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

REHABILITATOR'S OMNIBUS REPLY TO RESPONSES SUBMITTED BY THE POLICYHOLDERS' COMMITTEE AND NOLHGA REGARDING "UNCOVERED BENEFITS" IN THE SECOND AMENDED PLAN

The Rehabilitator submits this Omnibus Reply to the responses of the Policyholders' Committee and NOLHGA to 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."

I. INTRODUCTION

As is now plain to the Court, there is only one interested party in this matter seeking to eliminate the provisions of the Plan regarding Uncovered Benefits: the Health Insurers, a consortium of insurance companies that have appeared before the Court to advocate solely for their own economic interests, irrespective of how incompatible those interests might be with those of affected policyholders and the

public.[1] In contrast, both the Policyholders' Committee—which speaks for the individuals whose protection is paramount here—and NOLHGA—the organization whose member guaranty associations will be most directly and immediately affected by the Uncovered Benefits provisions (unlike the indirectly affected Health Insurers)—both *support* the Rehabilitator's approach and *oppose* the Health Insurers' attempt to strip away the necessary, appropriate, and fully lawful policyholder protections embodied in the Uncovered Benefits provisions.

Respectfully, the Court should strongly credit the concerns and reasoning articulated by the Policyholders' Committee and NOLHGA in deciding the Application. The Rehabilitator submits this Omnibus Reply to adopt certain aspects of those responses, and generally to provide the Court with the Rehabilitator's position on matters raised therein.

In addition to the crucial fact that two of the most important stakeholders oppose the Health Insurers' Application and support the Plan, the Health Insurers' position finds no support in the law. Indeed, their purported bifurcation of policy obligations between "Covered Benefits" within GA limits and "Uncovered

[1] As the Rehabilitator explains in detail in her separate reply to the Health Insurers' response to the Intervenors' application seeking rejection of the Plan, the Health Insurers have not satisfied the procedural requirements necessary to seek affirmative relief from the Court, because they are merely formal commenters, not intervenors who may request relief pursuant to Pennsylvania Rule of Appellate Procedure 3775. The Rehabilitator incorporates that argument as though fully set forth herein.

Benefits" in excess of those limits does not comport with statutory reality. They rely upon 40 P.S. § 221.21 to "compel" the elimination of just the Uncovered Benefits portion of the Companies' contractual policy obligations but not the Covered Benefits portion of the same obligations. No words in the statute even remotely suggest this bifurcation. If they did (and they do not), then all obligations of GAs would be "terminated" along with the vast majority of policies. This would mean that PTNA and ANIC could never fail and that no insurer would ever be liquidated. In effect, the Health Insurers would have the Court cram down the entire cost of an insurer's failure on its policyholders—a result to which neither the General Assembly nor any court has ever given serious consideration.

Health Insurers strain to find case law support for their position. In attempting to shoehorn the holding of *Warrantech Consumer Products, Inc. v. Reliance Insurance Co. in Liquidation*, 96 A.3d 346 (Pa. 2014), a decision in the property and casualty context, into this receivership for life companies, the Health Insurers have ignored the stark practical differences between property and casualty insurance and the policies at issue here, which include long term care. Insureds under long term care policies spend years and often decades paying premium for continuing, long term benefits so that those benefits will be available to them to pay for ongoing care requirements when such care is most needed, *i.e.*, later in life. To yank the rug out from under those policyholders by depriving them of their

bargained-for benefits would not be the same as cutting off benefits under a property and casualty policy that covers a discrete loss incurred in relation to a specified period of time. Applicable statutes and regulations expressly recognize this difference, and that is why they provide for completely different protective mechanisms for holders of life and health policies. The Plan similarly recognizes this reality, and that is why it makes provision for Uncovered Benefits to which policyholders are entitled.

Any contrary result would have the effect of limiting policyholder recovery from the estate to the varying limits of the GA laws, in contravention of Article V, the GA Act, and common law principles. Indeed, as courts have long recognized, each policyholder continues to have a claim against the estate for breach of contract that permits the policyholder to recover the liquidated value of his or her policy, which can be measured based on the reserve as of the liquidation. The Rehabilitator agrees with the Policyholders' Committee that nothing in the statutory or regulatory regime requires or contemplates limiting or eliminating those claims as to benefits not covered by state GAs in a long term care insurance context.

Finally, the Rehabilitator agrees with the Policyholders' Committee and NOLHGA that 40 P.S. § 221.21 does not affect the transfer of policy obligations as contemplated under the Plan, because the Rehabilitator is expressly authorized to

effect such a transfer under 40 P.S. § 221.23(8). The Rehabilitator further agrees with NOLHGA that, to the extent that the Court is not inclined to deny the Application, at a minimum it should not be decided at all until after the July hearing, when the factual record is fully developed.

II. ARGUMENT

A. *Warrantech* should not be extended to these circumstances for very practical reasons.

NOLHGA and the Policyholders' Committee properly assert that *Warrantech* should not extend to these circumstances, and the Rehabilitator agrees. The practical realities of long term care insurance require that an insurer's estate be administered like that of a life insurer, and not like that of a property and casualty insurer. Simply put, Health Insurers' argument is an attempt to place a square peg in a round hole.

The business of insurance has evolved into a complex arrangement of heavily regulated, but very distinct, types of coverage. An important distinction relevant to this matter is that certain policies, such as most property and casualty policies, generally are replaceable in the marketplace and are based on premiums paid in consideration of coverage for a specific period of time. Unlike property and liability lines of business, life, annuity, and guaranteed renewable or non-cancellable health policies, including long term care insurance (which is not

generally replaceable by older policyholders absent a large increase in premium), relate to very different risks and provide for long term financial security. Such policies commonly provide coverage that is effectively permanent in nature—premium is intended to be paid over an extended period of time, and assets associated with the policies are aggregated into a reserve. The distinctions are critical and require different approaches to safeguarding the interests of policyholders in the event of a liquidation, so much so that different guaranty associations exist to address the differing types of claims that policyholders may submit. *Compare, e.g.*, 40 P.S. §§ 991.1701 – 1718 (Pennsylvania Life and Health Insurance Guaranty Association Act (continuing coverage for life, health and other described coverages) *with* 40 P.S. §§ 991.1801 – 1820 (Pennsylvania Property and Casualty Insurance Guaranty Association).

NOLHGA and the Policyholders' Committee properly take those distinctions into account, and assert additional reasons why *Warrantech* cannot be applied here. For example, NOLGHA provides a compelling hypothetical that demonstrates how the Health Insurers' position would be harmful in a life and health setting: annuities with life contingent obligations would be cut off and effectively capped by the limits of guaranty associations, with no right to recover assets still available from the estate. This simply cannot be.

As NOLHGA points out, the result would be inconsistent with prior receiverships. NOLHGA, drawing on its extensive experience working closely with regulatory authorities in receiverships across the United States, explains that rights fixing statutes have been interpreted and applied in a manner consistent with the Rehabilitator's interpretation in all life insurance receiverships where future policy benefits for periods after fixing could exceed the varying limits of guaranty associations. "NOLHGA knows of no exception." Health Insurers are wrong to urge a different approach based on the *Warrantech* holding, which arose in the property and casualty context.

The fundamental characteristics of life and health insurance (including long term care insurance) distinguish it from property and casualty insurance. For example, the life insurer's liability consists of its reserves for long term liabilities such as life, annuity and related products.[2] Guaranteed renewable long term care

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[2] 40 P.S. § 71.1 directs:

> The Insurance Commissioner shall each year value or cause to be valued, or shall annually require the insurer to value or cause to be valued, the reserve liabilities, as of the thirty-first day of December of the preceding year, of every life insurance company doing business in this Commonwealth, with respect to all of its health and accident insurance policies. For all such policies, the company shall maintain a claim reserve for incurred but unpaid claims and an active life reserve which shall place a sound value on its liabilities and be not less than the reserve according to appropriate standards set forth in

insurance[3] is one such product, under the principle that it is a long term commitment, so long as premiums are timely paid. Like life insurance, the reserves are heavily weighted towards future life contingent obligations, not past insured events. The future event insured against is a serious financial risk, and the coverage for a long term care insurance claim can often exceed the limit of the guaranty association, just as life insurance and annuities often do.

Long term care insurance is based on the concept of "level premiums," where premiums remain level for the duration of the contract so that the aggregation of funds becomes sufficient to address the risks of the policy when it is more likely to be triggered, *i.e.*, much later in the life of the policyholder when long term care is more likely to be necessary.[4] Premiums are paid over an

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> regulations issued by the Insurance Commissioner. In no event, shall the active life reserve be less in the aggregate than the pro rata gross unearned premiums for such policies.

[3] The Pennsylvania Long Term Care Insurance Model Regulation provides that the term " 'guaranteed renewable' may be used only when the insured has the right to continue the long term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make a change in a provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis." 31 Pa. Code § 89a.105(2).

[4] "Level premium" is defined as:

> A premium calculated to remain unchanged throughout either the lifetime of the policy, or for some shorter

extended period, often over the course of decades. The investment in turn secures late life care, the expense of which can be so substantial that when no such coverage exists the patient's assets are quickly depleted.

Accordingly, the reserves established for a policy are substantial, and so are the liabilities of the insurer under Article V. 40 P.S. § 221.3. As NOLHGA points out, applying *Warrantech* in a liquidation where long term liabilities are in issue could "falsely 'cure' insurance insolvencies." Although not likely here due to the depth of the insolvency, the Rehabilitator agrees that applying the rationale of *Warrantech* in other life and health scenarios could effectively remove the liabilities of the estate and leave policyholders completely unprotected, with no access to benefits that exceed the limits of the GAs. NOLHGA argues this would give the estate and the shareholders a windfall, and would harm the policyholder in

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> projected period of years. The premium need not be guaranteed; in which case, although it is calculated to remain level, it may be changed if any of the assumptions on which it was based are revised at a later time. The annual claim costs are expected to increase each year and the insurer, instead of charging premiums that correspondingly increase each year, charges a premium calculated to remain level for a period of years or for the lifetime of the contract. In this case the benefit portion of the premium is more than needed to provide for the cost of benefits during the earlier years of the policy and less than the actual cost in the later years. The building of a prospective contract reserve is a natural result of level premiums.

Title 31 Pa. Code § 84a.3.

a manner never contemplated by *Warrantech* and Article V. Such an outcome, as NOLHGA points out, also would make Pennsylvania law internally inconsistent on this issue, requiring the posting of reserves for future insurance obligations, but then erasing the recorded liabilities and obligations if a company enters liquidation.

The Policyholders' Committee similarly elucidates the absurdity of applying *Warrantech* in this circumstance. They observe that, if long term care policies were terminated in the manner that the Health Insurers advocate, Company B would have no liability 30 days after liquidation, and the value of such claims would be zero. As a result, the GAs would necessarily have no obligations to pay such claims or, alternatively, if they were obligated, they could not exercise their subrogation rights under the GA laws. *See, e.g.,* 40 P.S. § 991.1706 (m)(1)-(3). For example, under Section 991.1706(m)(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." According to the Health Insurers, however, *Warrantech* would not recognize a claim under the priority statute under long term care policies more than 30 days after liquidation. The Policyholders' Committee correctly notes the absurdity of this result, which would preclude any right of subrogation, and entirely undermine the purposes of Article V and the insurance guaranty safety net.

B. The law should not be applied so as to limit policyholder claims to the varying limits of GA laws.

The Rehabilitator also agrees with the Policyholders' Committee that common law breach of contract claims available to policyholders entitle them to damages for breach and loss of the value of the policy. The measure of such damages at common law has often been based on the policy's net value, determined by a calculation of the policy's gross premium reserve. Historically, courts in various jurisdictions have recognized and applied this valuation method, and found that the gross premium reserve represents the value of the future claims and expenses of the policy less the present value of future premiums.[5]

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[5] *See, e.g., People v. Sec. Life Ins. Co. & Annuity Co.*, 78 N.Y. 114, 126 (N.Y. 1879) ("[D]uring the early years, the assured has paid more than sufficient to carry the risk during those years; and this excess is to aid in carrying the risk during later years when the annual premiums would be insufficient for such years. This excess is called the equitable value of the policy and goes to make up what is called the reserve fund."); *Carr v. Hamilton*, 129 U.S. 252, 256 (1889) ("By that act [liquidation] the company becomes *civiliter mortus*, its business is brought to an absolute end, and the policy-holders become creditors to an amount equal to the equitable value of their respective policies, and entitled to participate *pro rata* in its assets."); *Com. ex. rel. Attorney General v. Am. Life Ins. Co.*, 162 Pa. 586 (1894) (per curiam) ("[W]here policies are running at the dissolution, the measure of the damages suffered in each case by the policyholder is, as is said in the same case, 'the value of the policy which has been destroyed."); *Davis v. Amra Grotto M.O.V.P.E.R., Inc.*, 89 S.W.2d 754, 757-78 (Tenn. 1936) (insolvency gives rise to policyholder claim for value of the policy); *Hobbs v. Occidental Life Ins. Co.*, 87 F.2d 380, 384 (10th Cir. 1937) (insolvency gave rise to policyholder right to assert claim for lost value of policy); *Caminetti v. Pacific Mut. Life Ins. Co.*, 23 Cal.2d 94, 108-09 (Cal. 1943) (employing policy reserve as measure of damages for policyholders with non-cancellable disability policies with level premiums); *Comm'r of Ins. v. Massachusetts Accident Ins. Co.*, 50 N.E.2d 801, 805-11 (Mass.

The Rehabilitator agrees with the Policyholders' Committee that long term policies resemble certain life policies, and that an insurer's liabilities for future claims far outweigh its liabilities for current claims. The Rehabilitator agrees that liabilities for such estate obligations are fixed at liquidation, unless the obligations are transferred as permitted under Article V. If all or a part of the obligations are transferred, those policy obligations merely continue as policyholder obligations (including over-limit obligations) to be addressed by another insurer.

Although the Plan proposes transferring policy obligations as previously discussed, to the extent that obligations are not transferred a policyholder still has a claim for breach of contract, the damages for which would be measured based on the liabilities of the company as of the time when those liabilities are fixed. The Rehabilitator agrees with the Policyholders' Committee that a claim for breach of contract should provide for a claim against the company for losses within the meaning of the priority statute, 40 P.S. § 221.44(b). The loss of value of a

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1943) (noting that disabled and non-disabled policyholders are entitled to assert present claims against the estate in liquidation for loss of value of policy); *In re Exec. Life Ins. Co.*, 38 Cal. Rptr. 2d 453, 477 (Cal. App. 1995) ("The amount to be received on each claim is the value of the policy, 'that is, the value of the chance, based upon reasonable probabilities which is the essence of the insurance business.' [ ] This amount 'is each policyholder's share of the reserve.'"); *In re Integrity Ins. Co.*, 685 A.2d 1286, 1290 (N.J. 1996) ("On the date of liquidation, Integrity breached its contract with every policyholder, because it repudiated its prior promise to provide insurance and bear future losses. As a result of that breach, each policyholder was entitled to pursue a claim for damages pursuant to ordinary contract rules.").

continuous level premium policy in which the policyholder has committed payments, in some cases for decades, and the reserves qualifying as liabilities under Article V, support this position. The advent of the GA laws should not limit policyholders' claims against the estate or otherwise limit their total right of recovery so as to arbitrarily preclude recovery for claims that exceed GA limits.

The Rehabilitator agrees with the Policyholders' Committee that neither Article V nor the GA Act reflect any intention by the General Assembly to bar such common law claims. Indeed, the GA Act expresses just the opposite. For example, 40 P.S. § 991.1706 (m)(1) provides, in pertinent part, that:

> [a]ny person receiving benefits under this article shall be deemed to have assigned the rights under and 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***, ***continuation of coverage*** or provision of substitute or alternative coverages.

40 P.S. § 991.1706 (m)(1) (emphasis added.) Section (m)(1) plainly contemplates the potential for a partial assignment of rights "to the extent of the benefits received." Section (m)(1) further recognizes that the assignment may be in respect of either "contractual obligations" or "continuation of coverage." *Id.* The statute therefore reserves to the policyholder all rights to pursue contractual benefits and enforce any and all obligations *not* satisfied by the GA. In the plainest of terms, this provision recognizes the continuing vitality of the policyholder's contractual

rights, which can be asserted against the estate or third parties to the extent that the policyholder's claim exceeds the limits of the GA (*i.e.* "the extent of the benefits received").

Thus, if the policy obligations were not transferred as proposed by the Plan during the 30 day period after liquidation, then policyholders with claims that exceeded GA limits would be entitled to assert those claims against the estate and recover for that part of their claim that is not satisfied by the GA, *i.e.* Uncovered Benefits. This is consistent with common law principles and permitted under the statutory regime adopted by the General Assembly. Moreover, as explained above and in previous submissions, permitting policyholders to pursue the entirety of their claims without being limited by varying GA limits avoids absurdity in the application of insurance laws that exist to serve and protect policyholders.

C. Section 221.21 will not impact the proposed transfer of policy obligations.

The Policyholders' Committee briefly addresses the point that 40 P.S. § 221.21 will not impact the transfer of policy obligations as contemplated under the Plan in light of subsection (iv) thereof, and the authority provided in 40 P.S. § 221.23(8). The Rehabilitator agrees, and reiterates that the Plan comports with the provisions of Article V.

D. NOLGHA is correct in asserting the issue should not be decided without the benefit of a full hearing.

If the Court is not inclined to deny the Application immediately, the Rehabilitator would agree that the Court should address the issue only with the benefit of a fully developed factual record, which will not exist until after the conclusion of the full hearing on the Plan set to commence on July 13, 2015.

III. CONCLUSION

For each of the reasons set forth herein and in the Rehabilitator's principal response to the Health Insurers' Application, the Application should be denied.

Respectfully submitted,

Dated: April 30, 2015

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CERTIFICATE OF SERVICE

I certify that I will cause a Notice of Filing of the foregoing Rehabilitator's Reply to Reponses Submitted by Policyholder's Committee and NOLHGA 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 30, 2015, I served the foregoing Application for Relief, upon Intervenors Penn Treaty American Corporation and Eugene J. Woznicki as follows:

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