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**IN THE COMMONWEALTH COURT OF PENNSYLVANIA**

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

**SURREPLY IN FURTHER OPPOSITION TO THE APPLICATION FOR INTERVENTION FILED BY CERTAIN HEALTH INSURERS**

Teresa D. Miller, Insurance Commissioner of Pennsylvania, in her capacity as Statutory Liquidator for Penn Treaty Network America Insurance Company ("PTNA") and American Network Insurance Company ("ANIC"; collectively, the "Companies"), hereby submits this Surreply in Further Opposition to the Application for Intervention Filed by Certain Health Insurers. For the reasons set forth herein and in the Liquidator's Brief in Opposition, this Court should deny the Application to Intervene.

## ARGUMENT IN SURREPLY

### A. The Health Insurers Cannot Change the Effect of this Court's Prior Order by Mischaracterizing its Meaning

The Health Insurers take issue with characterizing the prior ruling as the "law of the case." But this nitpicking at terminology misses the point: whether the law of the case or otherwise, the Order correctly found that the Health Insurers' assessment obligations are not grounds for standing. In support of their argument, the Health

Insurers try to write this Court's prior Order out of the record by claiming the Court made no findings with respect to standing to challenge the Non-GA policyholder payments. The claims of standing in both instances, however, were based on increased assessments. The Court *did* rule on whether assessments created standing, as the Liquidator explained in her primary Brief in Opposition and reviews briefly here:

- In its Opinion, this Court stated that "as a threshold matter, the Court must decide whether . . . Health Insurers have standing to object . . . ."
- In its Opinion, this Court stated that "the burden of the assessments from the state insurance guaranty associations . . . does not constitute a direct or immediate interest" for purposes of a standing analysis.
- Before abandoning their appeal of the issue, the Health Insurers identified the following among the questions presented for review: "Did the Commonwealth Court err in concluding that the Health Insurers did not show a 'direct and substantial interest' in the approval of the Settlement Agreement?"

Opinion and Order at 4-5, *In Re: Penn Treaty Network Am. Ins. Co.*, No. 1 PEN 2009 (Pa. Commw. Ct. Sept. 23. 2016); Jurisdictional Statement to October 20, 2016 Appeal, attached hereto as Exhibit F.

It is therefore disingenuous and misleading for the Health Insurers to now say the Court did not make that finding. The Court rejected increased assessments as a basis for the Health Insurers' standing then, and they have offered no persuasive reason why it should not do so again now.

The Court's decision in September also recognized that the Health Insurers prior involvement in the case did not automatically confer standing with respect to

every issue in the Companies' receivership. Moreover, even if the Health Insurers had accurately characterized their involvement during the rehabilitation proceedings, Article V makes an important distinction between the more collaborative rehabilitation process and the liquidation of an insolvent insurer. Pennsylvania law provides that "the cooperation and management expertise of the insurance industry" is important for "*rehabilitating* insurers." 40 P.S. § 221.1 (emphasis added). The statute does not anticipate this level of cooperative involvement by the industry during liquidation. This Court's decision to allow the Health Insurers to participate in certain of the rehabilitation proceedings is consistent with Section 222.1, but it is not a reason to require continued participation here now that the Companies have moved to liquidation.

Indeed, this Court has already explained the difference between participating in the rehabilitation approval process and obtaining standing to intervene. The Court's decision to allow the Health Insurers to participate in certain proceedings arose as part of a broader collaborative process in which the Court entertained comments on the proposed Second Amended Plan of Rehabilitation from various potentially interested parties. *See* July 8, 2013 Letter to "Policyholders, Agents, Creditors, and Persons Interested in the Affairs" of the Companies, attached hereto as Exhibit G. After the Policyholders Committee moved to strike the Health Insurers' comments to the proposed Second Amended Plan of Rehabilitation, the

Court issued an order declaring that the "Health Insurers are not intervenors in these proceedings. They are "Formal Commenters" pursuant to a Case Management Order . . . which *placed no limit on who could file comments.*" *See* Opinion and Order at 2, *In Re: Penn Treaty Network Am. Ins. Co.*, No. 1 PEN 2009 (Pa. Commw. Ct. Apr. 17, 2015) (emphasis added). In so doing, the Court explained that the standard for standing and intervention which the Health Insurers now claim to satisfy based on their prior participation was not at issue in the rehabilitation commenting process. *Id.*

Thus, the Health Insurers' prior involvement is irrelevant to the question of intervention in liquidation based on the statutory differences between rehabilitation and liquidation, as well as the Court's prior order explaining that the Health Insurers were participating as commenters rather than Intervenors with standing.

The Health Insurers' reliance on federal appellate decisions is also unavailing and does not require changing the approach this Court adopted in its prior ruling. None of the three cases cited by the Health Insurers on their "active participant" theory involve Pennsylvania law, and all three address the issue of appellate standing rather than intervention at the ground level. As one of the cited decisions explained, appellate standing is a different question than standing or intervention in the lower court proceedings. *City of Cleveland v. Ohio*, 508 F.3d 827, 836 (6th Cir. 2007).

Guaranty association assessments do not create a substantial interest; this Court made that finding in September and should do so again now in denying the Application to Intervene.

## B. Nothing in the Health Insurers' Reply Establishes an Interest Meeting the Standing Standard

Guaranty association assessments as a category of harm are insufficient to give standing in insurance liquidation proceedings. The Health Insurers belatedly seek to show the extent of the assessment, but this mathematical analysis, apart from lacking a proper foundation, misses the point.

It is important to note that the Health Insurers misunderstood or misrepresent the Liquidator's reliance on the "zone of interests" protected in Article V. The Liquidator does *not* claim the zone of interests should be the definitive test. Instead, the Liquidator contends that the Article V interests are simply relevant considerations in a standing analysis. Not every protected interest will have standing, but the Court should be skeptical of intervention requests by those outside of the interests protected by Article V. Moreover, the Health Insurers are far more like shareholders than they are ready to admit. Other creditors, like the Health Insurers, may have restrictions placed on their ability to dispose of shares or debt. Similarly, some shareholder or other ownership agreements require capital contributions to the issuer on demand. Thus, the fact that the Health Insurers must pay assessments is not unique nor does it create a category of harm establishing

standing. Like shareholders, the Health Insurers may have a financial interest but it is not one recognized for purposes of intervention in liquidation.

The Health Insurers also try to provide more detail on their interests, but it is too little too late. The Health Insurers have now told three different stories about the ways in which assessments might affect them: the incomplete and misleading allegations of harm verified by their counsel in the Application to Intervene, the assurances given to regulators and the public that assessments will be accounted for and recovered, and the unfounded and still incomplete and misleading picture presented in the Reply brief. The Health Insurers rely upon the version of events convenient for the moment because there is no actual and substantial harm warranting intervention that they might suffer.

The Health Insurers have also changed their view of the guaranty associations. After contending that the guaranty associations' interests do not align with the Health Insurers' interests, the Health Insurers now claim that guaranty associations merely "act as the agent of the member insurers in the receivership and as a conduit for gathering the assessments." (Reply Brief at 10.) This agency relationship is purportedly a new grounds for standing, but, again, the Health Insurers seek to choose the narrative based on their needs rather than fact. The Health Insurers later argue that the statutory administrative remedies are insufficient because they cannot control the guaranty associations. This agency concept is too inconsistent with the

Health Insurers' other arguments in the application and elsewhere to warrant consideration.

### C. The Alleged Harm Remains Speculative Even After the Health Insurers Made a Wrongful Second Attempt at Proving Their Interests

As set forth herein, the Liquidator opposes the concept of insurer intervention based solely on assessments. If the math matters, however, the Health Insurers still fail to show any substantial interests.

Rule 3775 of the Pennsylvania Rules of Appellate Procedure sets forth the applicable procedures and requirements for intervention into these proceedings. Section (c) of the rule provides that intervention shall be allowed "if the proven or admitted allegations of the application establish sufficient interest in the proceedings. . . ." The Health Insurers have failed to prove such interest and such interest has not been admitted.

This is not the Health Insurers' first opportunity to establish that potential future guaranty association assessments constitute a sufficient interest. As explained in the Liquidator's principal Brief in Opposition, the Health Insurers filed objections to an Application for Approval of Settlement in 2016 objecting to a settlement pursuant to which, among other things, the Companies would pay their shareholder, Penn Treaty American Corporation (PTAC) $10 million. The Health Insurers asserted that such payment would circumvent the statutory distribution scheme under Article V and exceeds the benefits of the settlement to policyholders,

claimants, and the public. The Revised Objection at fn. 3 states: "[T]he Health Insurers are the parties that will bear the burden of the assessments from the state insurance guaranty associations. Their opposition to the Application, should, by itself, cast serious doubt on the value of the reduction at issue" [referring to the Receiver's assertion that the settlement would result in a reduction of the burden on state insurance guaranty association].

This argument was rejected by the Court, which found that the Health Insurers did not have standing and did not have a substantial interest arising from the assessments. The Health Insurers began an appeal on that specific issue but then withdrew it.

The Health Insurers now attempt to reassert their assessment interest argument supported first by an application verified only by their litigation counsel and then, in response to the Liquidator's answer to that application, an affidavit from a consultant to the Health Insurers (the "McDermott Affidavit"). The McDermott Affidavit should be stricken or given little or no weight. First, it is untimely. The time to make factual assertions was when the Health Insurers prepared the Application. In their Application, they were far from candid with this Court by failing to state that the alleged assessment liabilities could be recovered by tax offsets and policy surcharges. Only after the Liquidator identified this glaring deficiency did the Health Insurers attempt to bring new evidence, if it may

be generously characterized as such, which should have been included in their Application for Intervention if the Health Insurers wished to make full disclosure to the Court. Second, much of the McDermott Affidavit is not based on McDermott's personal knowledge and it relies on inadmissible hearsay and unfounded or baseless assumptions. *See* McDermott Aff. ¶¶ 3-5 (noting that findings are based on "publicly available information" and "understanding of the methodologies used by guaranty associations" leading to guesses as to what the recognized losses *might* be). Third, it is full of legal conclusions and fails to provide a factual basis to give it any weight. For example, nowhere have the Health Insurers provided proof of (i) what their assessments will be or how they will be determined, (ii) when will they be made and paid, (iii) how will any distributed estate assets be allocated by the guaranty associations among their number (which will have a bearing on whether any reduction in distributions could impact the amount, if any, of alleged unreimbursed assessments), (iv) why assessments cannot be recovered immediately through policy surcharges in the states that provide for them, or (v) why the use of a surcharge might make an assessed Health Insurer's product uncompetitive.

Note, even assuming UnitedHealth paid all of its alleged $350 million assessment liability immediately (and there is no proof that it will), it represents only 1/5$^{th}$ of 1% of its annual premium revenue of $144 billion. *See* Relevant

portions of 2016 10-K, attached as Exhibit H hereto. Surely the addition of such a small amount to its premium would not make its products uncompetitive in markets, if any, where it competes with insurers not subject to guaranty association assessments.

In addition, neither the Health Insurers' Reply nor the McDermott Affidavit advises this Court that the guaranty associations are pursuing rate increases on the Penn Treaty policies for which they have become responsible. *See, e.g.*, Request to Pennsylvania Insurance Department for Premium rate Increases dated March 22, 2017, attached as Exhibit I hereto.[1] They have also devised a plan to offer policyholders options in lieu of premium rate increases, including a lump sum cash payment, aimed at significant reducing the guaranty associations' obligations. Nowhere is this explained to the Court.

The McDermott Affidavit and the evidence in the Reply brief are untimely and should not be considered. Even if the Court examines the new contentions, however, it will find that the Health Insurers remain unable to establish standing.

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[1] The rate request is available as a public record from the Pennsylvania Insurance Department and the Court is requested to take Judicial Notice of these documents. Pa. R.E. 201(c)(2).

## D. The Health Insurers Provide No New Facts Showing Exhaustion or Relief from Administrative Requirements

The Health Insurers mischaracterize the Liquidator's position on administrative exhaustion as limiting standing, in all cases and for all time, to the guaranty associations. What the Health Insurers seem to ignore is that Pennsylvania has provided them with administrative remedies which they chose not to pursue. *E.g.*, 40 P.S. § 991.1709(c); Model GA Act § 11C. Under Pennsylvania law, this precludes them from now seeking relief in this Court. *Ohio Cas. Grp. v. Argonaut Ins. Co.,* 514 Pa. 430, 435 (1987).

The Health Insurers argue that their dislike for the process is reason to excuse them from its requirements. This is simply not the law, nor should this Court judge the wisdom of the legislature's approach. The Health Insurers objections, even if considered, wrongfully portray them as pressed for time in the Liquidation proceedings. But the Health Insurers have known of the proposed Non-GA policyholder payments for years. The Health Insurers could have pressed for action by the guaranty associations or demanded a commitment to later action. If the guaranty associations failed to so act or commit, the Health Insurers could have contested that decision in the ways set forth in 40 P.S. § 991.1709(c). The Health Insurers failed to show that they did so; to date, the Health Insurers have obtained only one letter promising to consider taking action if the Health Insurers do not become parties to these proceedings.

Indeed, the Health Insurers throw up their hands on controlling the guaranty associations in the same Brief in which they admit that the guaranty associations act as their agents. This contradiction shows that the Health Insurers could have followed the process but chose not to do so. Their failure to exhaust administrative remedies should be fatal to their application.

### E. The Health Insurers Response Does Not Change This Court's Due Process Analysis

The Health Insurers have no due process right to intervene and the Reply offers no additional reason to hold otherwise. To the contrary, the Health Insurers continued insistence that the guaranty associations "cannot adequately represent the Health Insurers' interests" is flatly inconsistent with the agency relationship portrayed elsewhere in the Reply. The Health Insurers suffer no due process injury where the guaranty associations are controlled by the Health Insurers to act only as their agents.

## CONCLUSION

As explained in her Brief in Opposition and herein, the Health Insurers cannot show a substantial interest of the type recognized under Rule 3775 sufficient to confer standing. The Court should deny the Application to Intervene and allow these proceedings to move forward without the continued involvement of the Health Insurers.

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Respectfully submitted,

/s/ James R. Potts

James R. Potts
Michael J. Broadbent
**COZEN O'CONNOR**
One Liberty Place
1650 Market Street, Suite 2800
Philadelphia, PA 19103
Tel: 215.665.2000
Fax: 215.701.2102

Leslie Miller Greenspan
Carl E. Singley
Kevin L. Golden
**TUCKER LAW GROUP, LLC**
Ten Penn Center
1801 Market Street, Suite 2500
Philadelphia, PA 19103
Tel: 215.875.6609
Fax: 215-559-6209

*Attorneys for Teresa D. Miller, Insurance Commissioner of Pennsylvania, in her capacity as Statutory Liquidator of PTNA and ANIC*

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