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 SUPPLEMENTAL BRIEF REGARDING "UNCOVERED BENEFITS" IN THE SECOND AMENDED PLAN

The Rehabilitator submits this supplemental brief regarding the Health Insurers'[1] "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." This brief responds to the Court's inquiries made during the hearing on May 11, 2015, and complements, but does not replace, the briefs the Rehabilitator previously submitted on these points.

[1] The Rehabilitator has agreed, and the Court has issued an order confirming, that the Health Insurers are limited intervenors in this proceeding for the purpose of presenting their views and objections to the Second Amended Plan. The Rehabilitator does not agree, however, that they have standing to present the views of guaranty associations (which are represented by NOLHGA or other counsel), policyholders, creditors, or the general public.

I. INTRODUCTION

This receivership centers on the unique business of long-term care insurance—a product issued here by two insurers (PTNA and ANIC, collectively the "Companies") to tens of thousands of insureds who have made, and in most cases continue to make, required premium payments over extended periods of time, in exchange for a promise and expectation of benefits likely to be paid much later in life. That promise to pay, the breach of that promise, and the failure to meet that expectation, result in liabilities of the estate to the affected insureds. The Court charged the Rehabilitator with fashioning a plan that provides for the rehabilitation of the business of PTNA and ANIC and eliminates inadequate and unfairly discriminatory rates. The Rehabilitator's proposed Second Amended Plan does just that, and it marshals estate assets to satisfy, to the extent possible, the Companies' liabilities, an approach that is fully consonant with governing law and should not be disturbed.

When an insured purchased a policy for long-term care insurance, a binding contract was formed, the price for which was set by the insurer and not subject to negotiation. Under that contract, the insurer undertook certain obligations, and the policyholder received certain corresponding rights. Those obligations must be satisfied by the insurer or any successor in interest, including the estate of the insurer should it become insolvent. Even if a portion of the obligation is met

through a statutory guaranty association ("GA") safety net, the policyholder nevertheless has a claim against the estate for any portion or amount the safety net will not cover.

In the context of a guaranteed-renewable long-term care policy, the obligation of the insurer is to provide benefits to the policyholder for care the policyholder will most likely require toward the end of his or her life. Because the insurer has no unilateral right to terminate the policy, the coverage obligations thereunder are lifetime obligations that cannot be cancelled by the insurer (except for non-payment of premium), and the insurer (or its successor estate or GA) must meet those obligations.

In light of these principles, it is critical for the Court to recognize that the obligations under a policy exist regardless of whether there has been any specific insurable loss or claim made under the policy. The policy represents, at any point in time, a promise by the insurer to pay covered losses in the future should they arise, in consideration for the policyholder's payment of the premiums required under the policy. The insurer is obligated to continue the coverage and pay contractual benefits for the policyholder's lifetime, subject to any policy limits, and, if and when it cannot do so, it has breached that obligation. Therefore, as is true in the life insurance context, when a long-term care insurer is unable to pay

contracted-for benefits due to insolvency, the policyholder becomes a claimant against the estate for the value of what has been lost as a result of the breach.

Article V, together with the Pennsylvania Life and Health Insurance Guaranty Association Act (the "L&H GA Act"), together with other states' guaranty association laws, contemplate exactly this and, accordingly, they provide for obligations of an insolvent insurer to be met (to the extent possible) through up to four dovetailing mechanisms:

- First, Article V empowers the receiver to transfer policy obligations to a solvent assuming insurer, which, if accomplished, has the effect of continuing policies and thus avoiding any breach of those policies. Notably, this provision draws no distinction between the portion of the policy obligations that would be covered by the GAs and the portion that would not. Under the Second Amended Plan, policy obligations will be transferred to GAs, which, under the L&H GA Act, function as assuming insurers.
- Second, in the event that the obligations are not transferred (or the policyholder does not find replacement coverage), Article V both (a) fixes as of a date certain all rights and liabilities of the estate and (b) provides for satisfaction of obligations that are not assumed by third parties (such as GAs or their members), including liabilities to

policyholders with rights to lifetime benefits payable under guaranteed-renewable long-term care policies, to the extent possible given available assets and other obligations of the estate.

- Third, simultaneous with the fixing of the estate's liabilities, the L&H GA Act (and similar GA laws in other states) "*continues*" policy obligations[2] and provides for their payment up to prescribed limits using an appropriate allocation of estate assets for GA covered benefits and funds collected from GA member insurers through assessments, and charges the GA with covering those obligations.
- Fourth, any portion of policy obligations that are not covered by the GA safety net become the subject of a claim against the estate by a policyholder for the loss of the value of the uncovered portion.

At all times—before, during, and after the triggering of these mechanisms—the policyholder has the right to enforce the insurer's contractual obligation to provide lifetime benefits under a guaranteed-renewable long-term care policy. The

[2] The Second Amended Plan (at 54 *et seq.*) provides for transfer of this portion of the obligations to other insurers acting collectively through the mechanism consisting of the GAs, which by law have the right to "guarantee, assume or reinsure or cause to be guaranteed, assumed or reinsured" such obligations or issue new policies; in other words, to function as an assuming insurer. 40 P.S. §§ 991.1706(a)(1); 991.1706(c)(1).

obligation and corresponding right are not eliminated by the fixing of liabilities. In fact, it is exactly to the contrary: the obligations of the insurer are liabilities of the estate (undifferentiated with regard to GA limits) and, as a result, the policyholder becomes a creditor at the policyholder claim level (40 P.S. § 221.44(b)) to the extent that the loss of value resulting from the insolvency exceeds any portion that the policyholder can recover from GAs. To the extent that a GA does provide coverage, it becomes a creditor in place of the policyholder.

In the instant receivership, the Rehabilitator has developed a plan providing for what she has determined is the procedurally and substantively fairest and most equitable approach to compensating policyholders for any unmet obligations. By allocating assets attributable to the uncovered benefits to an assuming insurer or other vehicle on an objective, pro rata basis, the Rehabilitator has endeavored to secure for the policyholder the value of his or her policy to the fullest extent possible. This approach is fully consistent with well-established principles for managing insolvent insurers, and it is designed to promote the best interests of policyholders—high-priority creditors who face serious harm as a result of the insurer's delinquency. As explained in detail below, the Rehabilitator's strategy is fully consistent with and does not contravene applicable common-law principles, and it should not be overruled on the basis of the unduly cramped, narrow, and erroneous reading of the law that the Health Insurers have presented to the Court.

II. ARGUMENT

A. Contractual obligations under life and health insurance policies continue after an order of liquidation when a GA assumes policy obligations.

Section 221.21 establishes that upon the entry of a liquidation order, the receiver has a 30-day window within which to transfer policy obligations to a "solvent assuming insurer." 40 P.S. § 221.21. If such a transfer occurs during that 30-day period, the policy obligations continue and must be satisfied by the assuming entity.

Two consequences follow in the event that such a transfer does not take place. First, coverage under a policy is assumed by a GA and continues in force, up to the applicable association's limits. Second, any remaining policy obligations, up to the full value of the policy, become fixed liabilities of the estate for which each affected policyholder has a common-law contract claim against the estate.

The first mechanism ensures that the policyholder will have at least some continuing coverage—intended as a seamless process to avoid any delays in policyholder coverage—after the insurer becomes insolvent. The second makes the policyholder whole, to the extent possible given available assets, for the value of his or her loss occasioned by the insolvency. The policyholder in such a

circumstance is entitled to claim from the insurer's estate the difference between the statutory GA cap and the remaining value of the policy.[3]

1. Under the L&H GA Act (and similar laws of other states), policy obligations continue upon the fixing of liabilities under Article V.

Section 221.21 cannot be read in a vacuum; rather, its provisions are to be read in conjunction with related provisions of Article V and the L&H GA Act. "[T]he Liquidation Act and the Guaranty Act should be read together, *in pari materia*—that is, as one statute—as they address a common issue, namely, losses to the insureds of insolvent insurance companies." *Universal Health Servs., Inc. v. Pa. Prop. & Cas. Ins. Guar. Ass'n*, 884 A.2d 889, 900 (Pa. Super. Ct. 2005) (citing 1 Pa.C.S.A. § 1932). Read together and properly reconciled, the liquidation provisions of Article V and the coverage provisions of the L&H GA Act provide for a *continuation* of policy obligations after the fixing of liabilities. GAs undertake the continued obligations up to any statutorily prescribed limits set state-

[3] To the extent that claims exceed GA limits, they are commonly referred to as "excess of cap" claims and are also referred to in the Plan as "Uncovered Benefits."

by-state, and policyholders remain claimants of the estate to the extent that the obligations exceed such limits.[4]

The ultimate effect of an order of liquidation on the obligations of an insolvent insurer to its insureds is that all "rights and liabilities" of the insurer and its policyholders become "fixed." 40 P.S. § 221.20(d). Under § 221.20(d):

> Upon issuance of the order [of liquidation], the rights and liabilities of any such insurer and of its creditors, policyholders, shareholders, members and all other persons interested in its estate shall become fixed as of the date of filing of the petition for liquidation, except as provided in [40 P.S. §§ 221.21 and 221.39].

Id. The exception referenced in § 221.21 provides that:

> All insurance in effect at the time of issuance [of] 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.

40 P.S. § 221.21.[5] In other words, under § 221.21, the "fix[ing]" of rights and liabilities is extended 30 days as to "insurance in effect" at the time of the

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[4] Each of the Health Insurers is a member of at least one of the GAs whose coverage will be triggered by the inability of the Companies to meet their policy obligations.

[5] It is notable that the later-enacted NAIC Insurance Receivership Model Act ("IRMA") includes in § 502 (the equivalent of Pennsylvania's § 221.21) an express provision concerning the Court's and the Liquidator's discretion under these

(footnote continued on next page)

liquidation order, which "shall continue in force" during that period "with respect to the risks in effect." *Id.* The 30-day extension also gives policyholders time to find replacement coverage or, alternatively, enable the liquidator "[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 [§ 221.44]." 40 P.S. § 221.23(8). If such replacement or transfer occurs, the policy simply continues uninterrupted, its obligations to be satisfied by the new insurer; if not, the GAs continue to fulfill policy obligations. Either way, the coverage *continues*.

Even in the event that any portion of the insurer's policy obligations is not transferred to a "solvent assuming insurer," and the insurance is somehow deemed to no longer be "in force" after 30 days, *the underlying contractual policy* ***obligations*** *continue*, and the insurer's inability to perform those obligations gives rise to a claim by each affected policyholder against the estate. This is so because a guaranteed-renewable long-term care policy does not give the insurer (which also has existing liabilities for reserves in respect of each policyholder) the unilateral right to terminate the policy and instead creates a lifetime obligation. Again, the liability of the insurer for that obligation is "fixed" pursuant to §§ 221.20(d). The only question is where or by whom it will be satisfied, in whole or in part.

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circumstances. The time limitations set forth in that section apply "unless further extended by the receiver with the approval of the receivership court."

The language of Article V does not compel any contrary conclusion. Nothing in Article V provides that extant policy obligations and liabilities vanish after the 30-day period. Nothing in Article V provides that the right of a policyholder to claim the full value of his or her policy (or any portion thereof not covered by a GA) is extinguished at the end of the 30-day period. And nothing in Article V addresses how a policyholder's claim to recover the insurer's fixed liability to the insured should be valued. Instead, it is the province of the receiver (and the supervising court) to determine that value, and to recognize and enforce each policyholder's claim against the estate for any portion of the value of the policy the policyholder does not receive from another source, such as a GA. *See infra*, Section II.A.3.

2. *Warrantech* did not change or displace Pennsylvania's statutory scheme for protecting health-care insureds.

Within this framework, long-term care insurance policy obligations cannot be treated as equivalent to property and casualty policy obligations. In *Warrantech Consumer Products Services, Inc. v. Reliance Insurance Company in Liquidation*, 96 A.3d 346 (Pa. 2014), the court held that what § 221.21 requires in the property and casualty context is that obligations continue, but only to the extent that specific claims for loss under policies have arisen within the 30-day period. This interpretation makes sense in the property and casualty context because those obligations are generally finite and discrete. They typically involve premiums

relating to coverage that (unlike that at issue here) is cancellable or can be non-renewed and is for loss occurring during, or related to, a specific period. Property and casualty policies differ from long-term care policies, however, in that they do not require that level premiums be paid over extended periods of time (sometimes decades) to aggregate sufficient value from which anticipated claims can ultimately be paid—most commonly near the end of life.[6] Long-term care policies are in fact distinguishable from any type of property and casualty or health insurance that an insurer has a right not to renew. They are better analogized to non-cancellable annuities and permanent life insurance (*e.g.*, universal life

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[6] Briefly summarized, the level premium system operates as follows:

> Under the level premium system, the purchaser pays the same premium rate each year. . . . The leveling of premiums is possible because premium rates charged under level premium policies are higher than needed to pay claims and expenses that occur during the early years of the policy. In the early years, the excess premium dollars collected—that is, those premium dollars not needed to pay claims and expenses that occur during the early years — are invested by the insurance company. As a group of people insured under level premium policies grows older, the company can anticipate an increasing number of death claims from the group each year. Under the level premium system, these claims can be paid in large part with the excess premium dollars, plus, investment income, that were collected during the early policy years. Thus, the premium on the policy can remain level throughout the duration of the policy.

DANI L. LONG & GENE A. MORTON, PRINCIPLES OF LIFE AND HEALTH INSURANCE 32 (2d ed. 1988); *see also* 31 Pa. Code § 84a.3 (defining "level premium").

insurance) where the insurer is obligated to provide coverage and benefits for the remainder of the policyholder's life, subject to conditions of the policy (*e.g.*, payment of premiums).

Recognizing the fundamental distinctions between these types of insurance, the General Assembly provided for separate and distinct safety net mechanisms for each of them. For property and casualty claims, the Pennsylvania Property and Casualty Insurance Guaranty Association Act (the "P&C GA 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 policy 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). This effectively tracks the continuation-of-coverage provision of § 221.21. The *Warrantech* court did not discuss GA coverage, but its analysis is consistent with the General Assembly's differing treatment of property and casualty coverage to be provided by GAs, on the one hand, and life and health coverage to be provided by GAs, on the other. Indeed, the *Warrantech* court found it appropriate "to cut off coverage under the [policies of an insolvent insurer] for *claims arising* from product breakdowns occurring after [the 30 days had lapsed]." 96 A.3d at 357 (emphasis added). Because

"Warrantech assume[d] obligations under the service contracts *in the event of claims from product breakdowns only*," if no such breakdown(s) occurred during the period, there could be no obligation. *Id.* (emphasis added).

In the context of guaranteed-renewable long-term care policies, however, the policy obligations are for lifetime benefits, and so they continue to exist even after an order of liquidation is entered. Critically, they *do not terminate* at the end of the 30-day period. They merely are assumed in a liquidation by the GAs to the extent of statutory limits. This is plain from the text of the L&H GA Act, which *does not* limit policy obligations to specific, individual claims for coverage under the policy "arising" within 30 days after liquidation. Rather, *all* obligations under a life and health policy *continue*, and coverage *must* be provided by a GA, up to any limits prescribed by the statute governing that GA (which limits depend upon the jurisdiction).

In express recognition of this difference, the L&H GA Act defines "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." 40 P.S. § 991.1702 (emphasis added); *id.* § 991.1703 (addressing coverage and limitations). And the Pennsylvania Life and Health Insurance Guaranty Association is empowered to "*assure* payment of the *contractual obligations* of the impaired insurer," not just individual claims under

the policies that are outstanding at the time when rights and liabilities are fixed. *Id.* § 991.1706(a)(2) (emphasis added). "The benefits for which the association may become liable shall in no event exceed the lesser of: . . . the *contractual obligations* for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or [a $300,000 statutory limit]," and they are not limited to benefits associated with specific claims for discrete losses that arise before the end of the 30-day period. *Id.* § 991.1703(c)(1) (emphasis added).

Conspicuously absent from the L&H GA Act is *any* language comparable to that of the P&C GA Act, which, unlike the L&H GA Act, expressly limits obligations to "claims existing" or "arising" during the identical 30-day period prescribed in § 221.21. 40 P.S. § 991.1803(b)(1)(i). Stated differently, the L&H GA Act correctly recognizes that the contractual obligations of the insurer remain in place even after an order of liquidation. Unlike the property and casualty claims at issue in *Warrantech*, the contractual obligations here are continuing ones, a portion of which are transferred to the GA, and the remainder of which are satisfied to the greatest extent possible by claims each affected policyholder holds against the estate. *See* 40 P.S. § 221.44(b) (providing that second-highest priority of distribution of estate assets goes to "[a]ll claims under policies for losses wherever incurred," excluding "[t]hat portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant"—

here, from a GA). These statutory provisions in Article V and the L&H GA Act work together and complement one another.).

In the unlikely event that the Court may find such provisions to be somehow inconsistent (and they are not), the Court should give effect to §§ 991.1702, 991.1706(a)(2), and 991.1703(c)(1) as later-enacted and more specific statutory provisions requiring the continuation of policy obligations once a GA has assumed coverage.[7] "The Legislature has made clear . . . that tension between statutes enacted on different dates is generally to be resolved in favor of giving the greatest effect to [the] later-enacted provision[.]" *Six L's Packing Co. v. W.C.A.B. (Williamson)*, 44 A.3d 1148, 1158 (Pa. 2012) (citing 1 Pa.C.S. § 1936 ("Whenever the provisions of two or more statutes enacted finally by different General Assemblies are irreconcilable, the statute latest in date of final enactment shall prevail.")). Moreover, under the Pennsylvania Statutory Construction Act:

> Whenever a general provision in a statute shall be in conflict with a special provision in the same or another statute, the two shall be construed, if possible, so that effect may be given to both. ***If the conflict between the two provisions is irreconcilable, the special provisions shall prevail and shall be construed as an exception to the general provision***, unless the general provision shall be enacted later and it shall be the manifest intention of the General Assembly that such general provision shall prevail.

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[7] Section 221.21 was enacted December 14, 1977. The General Assembly enacted § 1702 of the L&H GA Act on December 18, 1992.

1 Pa.C.S. § 1933 (emphasis added).

Here, there is a statute specially directed to life and health insurance that specifically addresses what happens to obligations under life and health policies when the insurer becomes insolvent. The plain intent and purpose of the L&H GA Act was to ensure that, unlike in the property and casualty context—where the only obligations of an insolvent insurer are those based on individual claims for loss under policies—obligations under life and health policies—which are often long-term commitments and not replaceable by the insured—continue after the fixing of liabilities and the assumption of coverage by GAs. The drafters of the L&H GA Act[8] were explicit in this regard, distinguishing it from its analogue in the P&C GA Act and expressly describing the purpose of the L&H GA Act as follows:

> After development of the guaranty association for property and casualty insurance, it was questioned whether there was need to develop legislation specifically to deal with insolvencies of life and health insurers. However, industry representatives cautioned that ***the approaches and solutions developed for property and casualty insurers were not only inadequate, but inappropriate for the life and health business.***

1970 Proceedings of the NAIC II 1072 (emphasis added). The drafters specifically explained the basis on which they arrived at this conclusion, stating:

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[8] The L&H GA Act is adopted from a model statute drafted by the National Association of Insurance Commissioners (the "NAIC").

> A policyholder with a life or health insurance contract in an impaired company is concerned with ***preserving the full benefit of his contract. Any plan which is designed to provide only for the payment of outstanding claims falls far short of meeting this concern.*** If the policyholder is in impaired health or at an advanced age, he would not be able to obtain equivalent insurance through a new policy issued by another company. ***This contrasts with the typical situation under property and casualty insurance coverages which are short term and under which a policyholder can ordinarily substitute a new policy.*** The drafters were urged to take these considerations into account when drafting the model statute.

Id. (emphasis added).

State appellate decisions similarly recognize that the effect of life and health GA statutes is to ensure that policy obligations continue to be enforceable by policyholders following an insolvency. *See, e.g., Miss. Ins. Guar. Ass'n v. Vaughn*, 529 So.2d 540, 544 (1988) (noting that life and health GA "was created not only to enable the guaranty of payments but also to enable *continuation of coverage*") (emphasis added) (internal quotation marks omitted). In *Maryland Life & Health Insurance v. Perrott*, the court explained the unique importance of a life and health protective fund:

> The NAIC and commentators have recognized that a guaranty fund against insolvency of insurers in the life and health lines should differ from a fund concerned with insolvency of casualty and property insurers. ***In the latter fields, coverage is generally purchased for relatively short periods of time and the emphasis of a guaranty fund is on the payment of claims arising out of specified occurrences. In the life and health fields, however, policies have a continuity of coverage; there are cash values to be considered, and there is the likelihood that because of age or poor health many insureds will not be able to substitute comparable coverage for policies issued many***

> ***years before. Hence, one important objective upon the insolvency of a life or health insurer is to provide for continuing the existing policies.***

482 A.2d 9, 13-14 (Md. 1984) (emphasis added). The L&H GA Act is thus clear that contractual obligations under a life and health policy—unlike those under a property and casualty policy—exist both before and after the insurer is liquidated.[9]

As the Rehabilitator has explained in this and prior briefs, those obligations may be transferred or replaced during the 30-day window immediately following the entry of the liquidation order. 40 P.S. §§ 221.21, 221.23(8). But even if they are neither transferred nor replaced, the obligations remain and become fixed liabilities of the insurer's estate, for which the policyholders may assert claims against the estate. Any different result would be contrary to the plain language of

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[9] As the NAIC explains in a recent publication:

> After the order for liquidation is issued, the receiver is charged with the duty to secure, marshal and distribute the assets of the estate. The power to perform these duties is provided by the order of liquidation and the state receivership statute. Courts have held the order of liquidation effectively cancels outstanding policies and fixes the date for ascertaining debts and claims against the insolvent insurer. ***However, the insolvency of a life insurer presents a unique situation. The NAIC Model Acts provide for the continuation of life, health and annuity policies.***

Troubled Companies and Receivership, NAT'L ASS'N OF INS. COMM'RS (May 14, 2015), available at http://www.naic.org/cipr_topics/topic_troubled_companies_and_receivership.htm (emphasis added).

the L&H GA Act and would read language into § 221.21 that is not there—incongruous language providing that the *fixing* of obligations amounts to the *termination* of those obligations. Even worse, it would result in the inequitable and perverse consequence of an insolvent insurer being allowed to skirt any and all obligations that happen to exceed the varying limits of GA coverage; it also would mean that there would be no continuing policies under which the GAs could continue to collect premium. That is not a consequence the General Assembly or the NAIC intended in drafting the statutes, nor is it in any way mandated by the holding of *Warrantech*.

3. Article V has preserved a policyholder's common law right to claim the value of his or her policy in excess of GA limits.

The fixing of rights under § 221.20(d) results in the fixing of the estate's liability for, and the policyholder's right to, the entirety of the value of the policy. Thus, far from eliminating or terminating rights, § 221.20(d) *creates* a right, separate and apart from the policyholder's right to continuing coverage and payment of benefits from a GA. Specifically, when the liability of the insurer becomes fixed, the policyholder becomes entitled to recover from the insurer's estate any portion of the policy value that the policyholder has lost as a result of the insolvency, *i.e.*, any portion that is not covered by a GA fund. This remedy exists under the common law, and it gives the policyholder a creditor claim at the policyholder priority level. 40 P.S. § 221.44(b); *see* 1-106 Appleman on Insurance

§ 106.4(1)(d) (2015) ("When a covered claim is in excess of the statutory cap, the balance of the claim is a valid claim against the estate of the insolvent insurer. The claim will then be handled by the liquidator in the same manner as other policyholder and third-party claims.").

Against this backdrop, it cannot be said that the fixing of rights and liabilities somehow terminates or limits the value of a policyholder's claim. Article V and the L&H GA Act plainly exist as shields to protect policyholders such as those at risk here from losing the benefit of their bargains with insurers, not as swords to be used by outside parties to cause *further* detriment. Under fundamental contract principles, a policyholder's claim for the loss of his or her guaranteed-renewable long-term care policy is entitled to proper valuation and an award of damages. Even if a policy ceases to be in force, there must be an allocation of available assets proportionate to the entire liability of the insurer to the policyholder, including any portion of the value of the policy that exceeds the limits of GA protection.

Historically, state insurance receiverships have followed the principle that creditors in the same class of priority of distribution must be treated identically, and creditors of a lower class cannot be paid until higher-class claims have been paid in full. To satisfy these principles in a life insurance liquidation, receivers have placed values on policyholder claims such that each policyholder gets his or

her fair share of the estate assets when an insurer becomes unable to meet its contractual policy obligations. *See Caminetti v. Pac. Mut. Life Ins. Co.*, 142 P.2d 741, 749 (Cal. 1943). This has similarly been the case with other types of policies, such as non-cancellable disability coverages. *See Comm'r of Ins. v. Mass. Accident Co.*, 50 N.E.2d 801, 805 (Mass. 1943) ("[P]olicyholders had contracts under which they were entitled to insurance protection, and those contracts, or at least some classes of them, must have had value. The policyholders have been deprived of their contracts by liquidation of the company."). Thus, where policy benefits become unavailable as a result of a liquidation, the liquidator must recognize, and place a value on, the policyholder's claim at the time of the fixing of rights. *Id.* at 806-07 (holding that, upon "the date of the decree fixing the rights and liabilities of the company," policyholders "held noncontingent claims for loss of their contracts, which claims were provable in their nature, if their policies then had value ascertainable in any reasonable way, and if they have suffered loss of that value").

Modern receivership statutes identify when rights are fixed and establish the priority of distribution. For example, in Pennsylvania, policyholders are accorded a level (b) priority under 40 P.S. § 221.44(b). Pennsylvania's receivership statutes are silent, however, on how any claim against the estate should be valued. Valuation is thus left to the receiver and the supervising court, and it is governed

by the common law and appropriate actuarial principles. *See, e.g., In re Integrity Ins. Co.*, 685 A.2d 1286, 1290 (N.J. 1996) (noting that liquidation statute does not "define the amount of any claim that may be filed due to the premature termination of an insurance policy" and, therefore, "[t]hose answers must be found in the common law").[10]

The valuation of policyholder claims is guided by precedent holding that a claim's value is based on the loss to the policyholder as a result of the insolvency. *See, e.g., Caminetti*, 142 P.2d at 747 ("[T]he proper measure of damages for the wrongful repudiation by the insurer of a life insurance policy is the value of the policy at the time of cancellation."); *Exec. Life Ins. Co. v. Aurora Nat'l Life Assur. Co.*, 38 Cal Rptr. 2d 453, 477 (Cal. Ct. App. 1995) ("The amount to be received on each claim is the value of the policy[.]") (citation omitted). A lifetime guaranteed-renewable policy lost as a result of liquidation is valued differently than a property

[10] *See also* Motion for Approval of Procedure for Notice, Comment and Hearing on Liquidator's Recommendations as to Methodology to Be Employed in Evaluating Policyholder Value, *In the Matter of the Liquidation of Inter-American Ins. Co. of Illinois*, No. 91 CH 10189, Ex. B (Cook Cnty. Cir. Ct. July 23, 1993), Appendix to Rehabilitator's Briefing on Applications Filed by Interested Parties ("Appendix"), tab 3 at Mot. ¶ 2 ("Pursuant to statute, the value of the policyholders' claims was fixed as of the liquidation date . . . . Thus, the liquidator must determine the value of the policies in effect at that date. There is no statutorily prescribed procedure under the Illinois Insurance Code for valuing or adjudicating the policyholders' claims.").

and casualty loss. Unlike in the property and casualty context, the valuation method for a guaranteed-renewable long-term care policy is similar to that used for life insurance and annuity products, which, like the products at issue here, are long-term, permanent commitments. *See, e.g.*, *Caminetti*, 142 P.2d at 747 ("In life insurance policies it is sometimes stated that the value is the face value of the policy less the premiums payable, both discounted to their present value."). Such a valuation is proper provided it is done on the basis of appropriate actuarial methods. *See, e.g.*, *In Re Exec. Life Ins. Co.*, 38 Cal. Rptr. 2d 453, 476 (Cal. Ct. App. 1995) (approving actuarially supported valuation method and rejecting claim that only one particular method of valuing policies existed).

This longstanding principle was reaffirmed recently in the Executive Life Insurance Company of New York ("ELNY") receivership. In approving a pro rata allocation of assets for the payment of policyholder claims resulting from loss of annuity benefits—including portions of those claims not included in what GA funds would cover—the court supervising the ELNY receivership specifically addressed what is the proper allocation of assets to pay policyholder claims in the liquidation of an insurer that would result in policyholders' loss of future benefits, including the value of those benefits that exceeded the limits of GA protection:

> In formulating the proposed plan over many months of consulting together, the Liquidation Bureau along with NOLHGA and other industry participants set forth the mathematical formula that must be applied to everyone in the same statutory class, objectors and non-

> objectors alike. ***Simply stated as testified to by the LBNY's witnesses, ELNY's remaining estate assets would be allocated equally to each person on a pro rata basis, meaning the same percentage of the present value of their annuity benefits.***
>
> That way, whether one's claim or policy was big or small, the same objective computation would apply, each payee getting the same percentage in accordance with the value of their annuity benefits.
>
> ***To distribute the estate in any other manner, such as allowing the same dollar amount to be distributed to each payee alike or by favoring one person's need over another's, would not be an objective calculation made in accordance with the statutes and the case law, but rather a subjective one favoring certain section of Class 4 payers over another. This is both illegal and discriminatory.***
>
> Therefore, as calculated by the current value of ELNY's estate, ***approximately one third (1/3) of the current value of their annuity benefits will be allocated to each payee.*** From there the 40 participating state guaranty associations will cover the difference between the 1/3 estate allocation and its state's cap for residents of that jurisdiction.

In re the Rehabilitation of Exec. Life Ins. Co. of New York, No. 8023/1991, 2012 WL 1577968, at *4 (NY. Sup. Ct. Apr. 16, 2012) (Galasso, J.) (emphasis added), *aff'd* 959 N.Y.S.2d 513 (N.Y. App. Div., 2d Dept. 2013). New York law, like Pennsylvania's, provides that, upon entry of an order of liquidation, "[t]he rights and liabilities of any such insurer and of its creditors, policyholders, shareholders, members and all other persons interested in its estate shall, unless otherwise directed by the court, be fixed as of the date the order is entered[.]" N.Y. INS. LAW § 7405(b) (McKinney 2015).

Here, like the asset allocation approved by the court in the ELNY receivership and affirmed by New York's Appellate Division, the Second Amended Plan marshals available assets for both covered and uncovered benefits claims on an objective, pro rata basis for the present value of long-term care benefits, to the extent that that value exceeds GA protection. The Second Amended Plan addresses the valuation of those claims based on actuarial work performed by PwC, and ultimately seeks to pay all claims of policyholders in PTNA as Company B, including those exceeding GA limits, to the extent possible by a strategy of transferring policy obligations to a trust or to an assuming insurer. While each receivership is unique, the Rehabilitator has chosen this methodology on the basis of the precedent cited herein and in prior briefing to the Court, and it is consistent with methodologies used in past receiverships, as demonstrated in part by materials provided in the Appendix and Supplemental Appendix.

The Health Insurers' creative arguments—supported as they are only by a single decision in an inapposite opinion issued in the distinguishable property and casualty context—should be rejected as inconsistent with established receivership practice and the laws of the Commonwealth. Indeed, the Rehabilitator is aware of no instance where the maximum amount of GA protection has served as a limitation on a policyholder's claims against an insolvent insurer, and the Health

Insurers have not cited or provided any such precedent.[11] Nor, of course, have they cited authority for the proposition that a troubled insurer's obligations to its policyholders can be truncated without consideration so as to increase the assets to be given to the GAs. The Court should reject the Health Insurers' arguments and should not become the first court in the U.S. to reach such an unfair and discriminatory result.

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[11] Importantly, no provision of the contracts, nor in fact any provision of Pennsylvania insurance law, draws a qualitative distinction between the portion of the contractual obligation created by the policy that is within the limits of a particular state's GA coverage and the portion that exceeds that limit. Indeed, it is worth noting that the GA limits are set by the legislatures of the individual states. If the Health Insurers were correct in their position, the consequence would be that the extent of eliminated uncovered claims for the policyholders of these Pennsylvania insurers would be set not by Pennsylvania law but by the laws of all the other states. For example, therefore, in New Jersey (where the GA's liability is not capped) the policyholders of these insurers would have no uncovered claims; all of their claims would be covered by the GA. In contrast, policyholders in Massachusetts, Missouri, Ohio, and Oregon would lose forever all of their claims over $100,000, the GA limits in those states. In the remaining states, claims over $300,000 (or somewhat more in some states, such as California, where the limit is at least $514,600; in Connecticut, Louisiana, Utah and Washington, where it is $500,000; and in Minnesota, where it is at least $410,000) would be lost as uncovered claims. While it may make public policy sense that each state can decide how much of a safety net to provide its residents, that does not compel the conclusion that the Pennsylvania General Assembly has delegated to all these states the power to decide the rights of their residents to the assets of these Pennsylvania insolvent insurers when they are subject to Pennsylvania proceedings.

B. The Health Insurers present a tortured interpretation of Article V and the L&H GA Act that should be rejected.

The Court should overrule the Health Insurers' objections once and for all and reject their attempt to conflate the *fixing* of rights and liabilities with *termination* of a long-term care policyholder's right to claim any value in excess of GA coverage limits. The Health Insurers' tortured arguments would result in an unprecedented limitation on the claims of policyholders who are owed obligations comparable to the obligations created by annuities and life policies. A close analysis of their proposed interpretation of the relevant statutes, as articulated at the May 11, 2015 hearing, reveals that the Health Insurers have grossly misinterpreted the governing law.

1. Obligations under long-term care policies do not terminate upon liquidation.

At the May 11, 2015 hearing before the Court, the Health Insurers argued that policies will terminate by operation of law within 30 days after the entry of the liquidation order. (Tr. 37-38.)[12] As explained above, this fallacious argument flies in the face of express statutory provisions establishing that coverage in fact "continues" under the policies, and is limited in recovery only from the GAs up to

[12] References are made herein to the Health Insurers' May 11, 2015, argument recorded in the transcript of proceedings, with specific page citations in the format "Tr. __."

the prescribed GA limits. Policyholders can separately assert a claim against the estate for the uncovered portion of their claims and for the lost value of their policy to the extent it exceeds GA protection, a claim that becomes irrevocable at the time when rights and liabilities are fixed. The Rehabilitator has fully addressed such rights against the estate through a transfer of that portion of the continuing policy obligation under the Second Amended Plan.

Nevertheless, the Health Insurers persist that the transfer of assets and obligations to a liquidating trust or to another insurer is inconsistent with the common-law claim for damages that the Rehabilitator seeks to honor, and they complain that the Rehabilitator intends through this approach to provide benefits under a "terminated" policy. (Tr. 38-39.) To be clear, the Rehabilitator is utilizing a mechanism that maximizes available assets (*i.e.*, transferring to GAs that GA covered portion and to another assuming insurer or a liquidating trust the GA-uncovered portion of policy obligations pursuant to 40 P.S. § 221.38(8)) to satisfy claims that policyholders will be entitled by law to assert against the estate.[13] Even

[13] The Health Insurers argue that the statute does not permit the Rehabilitator to protect the policyholders in this manner, asserting that "the statute was intended to permit a Liquidator to sell profitable blocks of business or at least to move blocks of business that could be moved with a payment of an amount no greater than what those policies would have received in liquidation." (Tr. 46.) What the Health Insurers refuse to recognize is that the Rehabilitator *is* moving obligations in two segments, *i.e.*, the covered portion to GAs and certain uncovered portions to an

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if the Rehabilitator did not address the policyholders' rights by this strategy, the policyholders would still be free to claim against the estate for any lost value in excess of GA protection (as further explained herein).[14] The Second Amended Plan's strategy appropriately recognizes those claims, and it merely seeks to achieve an equitable allocation of unavoidable loss resulting from the payment of those claims from a diminished asset pool.

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assuming insurer or liquidating trust—as specifically permitted by the statute, along with concomitant transfers of appropriate proportions of assets based on present valuation determinations. While the Health Insurers understandably wish to foist on the Court their own interpretation of the statute, and to rewrite it to serve their own purposes, § 221.23(8) permits the transfer as contemplated for a portion of the policy obligation that is in force. There is thus no basis to disturb the Rehabilitator's strategy, which fully comports with Article V.

[14] The Health Insurers' suggestion that the transfer prejudices priorities under Section 221.44 (Tr. 46-47), therefore, simply does not follow. During the May 11 hearing, the Court commented that "[t]he question is whether or not the – a claim can be brought against the estate that accrues more than 30 days after an order of liquidation." (Tr. 63; *see also* Tr. 77 ("The question is when did a claim arise?").) The fact is that a claim for the breach and lost value of the policy in excess of GA protection accrues at the time of liquidation. *See, e.g.*, *Exec. Life*, 38 Cal. Rptr. 2d at 477 ("Conservation because of insolvency constituted a breach of contract on the part of ELIC . . . . 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.'"). At the time of liquidation two things are certain: the GAs will cover their obligations, and the company will not perform on the contract to permit recovery beyond the GA coverage. A claim against the estate thus accrues immediately for breach and loss of value for protection above GA levels, and "liabilities" recognized by Article V. *See* 40 P.S. § 221.3 (defining "insolvency"). The liabilities cannot be extinguished by sleight of hand.

The Health Insurers further object that a transfer cannot be made to a liquidating trust under § 221.38(8) because the statute refers to a "solvent assuming insurer," which language the Health Insurers argue does not cover a trust. (Tr. 47.) But neither does that language cover GAs, which the Health Insurers expect to assume the portion of the coverages within statutory GA limits. In effect, however, in both cases insurers will ultimately be responsible for the coverages. With respect to the Uncovered Benefits, the Plan contemplates that ANIC will do so if the Rehabilitator does not contract with another insurer for that purpose. The Rehabilitator's use of a trust as a facilitating mechanism is fully consistent with what other receivers have done to address the transfer of policy obligations for payment by an assuming entity apart from the estate (*e.g.*, a trust assuming policy obligations under a reinsurance assumption agreement).[15] In fact, liquidating trusts

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[15] *See, e.g.*, Order Confirming Plan of Rehabilitation for Covenant Mutual Insurance Co., 4, Supplemental Appendix, tab 8 (approving transfer of liabilities and assets to liquidation trust as part of rehabilitation plan); *see also id.* at 4-5 ("On the Closing Date, the Commissioner is hereby authorized to cause the Liquidation Trust to reinsure and assume the Transferred Liabilities pursuant to the Reinsurance Agreement and the Assumption Reinsurance Agreement . . . ."); Rehabilitation Plan for Covenant Mutual Insurance Co., 17, Supplemental Appendix, tab 8 ("On the Closing Date, the Rehabilitator shall cause the Liquidation Trust to reinsure and assure all of the Transferred Liabilities. . . In consideration of its reinsurance and assumption of the Transferred Liabilities, the Liquidation Trust will receive the Transferred Assets.")). The Court will note that counsel for the Health Insurers was intimately involved in that receivership and transaction. *See also* Plan of Rehabilitation of The Confederation Life Insurance

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were created in the early 20th century to provide an IRS-recognized and bankruptcy-recognized vehicle for rehabilitating the business of otherwise insolvent entities.[16] It is also consistent with state statutory provisions authorizing

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Company of the United States, 18, Sec. V.B., Supplemental Appendix, tab 9 (summarizing transfer to liquidating trust).

[16] Although there is no specific IRS guidance or case law addressing the treatment of insurance company assets transferred to a liquidating trust, the concept of a liquidating trust itself is well-developed under the federal tax law. In addition, liquidating trusts are frequently employed to efficiently and equitably satisfy creditor and policyholder claims with respect to insurance companies in receivership or liquidation, and the insurance policies issued by such companies. Treasury Department Regulation Section 301.7701-4(d) provides that:

> An organization will be considered a liquidating trust if it is organized for the primary purpose of liquidating and distributing the assets transferred to it, and if its activities are all reasonably necessary to, and consistent with, the accomplishment of that purpose. A liquidating trust is treated as a trust for purposes of the Internal Revenue Code because it is formed with the objective of liquidating particular assets and not as an organization having as its purpose the carrying on of a profit-making business which normally would be conducted through business organizations classified as corporations or partnerships.

26 C.F.R. 301.7701-4(d). Such liquidating trusts are frequently treated as grantor trusts under Sections 671-677 of the Code, *see, e.g.*, Rev. Rul. 63-228, 1963-2 C.B. 229, but they are sometimes treated as taxable trusts. *See* Rev. Rul. 69-300, 1969-2 C.B. 167.

There are numerous reported bankruptcy and insurance cases plainly demonstrating that liquidating trusts are commonly employed to satisfy creditor and policy holder claims as described above. *See, e.g.*, *In re Alameda Invs., LLC*, BAP No. CC-13-1333-PaTaKu, 2014 WL 868605, at *7 (9th Cir. Bankr. App. Mar. 5, 2014) (affirming lower bankruptcy court's holding that liquidating trust was permitted to receive and hold interest in estate assets for benefit of creditors

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the transfer of insurance liabilities to "protected cells." *See, e.g.*, 215 Ill. Rev. Stat. 5/179A-1; NAIC Protected Cell Company Model Act (Model 290). The trust is, for all intents and purposes, the functional equivalent of an assuming insurer in this instance. In any event, however, the trust need not retain the obligations—it may transfer the obligations to another insurer, and, in fact, the Rehabilitator expressly reserves the right to transfer the allocated funds directly to another insurer. *See* 2d Am. Plan at 58.

During the May 11 hearing, the Court asked the Health Insurers' counsel, in relation to their transfer argument, whether subpart (8) "even deal[s] with when the policy obligation terminates?" (Tr. 48.) The Health Insurers provided only an anemic response. *Id.* As is readily apparent from the language of § 221.21(iv), however, a transfer in accordance with § 221.23(8) can be effected in circumstances where policy obligations would otherwise terminate. 40 P.S. § 221.21(iv) (extending coverage "until the liquidator has effected a transfer of the policy obligation pursuant to section [221.23(8).]"). In this circumstance, the

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because "the Trust was merely a representative of the estate concerning enforcement of Debtor's interest"); *Exec. Life Ins. Co.*, 38 Cal Rptr. 2d at 462 (noting that one of three entities that would receive assets from insurer under plan of rehabilitation was "a liquidating trust to be operated by the Liquidation Division of the Department of Insurance to dispose of ELIC real estate and other assets worth approximately $680 million").

policy obligations exist at the time of the transfer, because the transfer occurs within the 30-day period following liquidation, during which any policyholder may submit a claim triggering the policy. Moreover, the policy obligations *will continue* with the GA fund *even after* the expiration of the 30 days, a result that has been expressly mandated by the General Assembly in passing the L&H GA Act, for the very purpose of continuing coverage in exchange for continued premium payments.

While the Rehabilitator cannot transfer the entire policy obligation to an assuming entity at this time—as is often an option where adequate assets exist or an agreement is reached in coordination with NOLHGA and an assuming insurer—the Second Amended Plan retains the flexibility to do the next best thing: transfer obligations that cannot be satisfied by GAs, and thereby preserve and equitably protect policyholders' rights to estate assets. In the end, the transfer comports with the provisions of Article V, and the Court should reject the Health Insurers' self-serving efforts to impose an unprecedented, unnecessarily harsh result on policyholders, and unfairly derail a fully permissible strategy of equitable asset allocation that fully complies with the Court's directives to the Rehabilitator.

2. Article V has not abrogated policyholders' common-law claims.

The Health Insurers next take the position that the common law has been supplanted by the GA safety net such that the policyholders' claims are precluded

(Tr. 39.) They provide no authority for this proposition, and they cannot because it is plainly wrong. At common law, a claim's value in similar contexts (*e.g.*, life insurer insolvencies) is based on the policyholder's loss occasioned by the insolvency. To the extent that the loss falls within the limits of GA protection, the claim is the responsibility of the applicable GA but is replaced with a corresponding claim *by* the GA. To the extent that the loss exceeds GA limits, the policyholder retains the ability to claim the full value of the loss, just as he or she would be able to do under an annuity or a life insurance policy. Such claims have not been eliminated either by the advent of the GA safety net or by the provisions of Article V; they, too, are being transferred to a GA captive or other assuming insurer or liquidating trust. And, as noted above, the modern statutory regime plainly leaves the matter of valuation to the receiver and the court. *See, e.g.*, *Integrity Ins. Co.*, 685 A.2d at 1290. Absent a specific directive from the General Assembly indicating that the common law has been displaced with respect to these claims, the common law continues to apply, and the Rehabilitator may rely on it in endeavoring to achieve equitable allocation of any unavoidable loss.[17]

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[17] The Court inquired during the hearing whether "a creditor can put a company into common law receivership at Dauphin County Courthouse?" (Tr. 85.) The Rehabilitator notes that Article V is very precise in restricting the jurisdiction of other courts and the types of actions permitted and, under applicable provisions of Article V, a creditor does not have a right to bring an action. *See, e.g.*, 40 P.S. §

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Our Supreme Court teaches that abrogation of the common law simply is not a matter of implication; it must be express:

> Whenever we are called to interpret a statute and determine the legislative intent, the analysis must necessarily begin with the Statutory Construction Act. 1 Pa.C.S. § 1921 et seq. Under the Act ***an implication alone cannot be interpreted as abrogating existing law. The legislature must affirmatively repeal existing law or specifically preempt accepted common law for prior law to be disregarded.***

In re Appointment of Rodriguez, 900 A.2d 341, 344 (Pa. 2003) (emphasis added); *see also Commonwealth v. Miller*, 364 A.2d 886, 887 (Pa. 1976) ("[S]tatutes are not presumed to make changes in the rules and principles of the common law or prior existing law beyond what is expressly declared in their provisions."). There has been no affirmative preemption by the General Assembly of the common-law claim the receiver intends to recognize. Moreover, as this Court recognized, "a non-cancellable policy not yet on claim has a value. That's been recognized for a long, long time."[18] (Tr. 75.) The Rehabilitator's Plan addresses that value by

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221.4(a), (d); 40 P.S. § 221.9. Article V does not similarly restrict policyholder claims that existed at common law and are not expressly preempted or displaced by Article V.

[18] At the time of liquidation, some policies will be "on claim," *i.e.*, at that time the insurance company will be paying claims under the policy, while other policies will be "active policies," meaning that the insurance company is not paying claims under the policy at that time. More than 60% of policyholders can reasonably be expected to die or let their policies lapse without ever receiving benefits. Additionally, many of the Companies' policies contain "Extension of Benefits"

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anticipating that part of the claim may be covered by the GA, but some claims may be so large that there is a claim in excess of GA protection—a common occurrence in liquidations, and one that is routinely provided for in plans of liquidation.

3. Policyholder claims are not general creditor claims.

The Health Insurers contend that if policyholders have claims based on termination of their policies, they are only entitled to general creditor status pursuant to 40 P.S. § 221.44(e). (Tr. 39-40.) The Health Insurers posited to the Court at the May 11 hearing that the policyholders' rights to assert a claim are "very narrow," and then suggested a highly restrictive reading of the priority statute that would preclude policyholders from asserting claims against the estate, regardless of whether they have GA protection. (Tr. 40.)

The Health Insurers' proposed interpretation of the statute is self-serving and incorrect, and this Court should reject it. Section 221.44(e), the subsection

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clauses, which continue an obligation to a policyholder *even when a policy is no longer "in force."* At the time the policies are issued, neither the insurers nor the policyholders know which policyholders will be among the percentage that will actually receive benefits. This "spreading of the risk" is precisely what enables the insurer to make the policy relatively affordable for every policyholder even though benefits paid to some will greatly exceed the premiums they have paid. The assurance that the protection will be there if needed is of tremendous importance to these policyholders. Just as do automobile insurance policyholders, they know full well when they buy the coverage that they may never have a claim. But the protection against that eventuality is critically important to them (and a strong reason for their payment of the premiums) even in the face of that knowledge.

creating a class of general creditors, mentions one specific type of policyholder claims that fall within that class: "[c]laims under nonassessable policies for unearned premium or other premium refunds." 40 P.S. § 221.44(e). "[U]nder the principle of *expressio unius est exclusio alterius,* the express mention of a specific matter in a statute implies the exclusion of others not mentioned." *W. Penn Allegheny Health Sys. v. Med. Care Availability and Reduction of Error Fund*, 11 A.3d 598, 605-06 (Pa. Commw. Ct. 2010) (citation omitted). Because § 221.44(e) does not expressly include claims for policyholders who have lost all or a portion of the value of their long-term care policies due to insolvency, it can only be interpreted as excluding such claims, so that they must be recognized under § 221.44(b). To narrow the scope of claims under § 221.44(b) to preclude long-term care policyholders from accessing estate assets would discriminate against those policyholders without any legitimate purpose.[19]

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[19] That a claim for lost value of the policy exists today is a sound conclusion when considering the history of Article V. Accepting Health Insurers' argument, at the time the current version of the Act was passed in 1977, when there was no L & H GA protection in place, the claims of the policyholders in issue would necessarily be valued at zero. If that were the case, the Companies could return to business in sound financial condition free of billions of dollars of liabilities. That would be absurd and certainly would not have been the outcome. Prior to the L&H GA Act, policyholders would have had to have claims against the insolvent estate at the policyholder priority level for the lost value of their policies. The L&H GA Act says nothing to remove this right of claim, and exists for the purpose of providing seamless insurance protection to policyholders for an insolvent insurer that would

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Accordingly, long-term care policyholder claims, like life and annuity policy claims, must be recognized as policyholder level claims under § 221.44(b).[20] 40 P.S. § 221.44(b). Article V is to be "liberally construed to effect the purpose" stated in § 221.1(c), which calls for the "equitable apportionment of any unavoidable loss." 40 P.S. § 221.1(c)(iv); *see also* 1 Pa.C.S. § 1922 (5) ("[T]he General Assembly intends to favor the public interest as against any private interest."). The Rehabilitator's Plan gives effect to that purpose, without discriminating, in furtherance of a fair distribution scheme permitted under the law.

The Court should consider the broader impact of the Health Insurers' argument. If long-term care policyholders may only recover claims for losses up to the maximum available GA coverage, the consequences for the long-term care insurance market in the United States would be severe. If, as a matter of law, an insured's investment in long-term coverage were only protected up to the limits of

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not be in position to make payments to individual policyholders due to liquidation. The GAs provide the protective coverage, but to a defined cap identified by the legislature to manage the ultimate liability that might result in assessments to member insurers. The GA limits have no relation to limiting the right of recovery by policyholders where assets of the estate are available for that very purpose.

[20] During the May 11 hearing, the Court asked the Health Insurers' counsel what would occur in the event a policyholder had no GA coverage. (Tr. 101.) In responding to the question, counsel admitted that the policyholder would file a proof of claim with the estate, and acknowledged that the claim would have a policyholder level priority, *not a general creditor status claim.* (Tr. 101-02.)

the applicable GA fund, insureds in a liquidation—especially those in states with GA limits of only $100,000 or $300,000—would face the sobering reality that a product intended to avert financial risk in later life in fact *creates more risk.* Such a result cannot be reconciled with the overriding purpose of Article V: "the protection of the interests of insureds, creditors, and the public generally[.]" 40 P.S. § 221.1(c).

4. The Companies' liabilities are not cut off after 30 days.

The Health Insurers argue that *Warrantech* is clear that "liabilities" are cut off for "triggering events that occur after the 30th day following a liquidation order." (Tr. 41.) While that is true in the property and casualty context, as discussed above, the same rationale simply cannot be applied in this circumstance, because, as demonstrated above, coverage obligations and the policies under which they arise "continue" once assumed by the GA (unless the GA provides for their "assumption, reinsurance," or coverage under a new policy issued by the GA), and the GA will in fact be asserting claims against the estate on the basis of subrogation. 40 P.S. § 991.1706(m)(2). That the GA will have the right to assert claims for subrogation further establishes that rights, obligations, and liabilities arising from long-term care policies do not terminate after 30 days because, if they did, there would be no obligation for the GAs to enforce as a subrogee. *See Bell v.*

Slezak, 812 A.2d 566, 574 n.8 (Pa. 2002) (citation omitted) ("[A] subrogee has no greater rights than those held by the subrogor[.]").

The Health Insurers' contrary argument is based on a supposed bifurcation of the rights of policyholders against the estate between benefits that are covered by GAs and those that are not so covered. But no foundation for that bifurcation exists in the statutes. If § 221.21 is to be given the interpretation the Health Insurers advance, then it terminates not only policyholders' uncovered claims; it also terminates the GAs' creditor claims against the estate attributable to covered claims. Put simply, if the statute terminates any coverages 30 days after the order of liquidation, then it terminates *all* coverages on that day, and the GAs, as subrogees of the policyholders, have no claim at all against the estate.

Thus, if the estate's liabilities were simply cut off as a matter of law in this manner, the statutory framework in the Commonwealth, and every other U.S. jurisdiction, would be ineffective and meaningless, because all such statutes direct that the GAs assume positions of subrogation against the estate upon payment of a policyholder's covered claims. Recognition of those subrogation rights in turn requires the Court to recognize the continuation of the policies and the "liabilities" of the estate. Were it otherwise, even the GAs would not be able to assert the rights provided under the GA statutes, a result that would defy logic and common

sense, and would render superfluous the subrogation provisions of the GA statutes.[21]

[21] Moreover, the Health Insurers' position conflicts with the historical assumption of liabilities by assuming insurers in liquidations, including for long-term care transfers. Taking Health Insurers' argument to its logical conclusion, 30 days after liquidation there can be no liability in respect of long-term care policies for expenses that "accrue" thereafter (*e.g.*, incurred care expenses). This unprecedented position is a dangerous threat to consumers. If Health Insurers were correct, liquidators, independently or in coordination with GAs, would not be able to transfer the entire coverage obligation and complete liabilities of the policies, including pursuant to 40 P.S. § 221.23(8). Experience teaches, however, that 100% of the obligations and liabilities are addressed in one form or another when there is an assumption reinsurance transaction post-liquidation. For example, on June 25, 1993, the Commonwealth Court entered an order of liquidation against American Integrity Insurance Company, which had issued long-term care policies in various jurisdictions. Months later, in April 1994, Unum Life Insurance Company of America assumed 100% of the obligations and liabilities for all future claims along with the associated reserves. *See American Integrity Insurance Company, in Liquidation*, Agreement of Reinsurance and Assumption, Supplemental Appendix, tab 10; *see also id.* at 3-4 (defining "Reserve Liabilities" as the "total of the aggregate liability values for the Applicable Contracts calculated as of the Accounting Date. These items include Active Life Reserves (which include provisions for expenses), Claim Reserves (which include claims expense reserves), and Unearned Premium Reserves.") If Health Insurers' argument were to prevail, such agreements to protect consumers would not be possible. *See also, e.g., Liquidator's Final Accounting and Petition for Distribution of the Estate*, Docket 442 M.D. 2004, Appendix, tab 5, at Pet. p. 5 (describing Assumption Reinsurance Agreement) ("The estimated payments to Philadelphia American of approximately $7.9 million included $4.1 million (reserve estimate for the ultimate payment of benefits as of 1/1/07 plus an incentive to assume) *attributable to the obligations of guaranty associations* and approximately $3.8 million (reserve estimate for the ultimate payment of benefits as of 1/1/07 plus claim handling and risk expenses) *attributable to [long-term care] policyholder benefits for uncovered claims*.") (emphasis added).

The Health Insurers argue that this reasoning is inconsistent with *Warrantech*, but *Warrantech* did not address reserves. (Tr. 41-42.) Again, the fundamental difference between the risks involved dictates the role and confirms the unique importance of reserves in life insurance as opposed to property and casualty insurance. For example, unlike property and casualty reserves, the reserves for life products are set aside to guarantee the financial security provided by the policy for the policyholder's investment and life-critical arrangements. While property and casualty companies set reserves, the General Assembly has not enacted any statutory provisions to protect and secure similarly reserve-oriented rights and obligations in property and casualty liquidations. The public policy behind the protection for insureds in life and health liquidations is to attempt to provide the insured with the *full benefit* of his or her policy. *See* 1970 Proceedings of the NAIC II 1072 ("A policyholder with a life or health insurance contract in an impaired company is concerned with preserving the full benefit of his contract."). It is not an attempt to *limit* an insured to a maximum recovery so as to benefit lower-level creditors—or parties that are not even creditors at all, like the Health Insurers.

The Health Insurers nevertheless contend that §§ 221.20 and 221.21 apply to all policies, and do not distinguish between long-term care and other insurance. They concede that statutes in other states and the NAIC Model Act in fact make

the distinction, but content themselves with the bald declaration that "the [Pennsylvania] legislature has not seen fit to do so." (Tr. 42.) What the Health Insurers ignore is that the statutes which make the distinction are simply more recent statutes that embody the same principles and achieve the same purposes as §§ 221.20 and 221.21, but with more explicit and refined language—language that the NAIC has developed by drawing on the benefit of time and experience.

Our Supreme Court has acknowledged that NAIC developments inform construction of Pennsylvania's receivership law. *See Koken v. Reliance Ins. Co.*, 893 A.2d 70, 83-84 (Pa. 2006) (recognizing that Article V is based on NAIC model statute). Like the common law, which constantly evolves, state receivership statutes evolve, largely based upon NAIC proceedings, resulting in clearer and more detailed model statutes that more directly address matters that arise routinely in practice. The Insurance Department interprets § 221.21 consistent with the NAIC Model[22] and other state statutes that intend to accomplish the same

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[22] It is important to note that Pennsylvania is an NAIC-accredited state. Insurance business is conducted across state lines and accreditation ensures uniformity of law for the protection of policyholders, creditors and the general public across the country. As part of the accreditation process, a state must meet numerous delineated standards. Accreditation ensures the maintenance of "[a]dequate solvency laws and regulations in each accredited state to protect consumers and guarantee funds." *See Accreditation Informational Pamphlet*, 2 (Apr. 2015), http://www.naic.org/documents/committees_f_FRSA_pamphlet.pdf. Among the established "standards" are that: "State law should set forth a receivership scheme

(footnote continued on next page)

objectives as the statutory framework adopted in the Commonwealth decades before. That the language in other statutes arguably provides greater clarity is of no moment, because those statutes do not reflect any intention different from that of the Commonwealth's statutes. It is the Commissioner's obligation as both a regulator and receiver to see that the laws are enforced and applied both as written and as intended. Here, §§ 221.20 and 221.21 are to be interpreted consistent with more modern laws so as to avoid absurdity and recognize the intention of the General Assembly regarding continuation of coverage, which is plainly expressed in the later-enacted L&H GA Act.

For these reasons and the reasons expressed above and previously, the Health Insurers are simply incorrect that policy obligations somehow disappear after 30 days. Long-term care policy obligations continue under the L&H GA Act as provided therein, just as they do under analogous state statutes designed for the same purpose, albeit pursuant to more modern language. *See, e.g.*, Conn. Gen. Stat. § 38a-921(c) ("Continuance of coverage.") ("Policies of life or health insurance or annuities shall continue in force for such period and under such terms

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for the administration, by the insurance commissioner, of insurance companies found to be insolvent *as set forth in* the NAIC's Insurer Receivership Model Act." *Id.* at 9 (emphasis added). The Department interprets the laws of the Commonwealth consistently with such accreditation.

as is provided for by any applicable guaranty association."); *see also* National States Insurance Company In Liquidation, http://www.nstates.com /policyholders.asp (explaining that guaranteed-renewable policy is not cancelled in liquidation).[23]

5. The Second Amended Plan's allocation of assets does not violate § 991.1712(c) or § 221.36.

The Health Insurers next assert that the Second Amended Plan violates § 991.1712(c) of the L&H GA Act, 40 P.S. § 991.1712(c), and § 221.36 of Article V, 40 P.S. § 221.36. Specifically, they contend that, under those statutes, the GAs are to receive *all* of the assets attributable to each policy that receives benefit payments from GAs. (Tr. 42; *see also* Tr. 44 ("The statute is clear that the guarantee association gets the entire reserve."); Tr. 49.) Again, the Health Insurers are wrong.

The Health Insurers' error is founded on an overly broad reading of § 1712(c), which does not grant any right of action. Instead, a GA's ability to assert a claim against an insurer's estate is specifically provided for in

[23] The Rehabilitator reiterates that life and annuity policies under this language continue as provided for under the GA statute. Such policies very often involve amounts larger than recoveries available from GAs. However, it is undisputed that those policyholders commonly claim excess amounts from insurer estates. Health Insurers plainly intend to discriminate between types of policies to achieve their purposes by arguing that long-term care policyholders are not entitled to coverage beyond GA levels. Such discrimination is unlawful and inequitable.

§ 991.1706(m) of the L&H GA Act, which gives the GA a right of subrogation to the extent that the GA pays the covered benefit. 40 P.S. § 991.1706(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*** . . . .") (emphasis added). In other words, the GA stands in the shoes of the policyholder, and thus is entitled to claim against the estate for a proportionate share of what the policyholder could have claimed in the absence of GA coverage. The right of the GA is 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.***" 40 P.S. § 991.1706(m)(2) (emphasis added).

Section 221.36 of Article V serves a different purpose, as it provides specific directions to a liquidator regarding disbursements, and requires a proposal in respect thereof, including for disbursements to GAs in anticipation of policyholder claims. 40 P.S. § 221.36(c). The disbursement must be "at least equal to the claim payments made or to be made thereby ***for which such associations could assert a claim against the liquidator. . . .***" *Id.* (emphasis added).

Significantly, GAs are not authorized to withhold an overpayment of assets. In fact, each GA receiving any disbursement must return to the liquidator such assets previously disbursed as may be required to pay the claims of secured

creditors, administrative expenses, and "***the proportional share of the assets disbursed required by the liquidator to make equivalent distribution to creditors of the same class of priority as policyholders. . . .***" 40 P.S. § 221.36(b)(4) (emphasis added). In other words, the liquidator may withhold assets or require the return of assets to address a proportional share of policyholder-level claims by the estate. These statutory mechanisms demonstrate a clear intention to permit distribution of assets to the GA, but the assets that a GA may receive are limited—they do not consist of *all* of the reserve. The GAs are entitled only to the proportional value of reserve for the part of the policy obligation that is covered.

Contrary to the Health Insurers' assertions, § 1712(c) of the L&H GA Act does not provide the GA a right to all of the assets that are attributable to policies. Rather, § 1712(c) merely facilitates the overall financing mechanism for GA operations. The GAs are "deemed to be a creditor" in these circumstances because they are receiving early access distributions as authorized under § 221.36. 40 P.S. § 221.36. Although the GA is receiving early distributions, those distributions are generally estimates. *See* 40 P.S. § 221.36(c). The GA's right to assets is ultimately determined by the proportional amount it can claim as a subrogee against the estate or otherwise in respect of administrative expenses. The final figure must then be trued up against that amount which is distributed, and the

liquidator may withhold or demand return of funds to address claims such as those exceeding GA limits. *See* 40 P.S. § 221.36(b)(4).[24]

Section 991.1712(c) specifically defines assets attributable to covered policies as the proportion of assets which the reserves that should have been established for covered policies bear to the reserves that should have been established for covered and uncovered policies. 40 P.S. § 991.1712(c). The GAs, therefore, only receive assets proportional to covered liabilities; assets for uncovered liabilities remain in the estate. All that this provision does is allocate to each GA a share of assets proportional to the coverage protection that the GA provides. That is the full extent of what the GA is entitled to claim.

Notwithstanding the clarity of this statutory scheme's purpose and effect, the Health Insurers argue they are entitled to all of the insurer's assets, citing § 1712(c)'s provision that "[a]ssets of the impaired or insurer attributable to covered policies shall be used to continue all covered policies and pay all

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[24] The liquidator maintains close supervision over the assets disbursed to GAs. *See, e.g.*, 40 P.S. § 221.36(b)(5) ("The liquidator may require reports to be made by an association at such time and covering such matters as he may determine. A full report shall be made by the association to the liquidator when assets received have been disbursed or the obligation of an association to pay covered claims of the insolvent insurer has been fulfilled accounting for all assets so disbursed to the association, all disbursements therefrom, any interest earned by the association on such assets and any other matter as the court may direct.").

contractual obligations of the impaired or insolvent insurer as required by this article." (Tr. 42.) This section, however, does not state that *all* assets must be transferred to the GAs. Indeed, the precise definition of "contractual obligation" makes this clear. The L&H GA Act provides: "'Contractual obligation.' Any 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." 40 P.S. § 991.1702.

The Health Insurers' interpretation seeks to rewrite the statute and ignores the basis on which the GAs *assert a claim against the estate—i.e.*, subrogation, thereby directly conflicting with § 221.36(b)(4).[25] The Health Insurers are plainly mistaken in this regard, as this Court observed in *Koken v. Legion Insurance Company*, a case involving the meaning of a refund requirement under

[25] At the May 11 hearing, the Health Insurers' counsel argued that "[u]nder this section [991.1712(c)] the guarantee association is limited to two types of recovery, a subrogation claim for amounts that it actually paid to policyholders with respect to covered policies and a share of the assets attributable to amounts that it will have to pay in the future." (Tr. at 43.) The Health Insurers misrepresent the statute and gloss over its operative language. The L&H GA Act is clear in providing a right of subrogation to the GA at the same level of priority as a policyholder. 40 P.S. § 991.1706(m)(2). Section 1712(c) provides no such right of recovery – because there is no intention of providing a separate right. What § 1712(c) effects is early access to funds based on the liquidator's estimations for future liability which the estate will have. It is, in other words, an advance or retainer for the GA to employ in carrying out its obligations to pay policy benefits. The GA, however, does not receive assets at a higher priority than a policyholder claim.

§ 221.36(b)(4), in which the court stated, "***All policyholder claimants, including guaranty associations, are expected to receive the same pro-rata amount paid on their claim.***" 941 A.2d 60, 64 (Pa. Commw. Ct. 2007) (Leavitt, J.) (emphasis added). The Court added, "***Policyholders can, and presumably have, submitted proofs of claim for the amount of their loss that exceeds what the guaranty associations have paid to them. Because guaranty associations and policyholders share the same claim priority status, policyholders will be competing with guaranty associations for their fair share of the Legion estate.***" *Id.* at 68 (emphasis added). Moreover, in *General Reinsurance Corporation v. American Bankers Insurance Company of Florida,* 996 A.2d 26, 34 (Pa. Commw. Ct. 2010), this Court observed "***[b]ecause guaranty associations pay claims for policyholders, their claims fall, for the most part, in the policyholder priority class. Guaranty Associations are singled out for 'early distribution.' Otherwise they are treated no differently than all policyholder claimants. When the final distribution of the estate assets is made, all policyholder claimants, including guaranty associations, will receive the same percentage reimbursement on their claims.***" (emphasis added).

Tellingly, Health Insurers' position is entirely inconsistent with NOLHGA's publicly stated positions, and specifically with its testimony before the United

States Congress.[26] NOLHGA does not assert that GAs across the United States[27] are entitled to all of the assets. On the contrary, NOLHGA has testified, and the Rehabilitator agrees, that "[a] guaranty association's coverage limit or 'cap' does set a 'floor' for policyholder recoveries, no matter what else happens in the receivership case . . . . [T]he much more important factor—at least for policyholder claims significantly in excess of caps—is the liquidation ratio achieved in the insolvency. How many cents on the dollar is the receiver able to pay on policy-level claims?" (NOLHGA Test. (App'x A) at 16.) NOLHGA further explains, and the Rehabilitator agrees, that in each receivership the "liquidation ratio" is applied to determine what percentage of assets a claimant will receive in respect of the claims asserted against the estate. (NOLHGA Test. (App'x A) at 13.) Although policyholders receive GA coverage as a matter of law, NOLHGA explains they also claim against the estate *in pari passu* with the GAs asserting claims for subrogation. (NOLHGA Test. (App'x A) at 13) Multiplying the value of the total

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[26] *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, available at https://www.nolhga.com/resource/file/HFSCnolhgaTestimonyNov15_2011.pdf (cited herein as "NOLHGA Test. at __"), Supplemental Appendix, tab 11.

[27] All other L&H GAs, with the exception of Wisconsin, have identical or similar provisions to § 1712(c).

claim against the liquidation ratio provides the recovery figure due on the claim. NOLHGA provided illustrations describing exactly this process to Congress, and that testimony is very clear that the GAs *do not* get all of the assets.[28] In fact,

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[28] Illustrations provided in NOLHGA's congressional testimony demonstrate how estate assets are generally distributed in excess of GA limits in life insurer receiverships:

> Consider the outcomes illustrated in the following. . . . If the estate has 95 cents on the dollar available – a 95% liquidation ratio – the policyholder will recover $950,000 on that $1 million claim, even with no guaranty association protection. On the other hand, if the estate has zero cents on the dollar available at the policyholder level, the policyholder will recover nothing.
> Now imagine that the policyholder has the same claim for $1 million and resides in a state where guaranty association coverage is $100,000. Consider the outcomes illustrated in the next chart. In this case the policyholder will recover (from the guaranty association) 100% of the claim up to $100,000, and she will recover on the rest of her claim an amount determined by multiplying the excess claim (here, $900,000) by the liquidation ratio for the insolvency. If the insolvency estate marshals 95 cents on the dollar for policyholder claims— which is a bit lower than average for life insurance claims in insolvencies— that policyholder will end up with a total of $955,000 on her $1 million claim: $100,000 from the guaranty association and $855,000 (95% of $900,000) in respect of her excess policyholder claim. On the other hand, if the estate marshals zero cents on the dollar, the policyholder's total recovery is limited to the $100,000 that will be paid by the guaranty association.
>
> Imagine next a slightly different set of facts, illustrated in the next chart. Suppose the policyholder resides in a state with a $250,000 guaranty association "cap." In the first hypothetical outcome in this series of examples—a liquidation ratio of 95%— the policyholder's total recovery then would be $962,500 ($250,000 from the guaranty association and $712,500 from her excess claim): a modest increase

(footnote continued on next page)

NOLHGA testified that "a policyholder can—and often does—recover most or all of her claim in the insolvency, *even above* the level covered by guaranty associations." *Id.*

Illustrative receivership documents included in the Rehabilitator's Appendix provide examples supporting the proposition that the GA in any jurisdiction recovers only a proportional amount of the assets from the estate based on a right of subrogation (except for higher-priority expense claims).[29] The Health Insurers'

> of only $7,500 over what she would have received with guaranty association coverage to $100,000, even though the guaranty association "cap" is two-and-one-half times larger. But in the second hypothetical outcome—with a liquidation percentage of zero—the total policyholder recovery is still only $250,000. That is to say that a very large loss—$750,000—is borne by the policyholder, even with much more guaranty association coverage than in the prior case.

(NOLHGA Test. (App'x A) at 13-15); *see also Keeping Insurance Promises: The Context & Operation of the U.S. Insurance Guaranty System*, Presentation to U.S. Dept. of Labor ERISA Advisory Council, Aug. 29, 2013 at 20, available at http://www.dol.gov/ebsa/pdf/NOLHGA082913.pdf ("Plan often includes benefits in excess of GA coverage that can be provided from estate assets allocated to policyholders' equal-priority uncovered claims against insurer.") (emphasis added).

[29] *See, e.g.*, Motion for Approval of Procedure for Notice, Comment and Hearing on Liquidator's Recommendations as to Methodology to Be Employed in Evaluating Policyholder Value, *In the Matter of the Liquidation of Inter-American Ins. Co. of Illinois*, No. 91 CH 10189, (Cook Cty. Cir. Ct. July 23, 1993), Appendix, tab 3 at Mot. ¶ 4 ("The liquidator believes that there are three different groups who have a substantial interest in the valuation of these claims. The first is the policyholders themselves. *The second group is comprised of the various guaranty associations, who are subrogated to the policyholders to the extent of*

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claim that GAs are entitled to all assets of the estate attributable to covered policies is thus baseless.

Further, their position falls apart under a simple hypothetical. In a similar estate, assume that more assets are available to the estate (though it remains deeply

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their payments on the policyholders' behalf . . . .") (emphasis added); *id.* at Ex. A ("The Guaranty Associations which have provided coverage for Inter-American policies succeed to the claim of the policyholders against the Estate of Inter-American. *When the Guaranty Association has provided only partial coverage for any given policy, the policy value will be divided between the policyholder and the Guaranty Association in proportion to their interests.*") (emphasis added); Rehabilitation Plan for Covenant Mutual Insurance Co., 24, Supplemental Appendix, tab 8 ("A Guaranty Association shall be entitled to payment of administrative expenses under Class One and GA Subrogation Claims under Class Three on the basis of actual payments made by the Association to or for the benefit of Covered Claim Holders . . . . "); *see also* Plan for Disbursement of Assets to Guaranty Associations Pursuant to R.C. Section 3903.34, *Liquidation of American Chambers Life Insurance Company,* , Case No. 00 CV H03-2206 (Ct. Com. Pl., Franklin Cnty., Ohio), Appendix. tab 1, Ex. A to Order, Sec. II.G ("The liquidator shall make the following calculations and determinations based upon the best information available to him: . . . G. The estimated total amount of non-administrative expenses claims for statutory benefits paid or continuing coverage provided, and amounts reserved for the same, by the Associations to discharge obligations covered under state guaranty association statutes. *The Associations' claims for statutory benefits paid and continuing coverage provided are entitled to Class 2 priority . . . .*") (emphasis added); *id.* Sec. II.H ("The estimated total amount of claims that are entitled to Class 2 priority under R.C. § 3903.42(B), but are not covered by state guaranty association statutes. This amount shall include valid claims under policies of insurance issued or assumed by ACLIC that are not covered by the insurance guaranty associations, and amounts which exceed the guaranty association coverage provided under their respective statutes."); *id.* Sec. II.I ("The estimated total amount of claims that are entitled to Class 2 priority under R.C. § 3903.42(B) (the sum of Paragraph G. and Paragraph H. above).").

insolvent), but at the same time policyholders' claims and anticipated claims are generally much larger, exceeding GA limits in a majority of circumstances. Assume the insurer wrote level-premium whole life insurance with large death benefits and has policy reserves of $1 billion for that business. Assume further that the insurer has $800 million in assets and the GAs, due to statutory limits, assume only $300 million of liabilities. Under the Health Insurers' theory, the GAs would get $800 million in assets and only $300 million of liabilities. If the GAs only received the $300 million in assets, and any claims for the uncovered portions of claims disappeared, the insolvent insurer would then become solvent, with $500 million of assets. Such a result would be absurd, while precluding the estate from allocating assets to valid policyholder claims.

Even if the Health Insurers are willing to retreat from this position and argue only that they are entitled to all of the reserve because the reserve is not adequate to satisfy GA obligations, this, too, is absurd. Requiring that all the assets be transmitted to the GAs would injure policyholders with claims with values exceeding the cap by leaving them with no effective remedy. Such discrimination would result in a preference to GAs to the prejudice of policyholders entitled to assert the same level of priority claim against the estate. Moreover, policyholders with lesser claims would be entitled to the same ultimate amount as those with larger claims, defeating the pro rata strategy for equitable distribution of

unavoidable loss to the policyholders. This is just as unfair as it is unlawful. *See, e.g.*, *Exec. Life*, 2012 WL 1577968, at *4 (noting how alternative distribution method would be "both illegal and discriminatory").

Ultimately, the Health Insurers misconstrue and mischaracterize the position of the GA as an estate creditor. Contrary to what the Health Insurers suggest, GAs cannot be elevated above the policyholders in the statutory distribution scheme, except in the limited circumstances of recovery of claim-handling expenses. *See* 40 P.S. § 221.44(a) (providing for payment of "the expenses of a guaranty association in handling claims"). In respect of a GA's assigned share of a claim to which it is the subrogee, it is entitled to assert a claim based on a proportionate allocation derived from its subrogated right, *and nothing more*[30] (at the policyholder priority level). 40 P.S. § 991.1706(m)(2). While a GA might receive or hold additional assets for a time based on the early access processes and its "deemed" creditor status, it ultimately does not receive any greater proportion of assets based on 40 P.S. § 991.1712(c). A GA's entitlement to assets will be based on its rights of subrogation, and its proportionate rights to policyholder-level

[30] Logically, then, the policies cannot be cancelled without claims for future benefits, because the GAs would not be entitled to assert a claim against the estate in that scenario. Such an outcome would be absurd.

claims under the priority statute. 40 P.S. § 221.44(b). The Health Insurers' avowed position on this point is entitled to no credibility.

6. Justice Saylor's *Warrantech* concurrence undermines the Health Insurers' position.

Finally, even if the Court were to reject the Rehabilitator's fully supported and reasonable interpretations of the relevant laws, Justice Saylor's concurring opinion in *Warrantech* suggests that the Court should consider the overall purpose of Article V, and interpret it in a manner that achieves its objective of protecting the insurance consumer:

> I am unable to discern anything within the statutory liquidation and distribution scheme that would prevent proofs of claim (POCs) based on losses that fall outside Section 521's time window from being resolved via the ordinary distribution process undertaken by the liquidator. Indeed, to hold that POCs for such losses must automatically be assigned a zero value would run directly counter to Article V's stated purpose to equitably apportion loss and thereby protect insureds, creditors, and the public generally . . . .

96 A.3d at 359. Justice Saylor added, "It would make little sense to read the Act as mandating that claims against the estate falling in to priority level (c) and below may be paid out from the estate's assets, whereas claims (such as those at issue here) at priority level (b) have no value and cannot be paid out at all, simply because, under Section 521, they were no longer insurance claims as such." *Id.* These comments resonate with the Rehabilitator, particularly because the result of applying the statute as argued by the Health Insurers would lead to an absurd

outcome as argued in this and prior briefs, defeat the plain intention of the legislature to protect policyholders, and irrationally benefit lower level creditors to the prejudice of the parties in need of greatest protection.

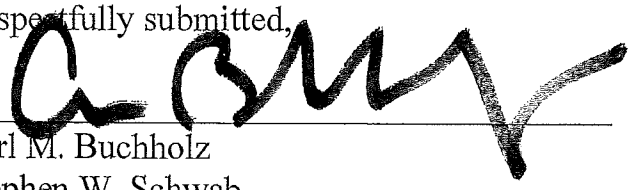
The Rehabilitator submits that the Second Amended Plan is lawful and an appropriate exercise of discretion, and respectfully asks that it be approved over Health Insurers' objections, which should be firmly and definitively overruled in these proceedings.

III. CONCLUSION

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

Dated: July 17, 2015

Respectfully submitted,



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CERTIFICATE OF SERVICE

I certify that I will cause a Notice of Filing of the foregoing Rehabilitator's Supplemental Brief Regarding "Uncovered Benefits" in the Second Amended Plan 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 July 17, 2015, I served the foregoing Application for Relief, upon Intervenors Penn Treaty American Corporation and Eugene J. Woznicki as follows:

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