mutual Fire II* and *Penn Treaty.*

III. CONCLUSION

For the reasons set forth above, the Rehabilitator respectfully requests that the Court apply the abuse of discretion standard as set forth in *Mutual Fire II* and *Penn Treaty* at the plan-approval hearing.

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Respectfully submitted,

/s/ Carl M. Buchholz

Carl M. Buchholz
Stephen W. Schwab
Jayne A. Risk
Carl H. Poedtke III
DLA PIPER LLP (US)
One Liberty Place
1650 Market Street, Suite 4900
Philadelphia, PA 19103
Tel: 215.656.3300
Fax: 215.656.3301

James R. Potts
COZEN O'CONNOR
One Liberty Place
1650 Market Street
Tel: 215.665.2000
Fax: 215.701.2102

Attorneys for Teresa D. Miller, Insurance Commissioner of Pennsylvania, in her capacity as statutory rehabilitator of Penn Treaty Network America Insurance Co. and American Network Insurance Co.