IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

HEALTH INSURERS' RESPONSE TO POLICYHOLDERS COMMITTEE'S APPLICATION TO STRIKE THE FORMAL COMMENTS OF THE HEALTH INSURERS

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INTRODUCTION

Aetna Life Insurance Company, Anthem, Inc., Cigna Corporation, HM Life Insurance Company, Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey, QCC Insurance Company, United Concordia Life and Health Insurance Company, United Concordia Insurance Company and UnitedHealthcare Insurance Company (collectively, the "Health Insurers") through their undersigned counsel hereby submit this response to the Policyholders Committee's (the "Committee") Application to Strike the Formal Comments of the Health Insurers (the "Application") on the proposed Second Amended Plan of Rehabilitation (the "Plan") for Penn Treaty Network America Insurance Company ("PTNA") and American Network Insurance Company ("ANIC" and, together with PTNA, the "Companies").

The Application requests that the Court strike the Formal Comments of the Health Insurers. The Application should be denied, first, because it is contrary to the Court's Case Management Order dated December 3, 2014 (the "2014 Order") and its Case Management Order dated June 5, 2013 (the "2013 Order"). Those Orders established procedures for filing Formal Comments and the Health Insurers have fully complied with them. The Committee attempts to read additional requirements into the Orders, but both the Orders themselves and the course of these proceedings refute that reading.

Second, the participation of the Health Insurers is not prejudicial to these proceedings. As the parties that could pay substantial amounts of loss (potentially hundreds of millions of dollars), the Health Insurers bring an important and unique perspective to these proceedings. The Committee's desire to shield the Court from that perspective is no reason to bar the Health Insurers from participating.

Third, even setting aside the Court's Case Management Orders, the Health Insurers plainly have standing to participate in these proceedings. They have a direct and substantial interest because they will absorb the loss from the liquidation of Company B and will pass some of that loss back to the public. The Committee's attempt to limit standing based on analogies to bankruptcy precedents fails. Bankruptcy proceedings are solely for the purpose of adjusting debtor and creditor relationships. Insurance receivership proceedings require the Court to consider the interests of more constituencies because liquidations pass losses back to guaranty association members and the public. The Committee's Application should be denied.

ARGUMENT

I. THE HEALTH INSURERS HAVE FULLY COMPLIED WITH THE PROCEDURES ESTABLISHED BY THIS COURT'S PRIOR ORDERS FOR FILING FORMAL COMMENTS

This Court's 2014 Order established clear, straightforward requirements for the filing of Formal Comments and obtaining the right to participate in the hearing

on the proposed Plan. It did not place any limitations on who could file comments, and in fact established procedures to ensure broad participation by parties that had any interest in providing input to the Court. The 2014 Order provided for the filing of Informal Comments as well as Formal Comments. Even for those that filed Formal Comments, the Court made it clear that providing those comments did not commit a party to litigation, stating "[a] person may submit Formal Comments without participating in the hearing on the proposed Plan of Rehabilitation." 2014 Order at 4. The Health Insurers submitted Formal Comments in the time specified by the 2014 Order and stated their intention to participate in the hearing on the proposed Plan, as required by the 2014 Order. Indeed, the Committee does not claim that the Health Insurers have failed to comply with the 2014 Order, or even discuss the 2014 Order in its Application except in passing.[1]

Instead, the Committee appears to argue that the 2014 Order should be construed to have an unstated restriction on who may file a Formal Comment. The Committee states, "[p]resumably, commenters should qualify as 'parties in interest,' as there is no prudential reason to entertain comments from persons who had no direct interest of their own to assert." This observation is directly contrary to the 2014 Order, which enabled any party to file a Formal or Informal Comment.

[1] Neither Order is even mentioned until page 10 of 13 of the Application, when the Committee acknowledges that the Court provides a procedure for participating in the proceedings that is distinct from a formal intervention motion. *See* Application at 10 ("Under the [2014 Order], persons who do not intervene may nevertheless file comments on the Second Amended Plan and may participate in the hearings on the confirmation of the Plan, upon notice to the Court.").

There is no intimation in the Committee's Application that the Court lacked the authority to invite participation in the proceedings from a broad range of parties. And there is nothing in the 2014 Order that suggests that the Court intended to place limitations on who could file Formal Comments.

The Committee's Application also ignores the fact that the Health Insurers have been active participants in hearings before the Court since 2013 and full participants in the Multi-Party Rehabilitation Group ("MPRG") process established by the Court at the hearing on September 24, 2013. At the hearing on February 20, 2015, the Court directly asked the Health Insurers if they intended to participate in the hearing on the proposed Plan–to which they responded affirmatively–and solicited their views on the Plan confirmation process. The Committee did not state any objection to the Health Insurers' participation at that time or suggest that it intended to file the present Application. It cannot be that the Court intended to bar the Health Insurers from filing their Formal Comments or that the Court intended to exclude the Health Insurers from participating in the hearings on confirmation of the Plan.

II. THE HEALTH INSURERS' PARTICIPATION IN THESE PROCEEDINGS DOES NOT PREJUDICE ANY PARTY

The Committee's Application does not identify any prejudice that results from the Health Insurers' Formal Comments or their participation in these proceedings, other than the fact that the Health Insurers and the Committee

disagree about the legality of certain aspects of the Plan. In entering the 2014 Order, the Court invited parties with differing points of view to fully participate in the proceedings. It is for the Court, not the Committee, to resolve ultimately the issues raised in the Health Insurers' Formal Comments. Granting the Committee's Application would entirely undercut the purpose of the 2014 Order.

The Committee argues that the Health Insurers' participation in the proceedings could "complicate and prolong the confirmation process." Application at 13. But this is nothing more than a wish to eliminate any opposition to the Plan without addressing the substance of the opposition.

Equally meritless is the Committee's "slippery slope" argument that permitting the Health Insurers to participate will open the floodgates to future objections by others. Here, again, the Committee fails to consider the Court's Orders, which actually and effectively prevent this very problem. This Court established a firm deadline for submission of Formal Comments and a statement of intent to participate in the hearing on the Plan. That deadline was February 13, 2015. It expired over a month before the Committee filed the present Application. The Health Insurers were the only health companies and guaranty association member insurers to submit Formal Comments and a statement of intent to participate in the hearing on the proposed Plan. There will be no others because

this Court's 2014 Order does not permit any new submissions by other parties at this time.

The procedure established in the 2014 Order invited the exact type of expansive participation that the Committee now seeks to suppress. This proceeding is the first of its kind with respect to a substantial long term care insurer, and is the largest or second largest insurance company insolvency ever. The Companies' rehabilitation proceedings involve complex legal and financial issues impacting over 90,000 policyholders, and member insurers and guaranty associations in nearly every state. The 2013 and 2014 Orders solicited input on the Plan from any party that cared to express an interest, and encouraged parties with the greatest interest to resolve differences as part of the MPRG process. The result has been the resolution of many issues and the consequent narrowing of the matters that will need to be considered in the Plan confirmation process.

The Health Insurers' Formal Comments raise important issues that are not raised by other parties in these proceedings. As discussed in their Formal Comments, the issues raised by the Health Insurers affect the ultimate cost of this insolvency to the public. No other party has advocated these interests. As the Court is well aware, protecting the interests of the public is one of the primary

purposes of Article V. *See* 40 P.S. § 221.1(c) ("[t]he purpose of this article is the protection of the interests of insureds, creditors, and the public generally…").[2]

III. THE HEALTH INSURERS HAVE A DIRECT AND SUBSTANTIAL INTEREST IN THE PROCEEDINGS

The Committee contends that the Health Insurers should not be able to file Formal Comments or participate in the hearing on the proposed Plan unless they meet the standards required of intervenors in an administrative proceeding. The 2014 Order does not impose this limitation on the parties' participation in these proceedings, and the Court has rejected the analogy to administrative proceedings in another case.[3] But even if this were the standard, the Health Insurers readily meet it because they have a "direct and substantial interest" in whether the Plan is approved as proposed.

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[2] The Committee misses the point in asserting that the Health Insurers may not establish standing by asserting the "general public's interest in procuring obedience to the law." Application at 9. The Health Insurers do not seek abstract or general compliance with the law but rather seek to prevent the illegal diversion of assets that will cause financial harm to the Health Insurers, some of which will be passed back to taxpayers and the public.

[3] In *Koken v. Legion Ins. Co.*, 831 A.2d 1196 (Pa. Commw. Ct. 2003), the Court distinguished proceedings under Article V from other administrative schemes:

> In many administrative schemes, the ultimate power of decision remains with the agency and the courts only monitor the agency's performance. In other schemes, the courts have the power of decision and the agency's decision forms the basis upon which the courts exercise that power. Each administrative scheme strikes a balance in the allocation of authority between total judicial dominance and total administrative dominance. Article V is an example of the second paradigm: the Court has the power of decision.

Legion Ins. Co., 831 A.2d at 1231 (internal quotation marks and citations omitted). *See also id.* ("the legislature did not establish a scheme whereby the Insurance Commissioner could operate an insolvent insurer unless and until one of her actions prompted a person who was aggrieved to seek judicial review. It could have, but it did not.").

While the Committee cites *Wm. Penn Parking Garage, Inc. v. Pittsburgh*, 346 A.2d 269 (Pa. 1975) as setting forth the standard, the Committee misconstrues it. In fact, the Health Insurers readily satisfy that standard. *Penn Parking* involved a city ordinance imposing a tax on all patrons of non-residential parking places. *Penn Parking*, 346 A.2d at 275. One of the issues on appeal was whether the plaintiffs, which included taxpayers and operators of commercial parking garages, had standing to maintain the appeal. *Id.* at 276. The Pennsylvania Supreme Court noted that the standard for determining whether a person is aggrieved by an order or other action has caused confusion for the lower courts, and the Court therefore took the opportunity to clarify that standard at length. The Court stated that the established formulation of what is necessary to render a person aggrieved by an order or other action is as follows:

> (The party) must have a direct interest in the subject-matter of the particular litigation, otherwise he can have no standing to appeal. And not only must the party desiring to appeal have a direct interest in the particular question litigated, but his interest must be immediate and pecuniary, and not a remote consequence of the judgment. The interest must also be substantial.

Id. at 191. The Court went on to say that the "core concept, of course, is that a person who is not adversely affected in any way by the matter he seeks to challenge is not 'aggrieved' thereby and has no standing to obtain a judicial resolution of his challenge." *Id.* at 192.

Having set forth the standard, the Court then unpacked the component parts. First, the Court held that "the requirement of a 'substantial' interest simply means that the individual's interest must have substance – there must be some discernable adverse effect to some interest other than the abstract interest of all citizens in having others comply with the law." *Id.* at 195. Second, the "requirement that an interest be 'direct' simply means that the person claiming to be aggrieved must show causation of the harm to his interest by the matter of which he complains." *Id.* Third, the requirements that the interest be "immediate" and "not a remote consequence of the judgment" reflect the concern regarding "the nature of the causal connection between the action complained of and the injury to the person challenging it." *Id.* at 197. The Court concluded that both taxpayers and garage owners had standing even though not all taxpayers would pay the tax and even though the tax was not paid by the garage owners.

The Health Insurers meet the *Penn Parking* standard. If the Plan is approved, the Health Insurers face potentially substantial guaranty association assessments as a result of the liquidation of Company B. The outcome of the issues raised in the Formal Comments by the Health Insurers will affect the amount of those assessments by determining what assets of the estate are available to the guaranty associations. As it stands, the Plan diverts hundreds of millions of dollars in assets to the support of Company A policies and the payment of claims that should not be

paid in a rehabilitation plan. The liquidation of Company B and the allocation of assets are not remote contingencies. They are the centerpiece of the proposed Plan, which is scheduled for confirmation this summer and is slated to become effective no more than six months thereafter. Plan § IV.V. at 77.

The potential magnitude of the financial outcome of the Plan readily meets the requirement that the Health Insurers' interest is substantial. Because the outcome of the litigation on the Plan will affect the amount of the Health Insurers' assessments, the Health Insurers interest is direct. The fact that the Plan is expected to be implemented within six months after confirmation satisfies the requirement that the Health Insurers' interest is immediate. It is undeniable that the outcome of the confirmation hearings on the Plan will have a "discernable adverse effect" on the Health Insurers, and that the effect would be an "immediate" and not a "remote" consequence of the Court's confirmation of the Plan.

The fact that the Health Insurers make payments through state guaranty associations does not break any required causal connection either. By statute, the guaranty associations pass through the entire amount of the loss from their activities.[4] The guaranty associations assess member insurers and estate assets to fund both their administrative and policyholder obligations. The Committee

[4] The Committee states that "[i]n effect, the Health Insurers claim to represent the interests of the Pennsylvania Life and Health Guaranty Association ("PLHGA") and other guaranty associations." Application at 6. The Health Insurers have never claimed to represent PLHGA or any other guaranty association. As the entities that absorb the loss, the Health Insurers have differing interests from the guaranty associations, which administer but do not absorb the loss.

elevates form over substance in arguing that since the loss from the liquidation will pass through the guaranty associations, the Plan will not cause harm to the Health Insurers.

The Committee also exaggerates the impact of certain tax credits associated with the payment of assessments in arguing that the Health Insurers' payment of substantial assessments will not "represent direct and immediate harm to the Health Insurers." Application at 5. These credits may mitigate some of the harm to the Health Insurers, but do not remotely reduce it to a level where the Health Insurers have no standing to be heard. In the first place, several states provide no tax credit, and others allow only a portion of the assessment to be used to offset taxes. *See, e.g.*, Md. Code Ins. § 9-401 *et seq.* (no provision for premium tax offset), 215 Ill. Comp. Stat. 5/531.13 (no provision for tax offset after January 1, 2003); *see also* RI Stat. § 27-34.3-13 (providing for tax offset of up to 10% of the assessment for each of 5 years following the year of assessment payment) and Mass. Gen. Laws ch. 175, § 146B(13)(A) (providing for tax offset of up to 10% of the assessment for each of 5 years following the year of assessment payment). Other states provide for tax offset over a 10-20 year period. *See, e.g.*, D.C. Code § 31-5410 (offset spread evenly over 10 year period following payment) and Fla. Stat. § 631.72 (offset spread evenly over 20 year period following payment). In addition, one state allows the insurer to add a surcharge on premiums charged for

health insurance policies rather than a tax offset. Cal. Ins. Code § 1067.08. Such surcharges are added to the cost of insurance paid by health insurance customers. But in a state such as California, where there are entities that sell health insurance products that are not subject to guaranty association assessment, health insurers cannot simply decide to add the surcharges to their policies without considering whether it would make them too expensive to compete in the market. Because the recovery of assessments is partial in some states, spread out over many years in others, and only recoverable through potentially infeasible premium surcharges in yet others, the economic value of the potential tax credits does not remotely eliminate the Health Insurers' direct and substantial interest in the Plan.[5]

The Committee likewise misses the mark in arguing that the "party in interest" requirements of the Bankruptcy Code should apply to the 2014 Order. While bankruptcy and insurance receivership are analogous in some respects, they are not analogous with respect to standing. As held in the cases cited and relied upon by the Committee, the purpose of bankruptcy proceedings is to adjust debtor-creditor relationships and nothing more. *See Krys v. Official Committee of Unsecured Creditors (In re Refco Inc.)*, 505 F.3d 109, 116 (2d Cir. 2007) ("Bankruptcy courts...were established to provide a forum where creditors and

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[5] Under applicable statutory accounting practice, health insurers must generally establish a reserve for the entire estimated guaranty association assessment liability immediately, while any potential tax offsets would be available only over a long period of time. This further illustrates the immediacy of the economic impact on the Health Insurers.

debtors could settle their disputes and thereby effectuate the objectives of the statute.") (internal quotations omitted); *see also id.* at 118 ("Bankruptcy court is a forum where creditors and debtors can settle their disputes *with each other*.") (emphasis in original). Insurance receiverships have a much broader scope in that they are designed for the "equitable apportionment of any unavoidable loss." 40 P.S. § 221.1(c). The exercise is not just one where creditors vie with each other over a limited pool of assets. Where guaranty associations are involved (and they will be here), the insolvency proceedings distribute the loss from the insolvency out to the insurance market and the public. The Health Insurers are an integral part of that system, separate and apart from the guaranty associations. It is the Health Insurers (not the guaranty associations) who, through premium offsets, increased premiums, and calculation of premium refunds under the Patient Protection and Affordable Care Act, pass a portion of the loss to the public.

Nothing in Article V of the Insurance Department Act or Pennsylvania case law limits participation in the case as suggested by the Committee. The only receivership case cited by the Committee was *In re Financial Guaranty Insurance Co.* ("*FGIC*"), 975 N.Y.S.2d 712 (N.Y. Sup. Ct. 2013). But that decision arose from the New York receivership of a financial guaranty company and therefore did not involve the guaranty associations or the spreading of loss to the public. As a

result, the application of narrower standing rules may have been warranted. Here, they are not.

IV. DEPRIVING THE HEALTH INSURERS OF THEIR OPPORTUNITY TO BE HEARD WOULD VIOLATE DUE PROCESS

The Health Insurers' due process rights also would be violated if they were denied any right to be heard in this proceeding. "Nothing can be more fundamental in representative government than that no one may be deprived of life, liberty, or property without due process of law." *Fulton v. Bedford County Tax Claim Bureau*, 942 A.2d 240, 244 (Comm. Ct. Pa. 2008) (internal quotations and brackets omitted). Denial of a party's right to participate in a proceeding that will affect the party's property rights violates due process of law. *See, e.g., id.*; *Pa. Coal Mining Ass'n v. Ins. Dep't.*, 471 Pa. 437 (1977) (finding a due process violation where coal companies were denied the right to intervene in a proceeding providing for increases in insurance rates for black lung coverage that coal companies were legally required to purchase). As discussed above and in the Health Insurer's Formal Comments, if not corrected, the flaws in the Plan identified by the Health Insurers could illegally divert hundreds of millions of dollars of assets that otherwise would be available to reduce the liability of the Health Insurers. Further, because no other party has raised these arguments, the Committee is asking the Court to ignore the legal principles raised in the Health Insurers' comments entirely. By asking the Court to turn a blind eye to established

legal principles and to deny the Health Insurers any opportunity to be heard, the Committee's Application seeks relief that is unconstitutional as well as violative of the Court's prior Orders and the basic standards governing participation in legal proceedings.

CONCLUSION

The Committee's Application ignores this Court's prior Orders establishing procedures for submitting Formal Comments and participating in the hearing on the proposed Plan. The Health Insurers complied with those Orders in their entirety, and the Committee has not offered any basis to subject the Orders to additional requirements. The Committee has failed to identify any prejudice that would result from the Health Insurers' participation in these proceedings, and seeks to deprive the Court of fundamental arguments regarding the permissibility of certain features of the proposed Plan. Although not required by the Court, the Health Insurers can demonstrate a substantial and direct interest in these proceedings. The granting of the Application would deny the Health Insurers due process of law. The Committee's Application should be denied.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on April 15, 2015, I caused a true and correct copy of the foregoing document to be served on the following persons by email at the email addresses indicated below:

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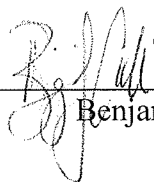

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