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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

OMNIBUS RESPONSE OF COMMISSIONER TERESA D. MILLER, IN HER CAPACITY AS STATUTORY REHABILITATOR, TO OBJECTIONS TO APPLICATION FOR SETTLEMENT APPROVAL

After years of difficult and often contentious negotiations (against a backdrop of expensive and time-consuming litigation), the Commissioner[1] has reached an agreement with PTAC that promises to eliminate a substantial portion

[1] Defined terms used in these responses are as set in the Application for Approval of the Settlement.

of the Companies' recurring expenses and, more importantly, resolve difficult tax issues and remove an obstacle to conversion of the proceedings from rehabilitation to liquidation. The Agents and the Health Insurers[2] (together, "Objectors") overlook this accomplishment, and instead would recast the consideration to be paid as a violation of liquidation distribution priorities, and condemn the deal as opportunistic, devoid of demonstrated merit, and bad public policy.

The Court should overrule the objections and approve the Settlement at the earliest opportunity for the benefit of the Companies' policyholders and other creditors, for three main reasons. First, the Companies will move quickly into liquidation, triggering valuable guaranty association protection for policyholders, saving the estates tens of millions of dollars (in administrative expense, agents' commissions, and actuarial and attorneys' fees), and enabling a strategy for mitigating substantial tax risks. Second, the Settlement Agreement details a resolution of disputed legal and tax issues that confers substantial benefits. And third, requiring a reasonable bond will protect the Companies' estates from vexatious litigation over the Settlement. For these reasons, as further developed below, the Settlement Agreement is fair and reasonable, furthers the best interests

[2] On July 21, 2016, the Court received a belated comment on behalf of a lone policyholder, characterizing the Settlement Agreement as "vile," "unfair," and "hidden from policyholders." Nothing about the Settlement Agreement is secret; the Commissioner publicly filed it of record, and the Court has received objections about it. More importantly, as described herein, the Settlement Agreement provides multiple material benefits to policyholders.

of the Companies' policyholders and creditors, and the general public, and should be approved as a reasonable exercise of the Commissioner's sound discretion.[3]

I. ARGUMENT

A. Established receivership law commits the settlement of litigation disputes to the Rehabilitator's discretion.

Objectors ignore established insurer receivership law governing the approval of settlements and improperly claim that bankruptcy law—which can apply here only by potential analogy—somehow imposes a more exacting standard that the Commissioner has failed to satisfy. They are wrong.

Initially, Objectors would improperly limit application of the Pennsylvania Supreme Court's holding in *In re Penn Treaty Network America Insurance Co.*,

[3] The Commissioner anticipates that, in response to the Objectors, the PTAC Intervenors may highlight a variety of disputed tax issues, including but not limited to the interpretation and effect of the tax sharing agreement to which the Companies and PTAC are parties and whether the Commissioner has the authority to use NOLs without PTAC's consent. The Commissioner has contested the PTAC Intervenors' positions on numerous tax issues, and would continue to do so absent the Settlement Agreement. This is one of the key reasons why the Settlement Agreement holds value: the Settlement Agreement provides the policyholders and the Settling Parties with certainty surrounding those issues. *See Linney v. Cellular Alaska P'ship*, 151 F.3d 1234, 1242 (9th Cir. 1998) ("The very essence of a settlement is compromise, a yielding of absolutes and an abandoning of highest hopes."). Nonetheless, if the Settlement Agreement is not approved or otherwise does not take effect, the Commissioner reserves her right to dispute issues advanced by the PTAC Intervenors. The Commissioner respectfully requests that the Court refrain from entering an order that adopts any position raised by the Settling Parties as to any dispute between them, specifically, with regard to tax matters.

119 A.3d 313 (Pa. 2015). They suggest that it applies only to the "Rehabilitator's decision to seek conversion [to liquidation]." (Health Insurers' Obj. at 5.) In fact, the Supreme Court more broadly held that "judicial review . . . should proceed subject to a more deferential overlay relative to the . . . Commissioner." *Penn Treaty*, 119 A.3d at 323. That holding applies to the entire receivership, not simply to conversion petitions. *See id.*; *see also Foster v. Mut. Fire, Mar. & Inland Ins. Co.*, 614 A.2d 1086, 1093 (Pa. 1992). Hence, the Supreme Court has long recognized that the Commissioner must "'use reasonable discretion in the rehabilitation of a seized company, with abuses of discretion to be checked by the judiciary.'" *See Foster*, 614 A.2d at 1093 (quoting *Kueckelhan v. Fed. Old Line Ins. Co.*, 444 P.2d 667, 674 (Wash. 1968)).

No separate, higher burden applies to the Commissioner's action when settling disputed issues, and the Objectors have found no precedent for such a burden. Receivership courts have repeatedly held that, under the abuse of discretion standard, the Commissioner need only demonstrate that a settlement is "fair and reasonable" to the insurer's estate and is in the best interests of policyholders. *See, e.g., In re Liquidation of Home Ins. Co.*, 913 A.2d 712, 725-26 (N.H. 2006) (applying fair-and-reasonable standard to affirm a settlement between the liquidator and policyholders); and *In re Exec. Life Ins. Co.*, 32 Cal. App. 4th 344, 358 (Cal. Ct. App. 1995) (holding that a receivership court may approve a

settlement upon a finding that it "overall [is] reasonable and to the benefit of the insolvency estate").

The Health Insurers mistakenly assert that "the cases cited by the Rehabilitator [in support of a deferential standard of review] do not support it" (Health Insurers' Obj. at 6); indeed, the cited decisions expressly reach that very holding. Thus, "the Court must give great weight and deference to the Rehabilitator's judgment that the Settlement Agreement is in the best interests of [the insurer] and its policyholders considered as a whole." *In re Rehab of Fin. Guar. Ins. Co.*, No. 401265/12, 2013 WL 4405157, at *2 (N.Y. Sup. Ct. Aug. 16, 2013) (unpublished) (emphasis added); *see also In re Golden Eagle Ins. Co.*, No. A094163, 2002 WL 1999757, at *10 (Cal. Ct. App. Aug. 30, 2002) (unpublished) ("Appellants acknowledge that the Commissioner is generally empowered to negotiate settlements subject to court approval, under an abuse of discretion standard…."). Accordingly, there is no basis to apply any other standard of review.

The Court should likewise reject the Health Insurers' assertion that the bankruptcy court holding in *In re Jevic Holding Corp.*, 787 F.3d 173 (3d Cir. 2015), is inconsistent with the abuse-of-discretion standard and approval of the Settlement. The Health Insurers misinterpret and misapply *Jevic*. Indeed, the *Jevic* court applied a fair and reasonable standard for settlement approval; the

decision provides a persuasive analogy that such a standard governs this matter. (Appl. ¶¶ 14-15.)

In fact, numerous bankruptcy courts have held that, when a trustee is appointed in a Chapter 11 reorganization, "[a]bsent evidence that the provisions of [a] Settlement are unreasonable, the court will defer to the trustee's judgment." *In re Marvel Ent't Group, Inc.*, 222 B.R. 243, 250 (Bankr. D. Del. 1998); *accord In re Indian Motocycle Co.*, 289 B.R. 269, 282 (B.A.P. 1st Cir. 2003) ("Compromises are generally approved if they meet the business judgment of the trustee.").

And a state supreme court has recognized that these bankruptcy principles are analogous to state insurer receivership law. *See Home Ins. Co.*, 913 A.2d at 726 (citing the bankruptcy principle regarding deference to trustee's settlement recommendation in connection with upholding the receivership court's determination that a settlement was fair and reasonable).

B. The record establishes the Settlement Agreement is fair and reasonable, and should be approved.

Objectors claim the Settling Parties have fallen "short of providing the evidentiary support" to establish the Settlement's benefits. (Agents' Obj. at 3; *see also* Health Insurers' Obj. at 9-24.) They claim that the Settlement is "too vague to evaluate its value to the estate" (Heath Insurers' Obj. at 19) and designed simply "for the convenience of the Rehabilitator by removing an obstacle to liquidation"

(Agents' Obj. at 4). The Court should overrule those objections because they ignore the substantial benefits that the Settlement Agreement provides.

1. The Settlement Agreement will yield millions of dollars in cost savings to the Companies' estates.

The Health Insurers challenge the settlement because "it cannot be seriously maintained that there would be a basis on which to challenge the [Commissioner]'s judgment to seek liquidation," and suggest that the value of the settlement is therefore illusory. (Health Insurers' Obj. at 13.) That objection, however, ignores a key benefit of the Settlement Agreement: the *expediency and cost efficiency* with which liquidation can be achieved because the PTAC Intervenors have agreed not to oppose a conversion petition. Regardless of the evidentiary basis for liquidation—and the Commissioner agrees that "the issue of liquidation here is not materially in doubt," (Health Insurers Obj. at 17)—absent the settlement, the PTAC Intervenors would retain the statutory right to contest a conversion petition under § 518(a), 40 P.S. § 221.18(a), all at the Companies' expense. The record reveals that the prior conversion hearing spanned 29 days of testimony over a nearly nine-month period, preceded by more than six months of informal discovery and negotiations and six months of formal discovery involving more than a dozen depositions and numerous expert reports. And absent this settlement, the PTAC Intervenors could also appeal from the liquidation order. Even if the parties

proceeded on an expedited basis, it is unlikely that all of trial and appellate proceedings could be concluded in less than a year.

The costs of estate administration alone during that time far exceed the $10 million value of the Settlement Agreement. In the absence of this resolution, a protracted liquidation hearing would cost the Companies many millions in premium taxes, agents' commissions and litigation expenses. Those expenses will be substantially reduced if the settlement is approved and the PTAC Intervenors do not contest liquidation. In no respect is the Settlement Agreement "too vague" (Health Insurers Obj. at 19), or lacking "fair value," (Agents Obj. at 5).[4]

2. The Settlement Agreement resolves disputed issues.

The Health Insurers mistakenly fault the mutual releases as valueless because there are no open disputes—"no war," as the Health Insurers say—between the Commissioner and the PTAC Intervenors. (Health Insurers Obj. at 13.) The Health Insurers ignore the state of the record and would have the Court believe that there is already "peace" simply because a hiatus exists in respect of multiple disputed issues between the Settling Parties. Initially, no one can dispute

[4] The Health Insurers repeatedly describe the proposed settlement as authorizing a payment of $15 million to the PTAC Intervenors. (Health Insurers' Obj. at 9.) On its face, however, the MOU provides for a cash payment of only $10 million. The remaining $5 million—if it is paid at all—would be made as a capital contribution to AINIC (not directly to the PTAC Intervenors) in connection with a sale of that entity that the Settling Parties would "negotiate in good faith." (MOU, ¶ I.G.2.) This is purely contingent on circumstances outside these proceedings.

that material disagreements related to tax issues and attributes have been at the center of the principal matters addressed by the Court in the past nine months of this receivership. Moreover, the following fully briefed but undecided disputes remain pending between the Commissioner and the PTAC Intervenors:

- the PTAC Intervenors' Objections Regarding the Propriety of Liquidation;
- the Commissioner's Application and subsequent filings re standard of review (initially filed February 2, 2015); and
- Commissioner's Application to Bar Intervening Parties from Calling Commissioner Miller to Testify (filed December 7, 2015).

The Health Insurers' assertion that there are no "disputes that need to be settled … [because] there are none currently pending" is simply incorrect. (Health Insurers' Obj. at 22-23.) Absent the settlement, important issues remain outstanding between the Commissioner and the PTAC Intervenors that would need to be litigated in a liquidation hearing. The mutual releases in the Settlement Agreement resolve those matters and, more importantly, avoid the related litigation costs. Far from being illusory, those releases provide a real, immediate benefit to the Companies' policyholders and creditors.

3. The Settlement Agreement provides immediate tax benefits regardless of the outcome of the PLR.

The Health Insurers fault the Settlement Agreement because money will be paid regardless of whether the PLR is successful. (Health Insurers' Obj. at 9-10.)

This overlooks the substantial potential benefits of the PLR, which would be much more difficult, if not impossible to achieve without the Settlement. It also misses the point of the PLR submission. To be sure, the PLR represents potential savings in tax liability, greatly exceeding the settlement cost. Certainly, the Commissioner hopes that the IRS will grant the requested rulings. But the PLR process otherwise holds value because it will provide certainty to the Companies and policyholders regarding tax matters, ***regardless of its outcome.***

A PLR cannot be requested without the agreement of PTAC (the common parent of the tax group of which PTNA and ANIC are members).[5] *See* Treas. Reg. § 1.1502-77(a)(1). PTAC had taken the position that it was not required to cooperate with the Commissioner. That cooperation provides a valuable benefit to the Companies and their policyholders, and is gained only by virtue of the Settlement Agreement.

Accordingly, the Settlement Agreement provides immediate, concrete benefits to the Companies' estates and is in the best interests of its policyholders and creditors.

[5] The IRS advised the Companies in August 2015 that PTAC would need to be involved in the process.

C. The Settlement Agreement does not violate the statutory priority scheme.

Objectors assert that the payments provided in the Settlement Agreement circumvent the statutory priority of distribution scheme under § 544 of Article V, 40 P.S. § 221.44. They are wrong for two main reasons:

- First, § 544 on its face sets priorities for distribution of estate assets (money) in satisfaction of administrative expenses and proofs of claim filed in liquidation proceedings, with claims filing deadlines applying to the filing of proofs of claim. 40 P.S. § 221.44. In rehabilitation, absent a Court-approved rehabilitation plan providing for the filing of proofs of claim and setting a claims filing deadline, there is no such deadline and no proofs of claim for the payment of money are required or filed. Rather, all contractual and other monetary claims and obligations are paid as they come due.
- Second, the Settlement Agreement resolves disputes that have arisen over both purported rights to certain estate tax assets and the meaning and application of the governing receivership law in rehabilitation. The Agreement results in the conferral of benefits to the estates in the form of substantial tax and other assets, as well as the resolution of numerous legal issues. The Objectors' protestations notwithstanding,

it does not involve or amount to a determination of the value of an equity holder's interest.

Assuming strictly *arguendo* that § 544 applies, it directs that the "order of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is herein set forth." 40 P.S. § 221.44. Section 544(a) specifies the first level of priority as "[t]he costs and expenses of administration, including but not limited to . . . *the actual and necessary costs of preserving or recovering the assets of the insurer*." *Id.* (emphasis added). Payment of the settlement consideration fits squarely within those parameters.

The Settlement Agreement payments are a "necessary cost of preserving and recovering assets" of the estates. *Id.* The two principle benefits of that agreement are (1) the substantial litigation-related cost savings, and (2) the tax certainties and savings gained from the PTAC Intervenors' cooperation in the PLR process. These benefits are entirely unrelated to any equity claim against the assets of the Companies' estates that the PTAC Intervenors might advance under § 544(i). Such a claim would not encompass tax issues, nor result in an agreement that the Companies may use all of the PTAC Group's NOLs in the event the PLR is not granted, and only reattribute NOLs to PTAC if the PLR is granted or NOLs are not exhausted, and then only in an amount not to exceed PTAC's tax basis.

The Settlement Agreement arranges for a coordinated tax strategy to mitigate tax liability for the Companies' estates, and therefore conserves and maximize assets available to pay policyholder claims. The Commissioner can only advance that strategy with the PTAC Intervenors' cooperation., *see* Treas. Reg. 1.1502-77(a)(1), and this Court has so required. The Settlement serves the purpose and permits the Companies to resolve significant tax issues for the Companies' estates and policyholders, including: (1) whether the Companies will incur discharge of indebtedness income as a result of cancelling part of their liabilities to policyholders; (2) control over the Companies' net operating loss carryforwards ("NOLs"); (3) whether PTAC has the right to take a worthless stock deduction; and (4) whether policyholders, as a result of policy restructuring, will experience adverse tax consequences. Litigation of those issues has already cost the estates hundreds of thousands of dollars, and, absent settlement, would cost hundreds of thousands more. Thus, the Settlement Agreement specifically relates to "preserving" the "assets of the insurer[s]" and provides for payments representing the "actual and necessary costs" thereof. It is entitled to treatment as a cost of administration under § 544. 40 P.S. § 221.44(a).

The Commissioner—keeping in mind the best interests of the Companies' policyholders and creditors, and the general public—carefully weighed the costs and benefits of settlement after negotiating extensively and conferring with the

Court, and only then entered into the pending Settlement Agreement. That balancing of interests and selection of a settlement approach was well within her discretion regarding what is "in the best interests of [the insurer] and its policyholders considered as a whole." *Fin. Guar. Ins. Co.*, 2013 WL 4405157, at *2. Although the Health Insurers suggest that some alternatives may exist (Health Insurers.' Obj. at 11-12) to resolve the outstanding tax issues after lengthy and costly litigation that could involve yet another appeal, it is of no moment that the Objectors might have preferred a different approach.[6] The Commissioner need only demonstrate that the approach chosen constituted the sound and reasonable exercise of her discretion.

The Supreme Court of New Hampshire's decision in *In re Liquidation of Home Insurance Co.*, 913 A.2d 712 (N.H. 2006) fully supports this conclusion. In *Home*, the court held that the liquidator had authority to enter into an agreement with reinsureds of the insolvent company, entitling them to a negotiated payment if the reinsureds submitted all claims to the liquidator. It was asserted that the agreement had the effect of elevating the claims of reinsured's Class I priority for "administrative expenses," even though those claims would otherwise have been Class V (general creditor) priority under the New Hampshire priority statute.

[6] In point of fact, they identify no law to support and provide no risk/benefit analysis of those supposed alternatives.

In upholding the settlement, the court analyzed New Hampshire's Insurer Rehabilitation and Liquidation Act (the "New Hampshire Act"). Like Article V in Pennsylvania, the New Hampshire Act is based on the 1967 Wisconsin Insurers Rehabilitation and Liquidation Act, which the National Association of Insurance Commissioner's ("NAIC") adopted as the "Model Act." Pertinent to the *Home* court's analysis was the NAIC's drafting note to Section 801 (Priority of Distribution) of the 2006 Insurer Receivership Model Act ("IRMA"). There, the NAIC noted that:

> Implicit in the powers conferred on the liquidator under this Act . . . is the right, subject to approval by the receivership court, to pay Class 1 administrative costs to persons in any priority class where those Class 1 administrative cost payments assist or result in the collection or recovery of property of the insurer for the benefit of creditors of the estate. Payments of administrative costs in these circumstances do not constitute distributions so as to circumvent priority classes or establish subclasses within a class.

913 A.2d at 720 (quoting 3 NAIC, *Model Laws Regulations and Guidelines* 555-1 to 555-96, at 555-84 (2006)). Noting the similarities between IRMA and the New Hampshire Act, the *Home* court concluded that the broad language of the New Hampshire Act conferred this same authority upon the liquidator. 913 A.2d at 721. The court accordingly considered the agreement with the reinsureds to be part of the costs of administering the estate.

The structure of New Hampshire's and Pennsylvania's statutory schemes is substantially similar. The Settlement Agreement confers real and material net benefits to the Companies' estates, policyholders, and creditors, and it accords with *Home*. Thus, the settlement is consistent with the purposes of Article V in protecting the interests of insureds and creditors, 40 P.S. § 221.1(c), and it does not violate the priority statute addressing distributions in liquidation, 40 P.S. § 221.44.

The Health Insurers' challenge to the Settlement Agreement by reference to *Jevic* is unpersuasive precisely because of the scope of benefits the Agreement provides. (Health Insurers' Obj. at 7.) Although relevant only by analogy, *Jevic* nonetheless permits bankruptcy "courts [to] approve settlements that deviate from the priority scheme" when "they have 'specific and credible grounds to justify [the] deviation.'" *Jevic*, 787 F.3d at 184 (second alteration in original) (quoting *Iridium Operating LLC*, 478 F.3d 452, 466 (2d Cir. 2007)). Here, the settlement payment will produce a net benefit to creditors of the estate because it will reduce potential litigation risk and tax uncertainty, has a substantial chance of reducing tax liabilities, and will preserve estate assets. Moreover, settlement of the litigated dispute will remove the last objection to liquidation, allow for an efficient conversion to liquidation, avoid further litigation expense, and terminate premium taxes and agent commissions. Accordingly, even if the Settlement Agreement

deviated from § 544's priority scheme, those benefits would nonetheless be sufficiently "specific and credible" to support the deviation. *Id.*

D. The Settlement Agreement accords with public policy.

The Agents fault the Settlement Agreement as "bad public policy" (Agents' Obj. at 7), when, in fact, that Agreement reflects a measured and carefully considered judgment by the Commissioner, in her discretion and specialized expertise, that the terms of the Settlement Agreement will benefit the public and carry out the policy objectives of Article V.

The overriding purpose of Article V is "the protection of the interests of insureds, creditors, and the public generally[.]" 40 P.S. § 221.1(c). The Commissioner is empowered to take steps to carry out that purpose, including through liquidation and related means of conserving estate assets, with appropriate deference from the supervising court. *See Foster v .Colonial Assur. Co.*, 885 A.2d 1078, 1104 (Pa. Commw. Ct. 2005) ("[I]t is worth repeating the well-settled principle that the purpose of the liquidation provisions of [Article V] is to protect the interests of the insureds, the creditors and the public generally and to protect the Liquidator's power to act in furtherance of the public good without hindrance from the courts.").

The Settlement Agreement protects and furthers the public good by maximizing the share of assets and other financial resources that will be applied to

claims in accordance with the priority provisions of Article V, 40 P.S. § 221.44. As demonstrated, the Settlement Agreement conserves estate assets for the payment of policyholder claims, including those made by state GAs. As a result, it limits GAs' assessments of their member insurers, thereby decreasing the burden imposed on the public in the form of premium tax credits and deductions.

On the other hand, disapproving the Settlement Agreement would cause harm to the public by forcing the Commissioner to continue making expenditures out of the Companies' estates for premium taxes, commissions, and litigation costs. Without the PTAC Intervenors' cooperation on tax issues, the Companies could be exposed to substantial potential tax liability—additional costs that would be borne by the public. The Agents offer no rationale for why these consequences are preferable to the benefits that will flow from the Settlement Agreement.

Instead, the Agents blithely criticize the Settlement Agreement as inconsistent with the statutory mechanism enabling shareholders to oppose liquidation where appropriate (Agents' Obj. at 7), and as a purported subversion of creditor priorities, insofar as it provides for a payment to the Shareholders as cost of administration of the estate. (*Id.* at 8). Neither criticism is a basis for disapproving the Settlement Agreement.

First, liquidation of the Companies is not "an arbitrary or unsupported exercise of power by the [Commissioner.]" (*Id.*) The Companies are indisputably

insolvent, the Commissioner has attempted rehabilitation without success, and sufficient grounds exist for converting the rehabilitation to liquidation. The statutory scheme thus has operated properly, allowing the PTAC Intervenors to assert their rights and interests, including their prerogative to resolve contested issues without further litigation, in the face of facts favoring liquidation.

Second, the Agents are wrong to characterize the payments to be made under the Settlement Agreement as anything other than administrative costs and expenses within the meaning of § 544(a). As discussed in Part C, those expenditures will not be made in satisfaction of claims by the Shareholders against the estate; rather, the Commissioner will make them to obtain benefits for the Companies' estates, policyholders, creditors, and the public.

In sum, the Settlement Agreement is good public policy. It is consistent with the purposes and requirements of Article V, it maximizes estate assets to pay claims, and it benefits the public.

E. The requirement to post a bond is reasonable.

The Health Insurers and the Agents cast aspersion on the request that an appeal be conditioned on the posting of a bond, claiming that it is "punitive" in nature (Agents' Obj. at 8), and not authorized by the Pennsylvania Rules of Appellate Procedure (Health Insurers' Obj. at 24.) Neither contention holds merit.

1. The bond requested serves the proper purpose of protecting policyholder assets.

The purpose of a bond is to "protect [the prevailing] party from injury during the appeal period" against harms that would impair the value or benefit of a final judgment. *Commonwealth v. Mayer*, 569 A.2d 415, 418 (Pa. Commw. Ct. 1990). Bonds may be required both to ensure the collectability of a money judgment, *Groner v. Groner*, 476 A.2d 957, 960 (Pa. Super. Ct. 1984), as well as to protect against other financial harms resulting from an appeal, *In re Cardizem CD Antitrust Litig.*, 391 F.3d 812, 818 (6th Cir. 2004). For example, when approving a class action settlement, courts have "consider[ed] requiring an appealing objector to post an appropriate bond to protect the value of the settlement to the class members." *In re MetLife Demutualization Litig.*, 689 F. Supp. 2d 297, 352 (E.D.N.Y. 2010); *see also Alapattah Servs., Inc. v. Exxon Corp.*, No. 91-0986, 2006 WL 1132371, at *18 (S.D. Fla. Apr. 7, 2006) (requiring a $13.5 million bond from an objector pending appeal due to "the highly detrimental impact of an appeal of the settlement agreement as to the entire class"). An appeal bond may therefore include "[d]amages resulting from the delay and/or disruption of settlement administration caused by [an] appeal." *In re NASDAQ Market-Makers Antitrust Litig.*, 187 F.R.D. 124, 128 (S.D.N.Y. 1999). In fact, courts have recognized that an appeal often will have the "practical effect [of] prejudicing the other injured parties by increasing transaction costs and delaying disbursement of settlement

funds," and that a bond is proper to protect against that harm. *Cardizem CD*, 391 F.3d at 818.

The Commissioner has requested the proposed bond for those purposes. The Settlement Agreement will save millions of dollars in premium taxes and agent commissions alone. If implementation of the Settlement Agreement is postponed pending an appeal, policyholders currently on claim will continue to be paid in full at the expense of future claimants, as assets available to reimburse GAs and to pay for benefits in excess of GA caps will continue to be depleted. And, without a PLR as provided in the settlement agreement, the Companies could potentially incur an alternative minimum tax liability of approximately $20 million—a point that even the Health Insurers recognize. (Health Insurers' Obj. at 10.) The bond will apply to *all* persons; it is not limited to any one party.

The Commissioner is required to advance the interests of policyholders above all other creditors. *See Grode v. Mut. Fire, Mar. & Inland Ins. Co.*, 572 A.2d 798, 801 n.5 (Pa. Commw. Ct. 1990) ("[T]he equitable purpose of rehabilitation and liquidation is to protect *first of all* consumers of insurance."). Policyholders should not be required to continue to bear the costs of agent commissions, premium taxes, litigation fees, and potential exposure to a multimillion-dollar tax liability when the Settlement Agreement, if approved, would remove those expenses. Nor should individuals with interests divergent

from policyholders[7] be permitted to hold that exposure open without taking a financial stake in the liabilities that policyholders have so long borne. The requested bond therefore serves the proper purpose of protecting policyholders from continued harm during the pendency of any unsuccessful appeal from an order approving the Settlement Agreement.

Moreover, the adverse consequences of an unsuccessful appeal are not eliminated by appellants failing to seek supersedeas of the court's order. The substantial uncertainty resulting from an appeal and inevitable inability of the parties to rely on the order to make irreversible steps to implement the settlement would have substantially the same effect.

2. The Court has authority to enter the requested bond under Pennsylvania law.

The Health Insurers lastly suggest that the Court should not require a bond because "[t]he present matter is not a situation for which the legislature has created statutory authority to condition the appeal … on the posting of a bond." (Health Insurers Obj. at 27.) Although Pennsylvania courts require a statutory authorization before a bond can be ordered as a condition precedent to pursuing an appeal, *see PPM Atl. Renewable v. Fayette County Zoning Hearing Bd.*, 81 A.3d

[7] The Health Insurers' primary interest in these proceedings is to reduce their exposure to assessments issued by guaranty association to cover policyholder benefits in liquidation. The sole interest of the Agents is the continued payment of commissions that cease with the fixing of rights upon issuance of a liquidation order. *See* 40 P.S. § 221.20(d).

896, 902 (Pa. 2013) (finding that Pa. R.A.P. 1701 does not itself allow a court to require a bond as a condition of appeal), Article V provides the necessary statutory grounds for such relief.

Section 505 of that Article authorizes the Court to grant:

> [S]uch restraining orders, preliminary and permanent injunctions, and other orders as may be deemed necessary and proper to prevent:
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> * * *
>
> (iv) waste of the insurer's assets;
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> * * *
>
> (vii) the obtaining of preferences, judgments, attachments, garnishments, or liens against the insurer, its assets or its policyholders; [or]
>
> * * *
>
> (xi) any other threatened or contemplated action that might lessen value of the insurer's assets or prejudice the right of policyholders, creditors, or shareholders, or the administration of the proceeding.

40 P.S. § 221.5(a). That section grants the Court broad authority to enter orders for the protection the Companies' estates and policyholders and must be "liberally construed to effect [that] purpose," 40 P.S. § 221.1(b).

Section 505 allows the Court to impose the bond requested by the Commissioner for at least three reasons. First, as discussed previously, an appeal would delay implementation of the Settlement Agreement and would prevent the Commissioner from immediately seeking liquidation without opposition from

PTAC. Commissions and premium taxes would continue to be paid during this delay. Those payments would constitute a waste of the Companies' assets, as the Settlement Agreement contemplates a quick end to such payments. The Court may establish a bond to prevent such waste under Clause (iv) of § 505(a). Second, continued delay in entry of a liquidation order would contribute to an inequitable preference between on-claim policyholders and future claimants, in that current claims would continue to drain assets properly assignable to future ones. Clause (vii) allows the Court to enter an order imposing a bond to protect against those preferences. Third, Clause (ix) generally permits the Court to enter any order necessary to prevent prejudice to policyholders or diminishment of the value of the insurer's assets. A bond would serve those very purposes, by ensuring that the added delay associated with an unsuccessful appeal does not cause further financial harm to the Companies' policyholders and estates. The Commissioner therefore requests that the Court overrule the objections of the Health Insurers and Agents, and establish an appeal bond of $36 million as a condition of taking any appeal from a settlement approval order.

3. If the Court concludes that Pennsylvania law does not authorize a bond as a condition of the appeal, it should nevertheless establish the bond required to seek supersedeas.

If the Court declines to establish a bond as a condition of taking an appeal, the Commissioner nonetheless requests that the Court enter an order establishing

the amount of any bond required to seek a stay of a settlement approval order. As the Health Insurers recognize, even when a bond is not a mandatory condition to exercising the right to appeal, it is nonetheless required to obtain a supersedeas (i.e., a stay) of an order of the lower court. (Health Insurers Obj. at 25-26.); *see also* Pa. R.A.P. 1731(a) (proving that the posting of a bond automatically operates as a supersedeas of a money judgment on appeal).

The trial court has discretion to "impose such terms and conditions [on the posting of a bond] as it deems just and will maintain the res or status quo pending final judgment or will facilitate the performance of the order [on appeal] if sustained." Pa. R.A.P. 1733(a); *see also City of Pittsburgh v. Charles Zubik & Sons, Inc.*, 171 A.2d 776, 779 (Pa. 1961) ("In the circumstances present the court had wide discretion in setting the amount of the bond."). Accordingly, if the Court declines to require a bond as condition of taking an appeal, the Commissioner requests that the Court nonetheless require any party seeking supersedeas of an order approving the Settlement Agreement to post a bond totaling $36 million.

II. CONCLUSION

Accordingly, for the reasons set forth above and in the Joint Application for Approval of Settlement Agreement, the Commissioner requests that the Court overrule the objections raised by the Health Insurers and Agents and approve the proposed Settlement Agreement with the PTAC Intervenors. Additionally, the

Commissioner requests that any interested person taking an appeal of the settlement approval order be required to post an appeal bond of at least $36 million. If the Court declines to impose such a mandatory appeal bond, the Commissioner requests that the Court order any party seeking to stay execution of the Settlement Agreement pending appeal be required to post a $36 million supersedeas bond.

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Respectfully submitted,

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