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

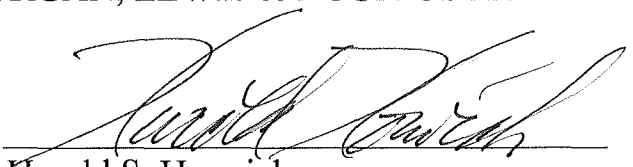
APPLICATION FOR LEAVE TO FILE A SUR-REPLY TO THE REHABILITATOR'S REPLY BRIEF REGARDING STANDARDS OF REVIEW APPLICABLE TO THE PROPOSED SECOND AMENDED REHABILITATION PLAN

Pursuant to 201 Pa. Code § 2113, 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 United Healthcare Insurance Company (collectively, the "Health Insurers") by and through their undersigned counsel hereby apply for leave to file the attached Sur-Reply to the Rehabilitator's Reply Brief regarding Standards of Review Applicable to the Proposed Second Amended Rehabilitation Plan. The Health Insurers submit that this Sur-Reply is necessary to

address the Rehabilitator's arguments regarding *de novo* review and burden of proof submitted in support of the Health Insurer's Formal Comments.

Dated: April 2, 2015

MORGAN, LEWIS & BOCKIUS LLP

By: 

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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

SUR-REPLY OF THE HEALTH INSURERS REGARDING STANDARDS OF REVIEW APPLICABLE TO THE PROPOSED SECOND AMENDED REHABILITATION PLAN

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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 sur-reply brief in order to respond to the reply brief of the Rehabilitator regarding the standard of review applicable to the proposed Second Amended Plan of Rehabilitation (the "Amended Plan") for Penn Treaty Network America Insurance Company ("PTNA") and American Network Insurance Company ("ANIC" and, together with PTNA, the "Companies").

ARGUMENT

A. There Are Numerous Legal Issues That Will Require *de novo* Review.

In her Reply Brief, the Rehabilitator erroneously asserts that she should be accorded a deferential abuse of discretion standard of review with respect to "the entirety" of the Amended Plan under *Foster v. Mutual Fire, Marine & Inland Insurance Co.* ("*Mutual Fire II*"), 614 A.2d 1086 (Pa. 1992). Contrary to the Rehabilitator's assertions, the Health Insurers' Formal Comment raises a number of specific issues of law that require *de novo* review of aspects of the Amended Plan, including:

- does the use of the estates' assets to pay Uncovered Benefits (as defined in the Amended Plan) violate 40 P.S. §§ 221.20 and 221.21?
- does Pennsylvania law require the use of Company A assets to pay commissions to agents on Company A policies?
- does the U.S. Constitution, as interpreted in *Carpenter v. Pacific Mutual Life Ins. Co.,* 74 P.2d 761, 772 (Cal. 1937), *aff'd sub nom. Neblett v. Carpenter,* 305 U.S. 297 (1938), require that the Amended Plan result in no greater loss to the guaranty associations than a liquidation of both Companies?

Simply put, *Mutual Fire II* does not stand for the proposition that the deferential abuse of discretion standard applies to the legal issues of whether the Amended Plan complies with Pennsylvania law and the U.S. Constitution. Rather, the scope of review for legal issues is, and must be, plenary. Compliance with the requirements of state and federal law is distinct from "the determinations of fact and public policy" on which substantial discretion is accorded the Rehabilitator. *Mutual Fire II*, 614 A.2d at 1091. Abuse of discretion review recognizes deference to "the skill, judgment and expertise" of the Insurance Commissioner in the "highly specialized" insurance industry. *Id.* at 1092. But this deference does not extend to whether the Amended Plan complies with state and federal legal requirements. On those legal issues, this Court has the power to review *de novo*

and must do so in order to ensure compliance with statutory and constitutional requirements. The Rehabilitator's assertions to the contrary are meritless.[1]

B. The Rehabilitator Carries The Burden Of Proof On Virtually All Issues Under The Amended Plan.

The Rehabilitator's basic decision to attempt a plan that does not impair the contractual rights of policyholders may be within her discretion. But the consequence of that decision is a liquidation of one of the Companies and the transfer of the vast majority of the policies to the guaranty associations. Because the assets being used to create the company being rehabilitated are being carved out of the recovery of the creditors of the liquidation, all of the issues surrounding whether the Amended Plan can be confirmed should be the subject of the higher burden of proof applicable to conversion of a rehabilitation into a liquidation, including: whether it is in the best interest of creditors; whether it is fair and equitable to creditors; and whether it is feasible.

Unlike *Mutual Fire II* and *Fidelity Mutual*, where policyholders with the

[1] The Rehabilitator attempts to buttress her incorrect legal contentions with selective and misleading quotation of the Health Insurers' brief, using ellipses to omit key language. At pp. 2-3 of her Reply Brief, the Rehabilitator asserts: "The Health Insurers state that 'questions . . . are reviewed *de novo,*' yet their brief does not explain how that principle of appellate review would apply to an administrative action such as proposal [sic] of the Amended Plan . . ." In fact, the complete text of these sentences in the Health Insurers' brief provides the very explanation that the Rehabilitator erroneously claims was missing: "The scope of review for such questions is plenary. *Id.* Since the Rehabilitator has even less discretion than an agency would have in a typical agency matter, the Rehabilitator's determinations of law should be entitled to even less discretion before the Court. Therefore, the Rehabilitator is not entitled to deference on her interpretation of the law with respect to the Plan. Any legal issues should be reviewed by the Court de novo." Health Insurers' Brief, at 3.

same policy on the same form were being treated equivalently (and being paid in full), here there will be a wide disparity in treatment because most (but not all) of the policies will be cast into liquidation. The level of judicial scrutiny under these circumstances should be the same as it would be if both Companies were being liquidated.

The Rehabilitator seeks a deferential standard for everything up to the point of the actual liquidation order, arguing that, "Liquidation of PTNA will not occur until a future time after policyholders have completed their elections." But this ignores the fact that the entire Amended Plan sets the stage for the liquidation, which is expected to be the fate of the vast majority of the Companies' policies and assets. The entire point of the plans in *Mutual Fire II* and *Fidelity Mutual* was to avoid liquidation. Here, in contrast, the proposed Amended Plan embraces liquidation as the centerpiece of the entire plan exercise.

C. Federal Bankruptcy Law Supports Maintaining The Burden Of Proof On The Rehabilitator.

In her opening papers, the Rehabilitator raised Chapter X of the Bankruptcy Act and *In re Van Sweringen Corp.*, 155 F.2d 1009 (6th Cir. 1946). But in her reply, the Rehabilitator beats a hasty retreat, attempting to cabin *Van Sweringen* as a case dealing with narrow issues of priority. Apparently the Rehabilitator has belatedly decided to distance herself from *Van Sweringen*, which recognized "that the court must use its own informed and independent judgment in every important

determination in the administration of the reorganization proceedings." *Id.* at 1012.

Notwithstanding the Rehabilitator's change of heart, *Van Sweringen* remains instructive on the task before this Court, and specifically the allocation of the burden of proof. The Health Insurers submit that Pennsylvania law, like Chapter X, requires the Court to make its own informed and independent judgment on the important determinations in this case. The Rehabilitator bears the burden of proof, as many decisions, including *Van Sweringen*, have recognized in the analogous bankruptcy context.

CONCLUSION

For the foregoing reasons and those stated in their previous submission, the Health Insurers respectfully request that the Court enter an order holding that the Rehabilitator bears the burden of proof on confirmation of the Amended Plan and that all issues of law will be reviewed *de novo*.

Respectfully submitted,

Dated: April 2, 2015

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CERTIFICATE OF SERVICE

I certify that on April 2, 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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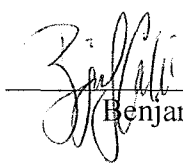

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