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

ORDER

AND NOW, this ___ day of _____, 2015, upon consideration of the Health Insurers' Application for Relief to Modify the Plan to Eliminate the Use of Estate Assets to Pay "Uncovered Benefits" Claims Made Under Policies Terminated Pursuant to 40 P.S. §§ 221.20 and 221.21, and of the Rehabilitator's response thereto, it is hereby ORDERED that the Application is DENIED.

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HON. MARY HANNAH LEAVITT
Judge of the Commonwealth Court

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

RESPONSE OF THE REHABILITATOR IN OPPOSITION TO THE HEALTH INSURERS' APPLICATION FOR RELIEF TO MODIFY THE PLAN TO ELIMINATE THE USE OF ESTATE ASSETS TO PAY "UNCOVERED BENEFITS"

Teresa D. Miller, Acting Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as statutory rehabilitator (the "Commissioner" or "Rehabilitator") of Penn Treaty Network America Insurance Company in Rehabilitation ("PTNA") and of American Network Insurance Company in Rehabilitation ("ANIC"; collectively, with PTNA, the "Companies"), by and through her attorneys, DLA Piper LLP (US), hereby responds to Health Insurers'[1] "Application for Relief to Modify the Plan to Eliminate the Use of Assets to Pay 'Uncovered Benefits' Claims Made Under Policies Terminated Pursuant to 40 P.S.

[1] "Health Insurers" are the interested entities that submitted the Application, *i.e.*: Aetna Life Insurance Company, Anthem, Inc., Cigna Corporation, HM Life Insurance Company, QCC Insurance Company, United Concordia Life and Health Insurance Company, United Concordia Insurance Company and UnitedHealthcare Insurance Company.

§§ 221.20 and 221.21" (the "Application"). For the reasons set forth below, the Application should be denied.

I. INTRODUCTION

Health Insurers ask this Court to rule that the Second Amended Plan of Rehabilitation ("Plan") cannot be approved unless it is modified to eliminate any mechanism by which the assets of the Companies might be used to fund policyholder claims that exceed the applicable guaranty association ("GA") claim limits ("over-limit" or "Uncovered Benefits" claims or obligations). Health Insurers argue that because there can be no over-limit claim, then no assets need to be allocated for same, and instead all Company B assets will be available to the GAs for payment of "Covered Benefits" (the claims within GA limits) before their members[2] are assessed to cover any shortfall. Health Insurers posit that policy obligations can only accrue prior to the termination of a policy, and policyholders will not be able to assert any claim that will exceed GA limits based on obligations that exist when, they argue, the policies are cancelled under 40 P.S. § 221.21. In effect, therefore, the Health Insurers ask the Court to impose a reallocation to the

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[2] All insurers licensed to market and sell applicable lines of business in a jurisdiction are obligated to be a member of the guaranty association in that jurisdiction. The costs of consumer coverage and operating expenses for a GA that are not provided for from assets of an insolvent insurer and the ongoing premium payments of policyholders are financed by assessments upon the members. *See, e.g.*, 40 P.S. § 1707.

GAs of assets intended to satisfy at least part of the policyholders' rights not protected by the insurance safety net.

As will be seen, the Health Insurers' argument amounts to the creation of a paper tiger which they then slay with great zeal. They create an artificial distinction in the rights of policyholders to benefits under the Companies' policies (between those covered and those not covered by GAs) and creatively construe Pennsylvania law as completely eliminating the latter.

The Health Insurers' position is premised on their incomplete and inaccurate analysis of Article V of the Insurance Department Act of 1921, and in particular 40 P.S. §§ 221.20 and 221.21.[3] The Plan contemplates the transfer of policy obligations (which are recorded as statutory liabilities of the companies) for Uncovered Benefits, together with those assets of Company B allocable under the

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[3] Section 521, 40 P.S. § 221.21, provides:

> All insurance in effect at the time of issuance an order of liquidation shall continue in force only with respect to the risks in effect, at that time (i) for a period of thirty days from the date of entry of the liquidation order; (ii) until the normal expiration of the policy coverage; (iii) until the insured has replaced the insurance coverage with equivalent insurance in another insurer or otherwise terminated the policy; or (iv) until the liquidator has effected a transfer of the policy obligation pursuant to section 523(8), whichever time is less.

Plan, pursuant to 40 P.S. § 221.23(8), *before* the last date by which policyholder rights are finally fixed under § 221.21. The transfer complies with Article V.

In order to overcome this obvious flaw in their argument, the Health Insurers ask this Court to construe the terms "claim" and "loss" in the context of long term care coverage to mean something less than the full policy obligations for which Company B will be liable. Their arguments fly in the face of the plain language of Article V, are inconsistent with longstanding precedent and the practices of the Pennsylvania Insurance Department ("Department") and the National Organization of Life and Health Insurance Guaranty Associations ("NOLHGA"), and fail to protect legitimate policyholder rights and interests.

The Court should deny the Health Insurers' Application. The provisions made for the payment of Uncovered Benefits in the Plan are lawful and should be approved.

II. BACKGROUND

Decades of receivership experience inform the issues presented here. The Department and its counterparts across the country have administered scores of receiverships, many involving life and health insurers. In each life and health

receivership, the Department coordinates with life and health insurance GAs that form the membership of NOLHGA.[4]

Achieving policyholder protection here requires liquidation of an entity in order to trigger GA obligations. Accordingly, the Plan contemplates the exercise of a liquidator's authority to transfer policy obligations. That authority is provided for in Article V, but it is challenged here because the Health Insurers claim there will be no "Uncovered Benefits" to which the policyholders will be entitled. As explained herein, they are simply wrong. The Department and the GAs must therefore coordinate in respect of the aspects of the business that will be liquidated.

It is customary, during the time that the Department prepares for liquidation of an insurer under Article V, that GAs prepare for the assumption of policy obligations pursuant to state GA laws. In serving the common objective of protecting the interests of consumers, the Commissioner and GAs have (among others) two aligned goals: to preserve assets for all policyholders, and to make provision for those policyholders with large claims, including those that exceed GA protection:

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[4] NOLHGA appears on behalf of its member associations in many receiverships, particularly in those that affect policyholders across many states, as is the case here. *See, e.g.,* 40 P.S. § 991.1706(o) (permitting the Pennsylvania Life and Health Insurance Guaranty Association to "join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.")

> [S]ince the obligation of a guaranty association is to assure that consumers are completely protected *up to* the association's limit of coverage, ***the amount of assets that can be marshaled by the receiver are critically important*** not only to the guaranty associations and those paying the associations' costs (by reducing the expense of providing coverage within the associations' limits), but also ***to policyholders with large claims (by maximizing the assets available to cover any portion of a policyholder's over-limits claim***). Accordingly, the comparative success of a receivership – and how well (or badly) policyholders with over-limits claims and other stakeholders fare in the receivership – is primarily a question of whether the receiver marshals assets covering a significant percentage of policy-level liabilities.
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> ***It is a common misunderstanding that policyholder recoveries in insurance liquidations are limited to guaranty association coverage limits or "caps."*** The truth is that whether a policyholder recovers all or most of her claim *above* guaranty association caps depends significantly on whether regulatory intervention occurs before the failed company's assets have been substantially dissipated, and whether assets are effectively protected and marshaled in the company's receivership. [. . . .]
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> ***Policyholders with claims against their insolvent insurer in excess of guaranty association caps have a priority claim against the insurer's assets for the excess amount.*** That excess claim ranks *pari passu* with all other claims at the policyholder level. For that reason, a policyholder can – and often does – recover most or all of her claim in the insolvency, *even above* the level covered by guaranty associations.

NOLHGA Testimony for the Record Before the House Financial Services Subcommittee on Insurance, Housing and Community Opportunity: Hearing

Entitled "Insurance Oversight and Legislative Proposals," November 16, 2011, at 4, Appendix (bold italicized emphasis added) (*see* discussion of Life and Health Insurance Company of America receivership at page 17, *infra*). Consistent with these principles, it is customary practice in life and health insurance company liquidations involving over-limit claims to allocate assets both for claims covered by the GAs and for claims that will exceed GA coverage limits.

This practice is not merely a matter of custom or generosity; it is mandated by applicable law. Under 40 P.S. § 221.44, *all* of a policyholder's claim for benefits due under his or her policy is given the same priority in the order of distribution of the liquidating insurer's assets. No distinction is drawn between claims for Covered Benefits and those for Uncovered Benefits. In turn, the only right of GAs to any of those assets is by statutory subrogation and therefore derivative of the rights of the protected policyholders. That right is expressly limited to "the extent of benefits received" from the GAs. *See* 40 P.S. § 991.1706 (m).[5] Thus, it is clear that the liquidating insurer's assets must be allocated fully to policyholders and then distributed to GAs *only* in proportion to Covered Benefits.

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[5] That provision reads, in full:

> (m)(1) Any person receiving benefits under this article shall be deemed to have assigned the rights under, and any causes of action relating to, the covered policy or contract to the association to the extent of the benefits received because of this article, whether the benefits are payments of or on account of contractual obligations,

In this case, the Rehabilitator has prepared a rehabilitation plan that provides for the liquidation of one company—PTNA as Company B—and has further provided for an allocation of assets to satisfy large long term care claims that may exceed GA coverage limits. The Plan employs a "Business Division" strategy under which (1) policies that are (or can be made to be) "self-sustaining" will remain in, or be assumed by, "Company A" (ANIC); and (2) all other polices will remain in, or be assumed by, "Company B" (PTNA). The Business Division strategy would reallocate between Company A and Company B assets representing reserves on the policies, such that assets attributable to policies that ultimately are placed with ANIC are allocated to ANIC, while assets attributable to policies that

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> continuation of coverage or provision of substitute or alternative coverages. The association may require an assignment to it of such rights and cause of action by any payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any rights or benefits conferred by this article upon such person.
> (2) The subrogation rights of the association under this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this article.
> (3) In addition to paragraphs (1) and (2), the association shall have all common law rights of subrogation and any other equitable or legal remedy which would have been available to the impaired or insolvent insurer or holder of a policy or contract with respect to such policy or contracts.

40 P.S. § 991.1706 (m).

ultimately are placed with PTNA are allocated to PTNA, and will be supplemented by the GAs.

For purposes of addressing Uncovered Benefits claims, the Plan provides for the transfer of such policy obligations to an assuming insurer or other mechanisms if that does not prove possible. *See, e.g.*, Plan Sec. I.E. at 8-9. The Rehabilitator proposes a simple process whereby those excess of GA obligations will be transferred pursuant to 40 P.S. § 223(8), as discussed further below.

Health Insurers' challenge to this strategy is transparently self-interested, and disregards the hardship their requested relief would impose on policyholders. The Rehabilitator is not aware of any other such challenge to over-limit claims by life or health insurers or GAs in any other receivership. Moreover, there is no reported decision of a receiver rejecting over the cap claims—because it does not happen. The challenge should be rejected.

III. ARGUMENT

A. Health Insurers' Argument Fails to Acknowledge That the Rehabilitator's Strategy Is Expressly Authorized and Contemplated by Law.

The Rehabilitator proposes to transfer assets with policy obligations as part of a global rehabilitation of the Companies' business in a manner that is specifically authorized by Article V. Health Insurers ignore the plain fact that *Section 221.21 extends policies* for a period of up to 30 days, or "(iv) until the

liquidator has effected a transfer of the policy obligation pursuant to section 523(8), whichever time is less." 40 P.S. § 221.21. Section 523(8) in turn provides that the "liquidator shall have the power: . . . [t]o use assets of the estate to transfer policy obligations to a solvent assuming insurer, if the transfer can be arranged without prejudice to applicable priorities under section 544." 40 P.S. § 221.23(8). The proposed use of assets to transfer policy obligations during the 30 day period after entry of the order of liquidation as proposed by the Rehabilitator accomplishes exactly this, and it does not prejudice any applicable priorities.

Health Insurers seem to take the position that no Uncovered Benefits may be addressed with the assets of Company B, because there will be limited obligations under policies and there will be no entitlement to "Uncovered Benefits." Their arguments ignore the fact that there are policy obligations that exist for which Company B will be responsible, and policy obligations are not fixed until after the 30 days have lapsed. At the time of the transfer of policy obligations as proposed, some policyholders will be "on claim" while others will not. In principle, however, any policyholder could go "on claim" at any time that the policy remains in force. Moreover, regardless of whether a policyholder is on claim, there will be policy obligations and liabilities that already exist.

Ongoing liabilities arise from the specific reserving requirements imposed upon long term care insurers. The Pennsylvania Long Term Insurance Model

Regulations direct that long term care reserves be determined in accordance with Sections 301.1 and 311.1 (40 P.S. §§ 71.1 and 93) and Chapter 84a of the Pennsylvania Insurance Regulations. Title 31 Pa. Code § 89a.116. Section 84a.3 defines the term "reserve" as follows:

> The term used to include all items of benefit liability, whether in the nature of incurred claim liability or in the nature of contract liability relating to future periods of coverage, and whether the liability is accrued or unaccrued. An insurer under its contract promises benefits which result in claims which have been incurred, that is, for which the insurer has become obligated to make payment, on or prior to the valuation date and in claims which are expected to be incurred after the valuation date. For the incurred claims, payments expected to be made after the valuation date for accrued and unaccrued benefits are liabilities of the insurer which should be provided for by establishing claim reserves. For the expected claims, present liability of the insurer for these future claims should be provided for by the establishment of contract reserves and unearned premium reserves.

Title 31 Pa. Code § 84a.3 (emphasis added).

Among the rights and liabilities fixed by operation of 221.20(d) and 221.21 are the "liabilities" of the insurer. "Liabilities" are defined by Section 221.3, for all Article V purposes, to include "reserves required by statute or by insurance department general regulations . . .." 40 P.S. § 221.3. The "liabilities" of Company B regarding policyholders who are "on claim" as of the fixing date will consist of the accrued and unaccrued covered benefits under the triggered policy.

The "liabilities" of the rest of the Companies' policyholders are for expected claims for benefits relating to future periods. Both are counted and reserved for as "liabilities." "Fixing" does not change this statutory reality. Moreover, as demonstrated previously before this Court and referenced below (*infra* p. 12), policyholders will have claims for breach of their policies and the loss of the value thereof.

Because the estate will have ongoing obligations and liabilities under policies, the receiver may arrange assets for distribution proportionately across *all* policyholders, including for excess of GA limit coverage. Protecting policy obligations as proposed by the Rehabilitator is therefore appropriate and, under the mechanism of Section 523(8), fully compliant with Article V. It also is consistent with Article V's stated directive to protect the "interests of insureds, creditors, and the public generally . . . ," 40 P.S. § 221.1(c), and with the overriding goal of equitably apportioning "any unavoidable loss," *id.* § 221.1(c). The policyholders, of course, are of paramount concern, as "the equitable purpose of rehabilitation and liquidation is to protect first of all consumers of insurance." *Grode v. Mut. Fire Marine, & Inland Ins. Co.*, 572 A.2d 798, 801 n.5 (Pa. Commw. Ct. 1990). The Court should declare the proposed transfer lawful.

B. Long Term Care Obligations "Continue" After Liquidation and are Assumed by Guaranty Associations Pursuant to Statutory Directive.

Contractual obligations under life and health policies continue even after an order of liquidation with a finding of insolvency, and the GA statutes recognize and provide for this. Life and health GAs have ongoing obligations to policyholders that are not cut off after any particular temporal period. That continuation of obligations differs starkly from how obligations are handled in the context of property and casualty risks, which is the context in which the Pennsylvania Supreme Court decided *Warrantech Consumer Prods., Inc. v. Reliance Insurance Co. in Liquidation*, 96 A.3d 346 (Pa. 2014), the authority on which Health Insurers' argument mistakenly relies.

For example, the Pennsylvania Property and Casualty Guaranty Association Act directs that the association is "obligated to pay covered *claims existing prior to the determination of the insolvency, arising within thirty (30) days after the determination of insolvency or before the policy expiration date if less than (30) days after the determination of insolvency or before the insured replaces the policies or causes its cancellation if he does so within thirty (30) days of the determination.*" 40 P.S. § 991.1803(b)(1)(i) (emphasis added). In contrast, the Pennsylvania Life and Health Insurance Guaranty Association Act does not limit coverage to claims existing before or within 30 days after liquidation. Rather,

obligations under a life and health policy continue, and coverage must be provided by the GA as prescribed by statute. *See, e.g.,* 40 P.S. § 991.1702 (defining "contractual obligation" as *[a]ny* obligation under a policy or contract or certificate under a group policy or contract or portion thereof for which coverage is provided under section 1703") (emphasis added); *id.* § 991.1703 (addressing coverage and limitations). The reality is that, in *life and health* liquidations, the GAs step into the shoes of the insolvent insurer and continue to be *obligated under the insurer's policies*, which *do not terminate* and for which policyholders continue to pay premiums. 40 P.S. § 991.1706(f)-(g).[6]

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[6] As the drafters of the Model Act observed, the basic purpose:

> is to protect policy owners, insureds, beneficiaries, annuitants, payees and assignees against losses (both in terms of paying claims and continuing coverage) which might otherwise occur to due to an impairment or insolvency of an insurer. Unlike the property and liability lines of business, life and annuity contracts in particular are long term arrangements for security. An insured may have impaired health or be at an advanced age so as to be unable to obtain new and similar coverage from other insurers. The payment of cash values alone does not adequately meet such needs. Thus, it is essential that coverage be continued. In like manner, and insured may be unable to obtain new health insurance or, at least, he may lose protection for prior illness.

Life and Health Insurance Guaranty Association Model act, July 2009, Drafting Note at 520-1.

In other words, both policies and claims continue—the obligations are simply satisfied after liquidation by the assuming GA. This does not mean that the policy obligation for over-limit claims (which will be transferred during the 30-days post liquidation) disappears. In both statutory accounting and claims practice, a policyholder claim is a single or unitary obligation; the accident of liquidation and the concomitant benefit of GA protection forces an allocation of assets to that portion of the claim below the GA limit *and* that portion above the limit. The Rehabilitator here has chosen to arrange for the transfer of the obligations for over-limit obligations as disclosed in the Plan, an approach that is specifically permitted by 40 P.S. § 221.23(8).

C. The Second Amended Plan is Consistent with Common Law and Established Receivership Practice.

Health Insurers' argument flies in the face of established common law and receivership practice. Not only does the Plan comply fully with Pennsylvania's controlling statutes in a manner that fully avoids the presumed limitation on which the Health Insurers would rely to take all the assets, it is also fully consistent with applicable and instructive common law.

First, as the Rehabilitator previously demonstrated in this matter, the policyholders will have valid claims for breach of their agreements and the loss of the value of their policies due to liquidation. This is based on the common law principle developed in similar circumstances that the loss of the policy itself results

in a present loss and is a current claim that is not contingent. *See, e.g.*, *Commonwealth ex. rel. Attorney General v. Am. Life Ins. Co., Appeals of McCouch, Little and Miller*, 29 A. 660 (Pa. 1894); *Caminetti v. Pac. Mut. Life Ins. Co.*, 142 P.2d 741, 749 (Cal. 1943); *Comm'r of Ins. v. Massachusetts Accident Ins. Co.*, 50 N.E.2d 801, 808-09 (Mass. 1943). Neither Article V nor the GA Act indicate any intention to displace the common law to prevent the policyholder from asserting these valuable claims, which will give them rights to over-limit benefits. As demonstrated above, at the time of liquidation, reserves established for both active lives and disabled lives will exist, and those reserves are part of the "liabilities" of the estate. 40 P.S. § 221.3 (defining "liabilities" for purposes of Article V).

Second, there is a distinction in property and casualty claims and life and health claims that Health Insurers ignore. They rely heavily on *Warrantech* to blur the distinction, but that decision does not mandate the outcome Health Insurers demand. *Warrantech* wrought no change in the law; it simply affirmed the proposition in a property and casualty context that a liquidating insurer's obligation to provide coverage in liquidation is limited to coverage under policies as to which coverage was triggered prior to the termination of the 30 days under Section 221.21. *Id.* at 358 ("Section 221.21 relieve[d] Reliance of all liability to indemnify Warrantech for claims arising from product breakdowns under the service

contracts that occurred after November 2, 2001.") It did not purport to establish a universal standard for loss and liabilities, or for what triggers coverage under a given policy or kind of insurance.[7]

Assuming strictly *arguendo* that the Health Insurers are correct (and they are not) that a policy must be triggered for an obligation to exist (and it does not), they still misconstrue the effect of a trigger in the long term care context. Typically, coverage under a long term care policy is triggered when the policyholder meets certain health status criteria and the policyholder's status is certified by a medical professional.[8] Once coverage is triggered and the policyholder is placed "on

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[7] Warrantech attempted to argue that the claim in issue should be analogized to asbestos cases, but the court rejected the argument, explaining that "[t]he insurance policies at issue merely involve claims arising from product breakdowns occurring under standard service contracts, which is entirely distinguishable from the unusual and prolonged etiology of asbestos-related diseases or similar toxic tort scenarios." 96 A.3d at 357. Long term care insurance is entirely distinguishable from both of those circumstances.

[8] In the sample specimen attached to Health Insurers' Application, the actual trigger that puts the policyholder "on claim" is that a "Licensed Health Care Practitioner certifies that Qualified Long Term Care Services are required because you are a Chronically Ill Individual." (LTCTP-6000-N at 6, Sec. II.) Benefit triggers are addressed in both the Long Term Care Insurance Act, 40 P.S. §§ 991.1101 – 991.1115, and the Long Term Care Insurance Model Regulation, Title 31 Pa. Code §§ 89a.101 – 89a.129. *See, e.g.*, 40 P.S. §§ 991.1103 (defining "Benefits trigger" as the "contractual provision in the insured's policy of long-term care insurance conditioning the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment."); *see also* Title 31 Pa. Code § 89a.107(f) ("Benefit triggers"); Title 31 Pa. Code § 89a.124 ("Standards for benefit triggers"); Title 31 Pa. Code § 89a.125 (additional standards for qualified long term care insurance contracts).

claim," benefits are paid until coverage is exhausted or the policyholder's health status changes. *See, e.g.*, National Association of Insurance Commissioners, Accounting Practices & Procedures Manual (NAIC Mar. 2014 V.1) (SSAP No. 50) at 50-8 ¶ 31 ("Under long term care contracts, the insured event is generally the inability of the contract holder to perform certain activities of daily living . . ..").

Making provision for over-limit claims is consistent with Pennsylvania's prior experience in life or health receiverships.[9] Thus, in the Life and Health Insurance Company of America ("L&H") estate, prior to the distribution of assets to GAs for "Covered Obligations," the Commissioner as liquidator allocated to policyholders "which were in claim on the August 1, 2004 rights fixing date" (30 days after the entry of the liquidation order), interim "uncovered claim" payments and arranged for the separate funding of other assets for uncovered obligations to an assuming reinsurer.[10] The final distribution was ordered on this basis by the

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While the form language above is an example of a trigger in one of the companies' policies, other products (such as non-tax qualified policies) include various other triggers.

[9] The Rehabilitator will provide to the Court an appendix consisting of receivership documents reflecting this approach.

[10] *See, e.g.*, "Liquidator's Final Accounting and Petition for Distribution of the Estate," Docket No. 442 M.D. 2004 (filed June 4, 2007).

Commonwealth Court in November 2007.[11] It was the same GAs who accepted and supported that plan who the Health Insurers now suggest should oppose the Second Amended Plan. Notably, NOLHGA—which speaks for them, not the Health Insurers—supports the Plan.

Against the stream of support from the GAs, the Health Insurers cling to the temporal scope of the benefits payable under a triggered policy, suggesting that only those benefits that "accrued" prior to the fixing date are liabilities of Company B. *Warrantech* does not reference "accrued benefits." Moreover, *Warrantech* did not address either long term care insurance, or what is a "claim" in the long term care context, or which claims are addressed as part of the liquidation of a life and health insurance company. In any event, Pa. Code § 89a.4, quoted above, recognizes the liability for both present and future incurred claims, and the policyholders will have claims for breach and the loss of value of the policies.

Health Insurers' erroneous arguments would treat long term care claims as a series of claims that must be reasserted each day the insured requires care, or coverage will cease and the insurer will no longer be obligated to pay benefits.

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[11] *See* Order (approving, among other things, final accounting and petition for distribution, and agreement with NOLHGA), Docket No. 442 M.D. 2004 (filed November 30, 2007). Even Intervenors have agreed that policyholders "on claim" have rights against the estate, observing that policyholders on claim at the time of liquidations will not have their rights to excess of guaranty association limits extinguished as a result of the operation of 40 P.S. § 221.21. *See, e.g.*, Intervenors' Reply Brief in Opposition to the Petitions for Liquidation (filed February 7, 2012) (5094a).

That is not how long term care coverage is provided, nor does *Warrantech* dictate otherwise. Even the *Warrantech* court recognized that benefits accruing after the final fixing date remained obligations of the estate, providing the claims were made within the 30-day period. In that scenario, Reliance had to pay its insured regardless of when the insured paid the contract holder, because the claim had already been made and thus the obligation had been incurred.

Health Insurers' reliance on this Court's May 3, 2012 opinion, *Consedine v. Penn Treaty Network Am. Ins. Co.*, 63 A.3d 368, 451-53 (Pa. Commw. Ct. 2012); *Foster v. Colonial Assurance Co.*, 668 A.2d 174 (Pa. Commw. Ct. 1995); and the Legion Insurance Company liquidation (*see* Health Insurers' App. 10) is similarly misplaced in respect of this argument because they did not address trigger.

D. The Health Insurers' Position is Unreasonable

Taken to their logical conclusion, the Health Insurers' arguments lead to an absurd outcome that wholly unwinds Article V's protection.

Long-term care policyholders spend years, if not decades, paying substantial level premiums under *guaranteed-renewable* (and thus *non-cancellable*) policies in anticipation that one day they will need very important and expensive health related services. The reserve liabilities relating to such policies (both active life reserves and disabled life reserves) are very large. Applying the interpretation of Article V championed by Health Insurers, and thus barring recovery for

"Uncovered Benefits," will immediately result in a windfall to the equity interest holders and guarantee an extraordinary hardship for policyholders because large liabilities will effectively be wiped from the ledger.

The Health Insurers strain to accomplish this by asking the Court to bifurcate the obligations created by the Companies' policies between the portion within the limits of the guaranty fund safety net (which varies from state to state), being the "Covered Benefits," and the portion in excess of those limits, being the Uncovered Benefits. They then ask the Court to treat these two artificially created segments of the same contractual obligation as if they created materially different policyholder rights against the Companies. No authority cited by the Health Insurers contemplates this absurd result and indeed no such authority exists. To support this outcome, the Health Insurers confuse the limits imposed by state laws on the extent to which the GA safety net will protect policyholders with the rights of those policyholders against the Companies. They then advance the novel theory that 40 P.S. § 221.21 compels the elimination of one portion (the Uncovered Benefits) of the Companies' contractual obligations under their policies but not the elimination of the other portion (the Covered Benefits) of those very same obligations.

Among the many ways in which the absurdity of this theory can be made plain is consideration of how it applies in different states. In states with GA limits

of $100,000, the eliminated Uncovered Benefits would be much larger for the very same policy than in states with the more common $300,000 limit. And this distinction would have nothing to do with Pennsylvania law.

Nowhere do the Health Insurers even remotely begin to explain why 40 P.S. § 221.21 eliminates the Uncovered Benefits portion of the contractual obligation without affecting the Covered Benefits portion. Certainly, no portion of the statute even hints at such a distinction. Of course, the Health Insurers do not suggest that 40 P.S. § 221.21 eliminates *all* of the GAs' obligations (by eliminating the policyholders' rights to Covered Benefits). They simply take one slice of the policyholders' rights and make it disappear so as to increase the total of the Companies' assets that they will take.[12]

The sudden reduction in liabilities that Health Insurers seek will be at the sacrifice of the policyholders, who will suffer the devastating, unprecedented, loss. There is a projected policyholder liability of approximately $4.3 billion in comparison to NOLHGA's projected covered liability for GAs of approximately $2.3 billion. At the same time, policyholders will not be able to individually replace their long term care policies, which often provide protection far in excess

[12] It is also worth noting that if 40 P.S. § 221.21 were to be interpreted as the Health Insurers suggest, even those of the Companies' policies that were sold years ago to other insurers would suddenly cease to provide coverage to their holders. For nowhere do the Health Insurers recognize the ability clearly provided in 40 P.S. § 221.23 to allow the full obligation created by the policies to survive by transfer to another insurer, precisely the mechanism incorporated in the Plan.

of applicable GA limits. Notwithstanding the large loss of coverage, Health Insurers still seek to deny policyholders Uncovered Benefits, which would lessen their loss.

The theory advanced by the Health Insurers leads to an absurd result. Taken to its logical conclusion it would permit the "salvation" of insolvent insurers by abruptly making large amounts of contractual obligations to policyholders disappear without consideration. To be sure, this would be welcome news to creditors of inferior priority (such as stockholders). But it is assuredly not the public policy of this Commonwealth to mistreat consumers in this manner. For example, if the Health Insurers' were to prevail in their position, in a future hypothetical liquidation of an estate with $500,000,000 of available assets, $50,000,000 in administrative expenses, $250,000,000 of policyholder claims covered by the GAs and an additional $1,000,000,000 of uncovered policyholder claims, estate expenses and GA claim payments would be reimbursed in full, uncovered policyholder claims would receive no payment and there would remain $200,000,000 in estate assets. This is an illogical and absurd reading of Article V.

At a minimum, under the Health Insurers' interpretation advocated by, more funds will be available for GAs (or so they think[13]), and funds available for long

[13] The Rehabilitator notes that the Health Insurers effectively assume that GAs will have the rights of subrogation against the estate. *See, e.g.,* 40 P.S. § 991.1706(m)(2) ("The subrogation rights of the association under this section shall

term coverage may even bypass policyholders in need in favor of lower classes of creditors in the priority of distribution scheme. This too is illogical.

The Health Insurers are asking the court to interpret laws intended to protect policyholders in a manner that harms them. Ultimately, the Health Insurers' arguments are both legally incorrect and wholly inequitable. The Application should be rejected.

E. The Court Should Reject Health Insurers' "Best Interests of the Creditors" Argument.

Finally, this Court should not accept Health Insurers' proposal that the Plan be rejected as not in accordance with "the best interest of the creditors test." (Health Insurers' App. 11.)[14] First, this Court has already held that that test does not constitute a bright-line, *per se* rule, and that a far more flexible and

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have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this article.") But if, as the Health Insurers argue, the policies are no longer in force for all purposes, the Health Insurers cannot assert at the same time that the GAs will still have rights of subrogation against the estate under the GA acts. If the policyholder cannot assert a contract right against the estate, then there will be no right of subrogation that the GAs can exercise. Health Insurers' arguments are simply wrong.

[14] Health Insurers' Application does not engage in extensive discussion of this issue, presumably because the interests of Health Insurers, as non-creditors, in this issue are highly attenuated and of limited relevance to this Court's analysis. Instead, Health Insurers refer the Court to their Formal Comments, in which the "best interest of the creditors" test is cited as a reason why the Plan should be rejected or modified. (Health Insurers' App. 11.) Accordingly, the Rehabilitator will focus its response on the arguments set forth in Health Insurers' Formal Comments.

policyholder-centric standard controls the Court's analysis of whether a plan of rehabilitation should be approved. Second, the Court should decline Health Insurers' invitation to treat this receivership like a bankruptcy, in which compensating ordinary creditors is the primary objective, and consumer-protection considerations are of limited or no significance.

The so-called "best interest of the creditors" test was addressed only in concept in a 1938 decision of the Supreme Court in *Neblett v. Carpenter*, 305 U.S. 297, 335 (1938) (affirming *Carpenter v. Pac. Mut. Life Ins. Co. of Cal.*, 74 P.2d 761, 778 (Cal. 1938)). In *Neblett*, the Court upheld a rehabilitation plan on the basis that it treated policyholders at least as favorably as what they would have received in a liquidation. 305 U.S. at 305. Pennsylvania courts have from time to time referred to the *Neblett/Carpenter* holding in approving the concept of favoring rehabilitation plans that provide for policyholders to fare at least as well in rehabilitation as they would in liquidation. *Grode*, 572 A.2d at 803, *aff'd by Foster v. Mutual Fire, Mar. & Inland Ins. Co.*, 614 A.2d 1086, 1098-101 (Pa. 1992) ("*Mutual Fire II*").

This Court, however, has declined to adopt a blanket, *per se* rule that "every single policyholder, or other creditor, must fare as well in rehabilitation as in liquidation." *Consedine*, 63 A.3d at 451-53 (noting additionally that "*Neblett* did not establish the broad principle that a rehabilitation plan is *per se* invalid unless

every policyholder will fare as well in rehabilitation as in liquidation."); *id.* at 451. A recent Wisconsin decision similarly declined to adopt such a *per se* rule. *Nickel v. Wells Fargo Bank (In the Matter of the Rehab. of Segregated Acct. of Ambac Assur. Corp.*, 841 N.W.2d 482 (2013)) ("We find no support in *Neblett* for the interested parties' contention that a rehabilitation plan is invalid as a matter of law unless policyholders are given the option to opt out and receive at least the liquidation value of their claims.") (citing *Consedine*, 63 A.3d at 453).

Instead of adopting the bright-line rule set forth in *Neblett*, this Court acknowledged the test set forth in *Mutual Fire II*.

> This Court must be guided by the three-part test adopted in *Mutual Fire II*. The "threshold inquiry" is whether state action "has operated to *substantially* impair contractual relationships." *Mutual Fire II,* 531 Pa. at 615 n. 4, 614 A.2d at 1094 n. 4 (emphasis added). An impairment of contractual rights is not a *per se* violation of law. *Id.* If a particular policyholder is found to be worse off under a rehabilitation plan, the impairment could be considered "substantial," but the Court still needs to determine whether (1) the rehabilitator has acted for a legitimate and significant public purpose and (2) the adjustment of contractual rights is reasonable and of a nature appropriate to that public purpose. *Id.* To that end, the Court must be ever mindful that one of the primary goals of Article V is "the protection of the interests of insureds, creditors, and the public generally...." Section 501(c) of Article V, 40 P.S. § 221.1(c).

Consedine, 63 A.3d at 453. Under *Mutual Fire II*, the Rehabilitator's approach to asset allocation is lawful. The Rehabilitator has included the "Uncovered Benefits" provisions in the Plan to fulfill the obligation to protect policyholders' rights to Uncovered Benefits, a result required by law. The asset allocation

strategy the Rehabilitator has chosen is reasonable and appropriate, in that it serves the best interests of the policyholders and is compliant with Article V.

Health Insurers would brush aside this Court's interpretation of *Neblett* and adoption of the *Mutual Fire II* standard by suggesting they do not apply here simply because the rehabilitation approach set forth in the Plan contemplates the future liquidation of one of the Companies. (Health Insurers' Formal Comments 19.) Article V, however, provides substantial discretion in rehabilitating the business of an insurer. The Rehabilitator may reorganize, consolidate, convert, reinsure, merge, or *otherwise transform* the company. 40 P.S. § 221.16(d). The statute is not restrictive, but discusses the broad options of the receiver. In other words, the company or companies that enter rehabilitation are not required to ascend therefrom in the same form. Here the rehabilitation strategy involves a plan to consolidate the self-sustaining business of the affiliated companies in one company in an effort to allow at least one entity to survive, while the other entity with unsustainable business will enter liquidation and have access to in excess of $2 billion of financial protection from GAs that is otherwise not available. The Plan as proposed is in the bests interest of insureds, creditors, and the public generally, 40 P.S. § 221.1(c), as determined by the Rehabilitator. Because the Rehabilitator's business division strategy and asset allocation approach are fully consistent with Article V in this regard, Health Insurers refer to inapposite

bankruptcy principles, stating that the "best interest of creditors test" is "explicitly required under Section 1129(a)(7) [of] the Federal Bankruptcy Code." (Health Insurers' Formal Comments 16-17.)

As this Court noted in its Memorandum resolving the Policyholders' Committee's Application, this matter is not a bankruptcy proceeding.[15] *See* Mem. & Order, *In re Penn Treaty Network Am. Ins. Co. in Rehabilitation*, 1 PEN 2009 (Apr. 17, 2015). And unlike bankruptcy rules, insurance receivership mechanisms are not designed primarily to ensure the payment of ordinary secured and unsecured debt. Instead, those mechanisms place chief importance on and are designed to protect *the interests of policyholders*—the consumers of the product that the insolvent insurer sold. *Grode*, 572 A.2d at 801 n.5. While bankruptcy principles may supplement the Court's analysis of some issues, no such reference is needed on the issue presented. Indeed, the Health Insurers *are not even creditors* of the Companies. They are the guarantors or obligors of GAs, outsiders seeking to participate in this receivership for the ostensible purpose of protecting themselves from what they apparently believe to be the possibility of later GA coverage payments and corresponding assessments on insurers. The interests they seek to protect here are not those of creditors, but private financial interests that are contingent and attenuated.

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[15] Domestic U.S. insurance companies are specifically excluded from the definition of "debtor" under the U.S. bankruptcy code.

IV. CONCLUSION

For the reasons set forth herein, the Rehabilitator respectfully requests that the Court deny Health Insurers' Application.

Respectfully submitted,

Dated: April 22, 2015

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 19103-7300
Telephone: 215.656.3300
Facsimile: 215.656.3301

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

CERTIFICATE OF SERVICE

I certify that I will cause a Notice of Filing of the foregoing Response to be served on all parties listed on the Master Service List by electronic mail or facsimile, or by U.S. Mail where no electronic mail address or facsimile number was available, and that, on April 22, 2015, I served the foregoing Application for Relief, upon Intervenors Penn Treaty American Corporation and Eugene J. Woznicki as follows:

Douglas Y. Christian
Benjamin M. Schmidt
Ballard Spahr LLP
1735 Market Street, 51st Floor
Philadelphia, PA 19103-7300
christiand@ballardspahr.com
schmidtB@ballardspahr.com

Elizabeth J. Goldstein
Dilworth Paxson, LLP
112 Market Street, Suite 800
Harrisburg, PA 17101
egoldstein@dilworthlaw.com

James R. Potts
Cozen O'Connor
1900 Market Street – Fourth Floor
Philadelphia, PA 19103
JPotts@cozen.com

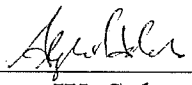
Stephen H. Warren
O'Melveny & Myers LLP
400 South Hope Street
Los Angeles, CA 90071
swarren@omm.com

Paul M. Hummer
Saul Ewing LLP
Centre Square West
1500 Market Street, 38th Floor
Philadelphia, PA 19102-2186
PHummer@saul.com

Harold S. Horwich
Benjamin J. Cordiano
Morgan Lewis LLP
One State Street
Hartford, CT 06103-3178
harold.horwich@morganlewis.com
benjamin.cordiano@morganlewis.com

Charles T. Richardson
Caryn M. Glawe
Faegre Baker Daniels
1050 K Street NW, Suite 400
Washington, DC 20001-4448
charlie.richardson@FaegreBD.com
caryn.glawe@FaegreBD.com

Thomas A. Leonard
Richard P. Limburg
Obermayer Rebmann Maxwell & Hippel LLP
One Penn Center, 19th Floor
1617 John F. Kennedy Blvd.
Philadelphia, PA 19103-1895
thomas.leonard@obermayer.com
richard.limburg@obermayer.com



Stephen W. Schwab
DLA PIPER LLP (US)
One Liberty Place
1650 Market Street, Suite 4900
Philadelphia, PA 19103-7300
Telephone: 215.656.3300
Facsimile: 215.656.3301