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1 PEN 2009

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

ANSWER TO THE APPLICATION OF THE HEALTH INSURERS FOR LIMITED INTERVENTION

Teresa D. Miller, as Insurance Commissioner of Pennsylvania and in her capacity as Statutory Liquidator of Penn Treaty Network America Insurance Company ("PTNA") and American Network Insurance Company ("ANIC"; collectively, the "Companies"), hereby submits the following Answer to the Application of the Health Insurers for Limited Intervention. As set forth below and for the reasons stated in the Statutory Liquidator's Brief in Opposition to the Application of the Health Insurers for Limited Intervention, this Court should deny the Application.

Alleged Interests of the Applicants

1. Denied. The Statutory Liquidator is without knowledge or information sufficient to form a belief as to the truth of each and every allegation contained in Paragraph 1 of the Application, except that the implication that the Health Insurers will suffer any harm as a result of the distribution of the Companies' assets is specifically denied.

2. Admitted in part, denied in part. It is admitted only that the Guaranty Associations will commence funding benefits after the entry of a liquidation order. The remaining allegations of Paragraph 2 are denied, as the Statutory Liquidator is without knowledge or information sufficient to form a belief as to the truth of each and every allegation contained in Paragraph 2 of the Application, except that the implication that the Health Insurers will suffer any harm as a result of the distribution of the Companies' assets is specifically denied.

Alleged Purposes For Which Applicants Seek to Intervene

3. Denied. The allegations of Paragraph 3 assert a legal conclusion to which no answer is required.

4. Denied. The Statutory Liquidator's Application to Approve Statement Regarding, and Authorize, Restructuring of Insurance Liabilities in Liquidation is in writing and speaks for itself, and should be reviewed for its terms or averments in context. Any characterization of the terms or averments therein is therefore denied.

5. Admitted in part, denied in part. It is admitted only that the Statutory Liquidator intends to provide for an allocation of a portion of the Companies' assets for the provision of benefits to policyholders in excess of the benefits provided by the state guaranty associations as part of a distribution plan under

Section 536 of Article V as previously stated in her Statement Regarding Restructuring of Insurance Liabilities in Liquidation. The Statutory Liquidator's Application to Approve Statement Regarding, and Authorize, Restructuring of Insurance Liabilities in Liquidation and the Second Amended Plan of Rehabilitation are in writing and speaks for themselves, and should be reviewed for their terms or averments in context. Any characterization of the terms or averments therein is therefore denied.

6. Denied. The Statutory Liquidator's Application to Approve Statement Regarding, and Authorize, Restructuring of Insurance Liabilities in Liquidation is in writing and speaks for itself, and should be reviewed for its terms or averments in context. Any characterization of the terms or averments therein is therefore denied.

7. Denied as stated. The amount of the Companies' assets that the Liquidator will propose to be allocated to provide policyholder benefits in excess of guaranty association coverage is currently undetermined, but may exceed $100 million.

8. Denied. The Statutory Liquidator is without knowledge or information sufficient to form a belief as to the truth of each and every allegation contained in Paragraph 8 of the Application, except that any implications that the

Statutory Liquidator will not act in accordance with Article V, or that the Health Insurers will suffer any harm as a result of the distribution of the Companies' assets, are specifically denied. By way of further answer, the Statutory Liquidator intends to provide for an allocation of a portion of the Companies' assets for the provision of benefits to policyholders in excess of the benefits provided by the state guaranty associations as part of a distribution plan under Section 536 of Article V as previously stated in her Statement Regarding Restructuring of Insurance Liabilities in Liquidation.

9. Denied. The allegations of Paragraph 9 assert a legal conclusion to which no answer is required. To the extent an answer is required, the Statutory Liquidator denies any assertion that the Companies' policyholders do not have "claims" for benefits in excess of guaranty association coverage under Pennsylvania law.

10. Denied. The allegations of Paragraph 10 assert a legal conclusion to which no answer is required.

11. Denied. The allegations of Paragraph 11 assert a legal conclusion to which no answer is required.

12. Denied. The allegations of Paragraph 12 assert a legal conclusion to which no answer is required.

13. Denied. The allegations of Paragraph 13 assert a legal conclusion to which no answer is required. To the extent an answer is required, the Statutory Liquidator denies that any part of an individual policyholder's benefits are not "claims" under Pennsylvania law.

14. Denied. The allegations of Paragraph 14 assert a legal conclusion to which no answer is required.

Applicants Do Not Satisfy The Rule 3775 Standard For Limited Intervention

15. Denied. The allegations of Paragraph 15 assert a legal conclusion to which no answer is required. To the extent an answer is required, the Health Insurers are not entitled to intervene and the Health Insurers do not have a "direct and substantial interest."

16. Denied. The allegations of Paragraph 16 assert a legal conclusion to which no answer is required. To the extent an answer is required, the Health Insurers are merely speculating as to the extent of any distribution, assessment, or funding, and they are not entitled to intervene. The Statutory Liquidator is without knowledge or information sufficient to form a belief as to the amount or calculation of any assessment to be funded by the Health Insurers except that, on information and belief, the Guaranty Associations intend to increase rates to reduce potential future assessments. By way of further answer, the Health Insurers will

recoup future guaranty association assessments through the premium rates they charge policyholders and/or premium tax offsets.

17. Denied. The allegations of Paragraph 17 assert a legal conclusion to which no answer is required. To the extent an answer is required, the Health Insurers are not entitled to intervene and the Health Insurers do not have a "direct, immediate and substantial pecuniary interest."

18. Denied. The allegations of Paragraph 18 assert a legal conclusion to which no answer is required. To the extent an answer is required, the Health Insurers are not entitled to intervene.

19. Denied. The allegations of Paragraph 19 assert a legal conclusion to which no answer is required. To the extent an answer is required, the Health Insurers are merely speculating as to the extent of any distribution, assessment, or funding, and they are not entitled to intervene. The amount of the Companies' assets that the Liquidator will propose to be allocated to provide policyholder benefits in excess of guaranty association coverage is currently undetermined, but may exceed $100 million. The Statutory Liquidator is without knowledge or information sufficient to form a belief as to the amount or calculation of any assessment to be funded by the Health Insurers except that, on information and belief, the Guaranty Associations intend to increase rates to reduce potential future

assessments. By way of further answer, the Health Insurers will recoup future guaranty association assessments through the premium rates they charge policyholders and/or premium tax offsets.

20. Denied. The allegations of Paragraph 20 assert a legal conclusion to which no answer is required. To the extent an answer is required, the Health Insurers are merely speculating as to the extent of any distribution, assessment, or funding, and the Health Insurers are not entitled to intervene. The Statutory Liquidator's Application to Approve Statement Regarding, and Authorize, Restructuring of Insurance Liabilities in Liquidation is in writing and speaks for itself, and should be reviewed for its terms or averments in context. Any characterization of the terms or averments therein is therefore denied. By way of further answer, the Health Insurers will recoup future guaranty association assessments through the premium rates they charge policyholders and/or premium tax offsets.

21. Denied. The allegations of Paragraph 21 assert a legal conclusion to which no answer is required. To the extent an answer is required, the Health Insurers do not have a substantial interest and are not entitled to intervene. By way of further answer, the Health Insurers will recoup future guaranty association

assessments through the premium rates they charge policyholders and/or premium tax offsets.

22. Denied. The Guaranty Associations, each of which may have a right to participate at this stage of the liquidation, have participated in these proceedings in the past through the National Organization of Life and Health Insurance Guaranty Associations, and may do so again in the future. The remaining allegations of Paragraph 22 assert a legal conclusion to which no answer is required. To the extent an answer is required, the Health Insurers do not have standing to intervene. By way of further answer, the Health Insurers will recoup future guaranty association assessments through the premium rates they charge policyholders and/or premium tax offsets.

23. Denied. The allegations of Paragraph 23 assert a legal conclusion to which no answer is required. To the extent an answer is required, the letter from the Virginia Life, Accident & Sickness Insurance Guaranty Association attached as Exhibit 1 to the Application is in writing and speaks for itself, and should be reviewed for its statements in context. Any characterization of the statements therein is therefore denied.

24. Denied. The allegations of Paragraph 24 assert a legal conclusion to which no answer is required. To the extent an answer is required, the Statutory

Liquidator is without knowledge or information sufficient to form a belief as to the truth of each and every allegation contained in Paragraph 24 of the Application, except that it is specifically denied that the Health Insurers' due process rights are violated or that the Health Insurers will have no opportunity to be heard in light of the administrative procedures set forth in, *e.g.*, 40 P.S. § 991.1709(c) and Model Guaranty Association Act § 11C.

25. Denied. The allegations of Paragraph 25 assert a legal conclusion to which no answer is required. To the extent an answer is required, the Statutory Liquidator is without knowledge or information sufficient to form a belief as to the truth of each and every allegation contained in Paragraph 25 of the Application, except that any implication that the Health Insurers hold any interest warranting intervention is specifically denied. By way of further answer, if the Health Insurers believe that the Guaranty Associations have a different interest, or are not protecting the Health Insurers' interests, the Health Insurers may challenge any action or inaction by the Guaranty Associations, including assessments, under administrative procedures set forth in, *e.g.*, 40 P.S. § 991.1709(c) and Model Guaranty Association Act § 11C. Upon information and belief, the Health Insurers have not done so.

26. Admitted in part, denied in part. It is admitted that the Health Insurers filed on February 28, 2017, a Brief in Support of Application of The Health Insurers For Limited Intervention in Order to Seek Determination of Authority to Use Estate Assets to Pay "Uncovered Benefits" in Liquidation, together with an exhibit thereto. The Statutory Liquidator is without knowledge or information sufficient to form a belief as to the truth of the remaining allegations contained in Paragraph 26 of the Application.

WHEREFORE the Statutory Liquidator respectfully requests that the Application be denied and that the Health Insurers be denied any opportunity to intervene in these proceedings.

Dated: March 30, 2017

Respectfully submitted,

/s/ James R. Potts

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

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VERIFICATION

I, Robert L. Robinson, hereby state that I am the Chief Liquidation Officer for Penn Treaty Network America Insurance Company and American Network Insurance Company, and I am authorized to take this verification on the Statutory Liquidator's behalf. The statements made in the foregoing pleading are true and correct based on my knowledge, information, and belief. I understand that the statements made herein are made subject to the penalties of 18 Pa. C.S.A. §4904 relating to unsworn falsification to authorities.

Date: March 30, 2017

Robert L. Robinson

Robert L. Robinson

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EXHIBIT A

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2016

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____

Commission file number: 1-10864

UNITEDHEALTH GROUP®

UnitedHealth Group Incorporated
(Exact name of registrant as specified in its charter)

Delaware	**41-1321939**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
UnitedHealth Group Center **9900 Bren Road East** **Minnetonka, Minnesota**	**55343**
(Address of principal executive offices)	**(Zip Code)**

(952) 936-1300
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

COMMON STOCK, $.01 PAR VALUE	**NEW YORK STOCK EXCHANGE, INC.**
(Title of each class)	**(Name of each exchange on which registered)**

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one)

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion should be read together with the accompanying Consolidated Financial Statements and Notes to the Consolidated Financial Statements thereto included in Item 8, "Financial Statements." Readers are cautioned that the statements, estimates, projections or outlook contained in this report, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 7, may constitute forward-looking statements within the meaning of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. A description of some of the risks and uncertainties can be found further below in this Item 7 and in Part I, Item 1A, "Risk Factors."

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health and well-being company dedicated to helping people live healthier lives and helping to make the health system work better for everyone. Through our diversified family of businesses, we leverage core competencies in advanced, enabling technology; health care data; information and intelligence; and clinical care management and coordination to help meet the demands of the health system. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

We have four reportable segments across our two business platforms, UnitedHealthcare and Optum:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global;
- OptumHealth;
- OptumInsight; and
- OptumRx.

Further information on our business and reportable segments is presented in Part I, Item 1, "Business" and in Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Recent Developments

We have recognized in our financial results for the fourth quarter 2016 and the year ended December 31, 2016 the previously disclosed $350 million impact of our estimated share of guaranty association assessments resulting from the liquidation of Penn Treaty Network America Insurance Company and its subsidiary (Penn Treaty), following accounting, legal and regulatory consultations in connection with our 10-K filing. This charge will be funded over several years and affected by premium tax credits over time.

For more detail related to the Penn Treaty liquidation, see Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Business Trends

Our businesses participate in the United States, Brazilian and certain other international health markets. In the United States, health care spending has grown consistently for many years and comprises approximately 18% of

EXHIBIT B

NEWS RELEASE

UNITEDHEALTH GROUP®

For Immediate Release

UNITEDHEALTH GROUP RECORDS PREVIOUSLY DISCLOSED PENN TREATY ASSESSMENT IN 2016 RESULTS
Files Annual Report on Form 10-K

NEW YORK, N.Y. (February 8, 2017) – UnitedHealth Group (NYSE: UNH) has recognized the previously-disclosed $350 million impact of its Penn Treaty assessments in the fourth quarter 2016, following further accounting, legal and regulatory consultations in connection with its 10-K filing. As a result, UnitedHealth Group reduced its fourth quarter and full year 2016 earnings before income taxes by $350 million or $0.23 diluted net earnings per share. The adjustment has no impact on the Company's previously reported fourth quarter and full year 2016 adjusted net earnings or adjusted net earnings per share.

The information is included in the Company's Annual Report on Form 10-K for the year ended December 31, 2016 which was filed today with the Securities and Exchange Commission.

About UnitedHealth Group

UnitedHealth Group (NYSE: UNH) is a diversified health and well-being company dedicated to helping people live healthier lives and making health care work better. UnitedHealth Group offers a broad spectrum of products and services through two distinct platforms: UnitedHealthcare, which provides health care coverage and benefits services; and Optum, which provides information and technology-enabled health services. For more information, visit UnitedHealth Group at www.unitedhealthgroup.com or follow @UnitedHealthGrp on Twitter.

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Investors:

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EXHIBIT C

UNITEDHEALTH GROUP®

UnitedHealth Group
Fourth Quarter 2016 Results
Teleconference Prepared Remarks
January 17, 2017

Moderator:
Good morning, I will be your conference operator today. Welcome to the UnitedHealth Group Fourth Quarter and Full Year 2016 Earnings Conference Call. A question and answer session will follow UnitedHealth Group's prepared remarks. As a reminder, this call is being recorded.

Here is some important introductory information. This call contains "forward-looking" statements under U.S. federal securities laws. These statements are subject to risks and uncertainties that could cause actual results to differ materially from historical experience or present expectations. A description of some of the risks and uncertainties can be found in the reports that we file with the Securities and Exchange Commission, including the cautionary statements included in our current and periodic filings.

This call will also reference non-GAAP amounts. A reconciliation of the non-GAAP to GAAP amounts is available on the "Financial Reports & SEC Filings" section of the Company's Investors page at www.unitedhealthgroup.com.

Information presented on this call is contained in the Earnings Release we issued this morning and in our Form 8-K dated January 17, 2017, which may be accessed from the Investors page of the Company's website. I would now like to turn the conference over to the chief executive officer of UnitedHealth Group, Stephen Hemsley.

Stephen Hemsley:

Good morning and thank you for joining us. We plan to keep our prepared remarks brief today. Just a month and a half ago, we held our annual Investor Conference and fourth quarter results are very much in line with or slightly stronger than we discussed at the conference – so our focus is now well into 2017.

We ended the year with modestly stronger than expected growth across our businesses. And as the story has been throughout the year, customer retention and expanding relationships played a central role in our member and revenue growth for both UnitedHealthcare and Optum.

To briefly recap 2016, revenue of $184.8 billion grew nearly $28 billion or 18 percent as earnings from operations advanced over 20 percent to $13.3 billion. Net earnings advanced 24 percent to $7.3 billion and adjusted net earnings per share grew 25 percent to $8.05 per share for the year.

Fourth quarter 2016 results included:

- $47.5 billion in revenues;
- More than $3.5 billion in earnings from operations;
- Net earnings of $1.9 billion; and
- Adjusted earnings per share of $2.11.

All of these results were at or modestly ahead of the expectations set at our Investor Conference in late November.

Operating cash flows for the year were $9.8 billion, 1.34 times net earnings, within our range of expectation despite timing changes in several state payments.

We look forward to the opportunities of 2017 as we continue to drive our agenda of quality-based net promoter or NPS performance and growth, building on the momentum of strong NPS gains in 2016. In that vein, we began 2017 with one of the stronger operational starts to a new year we have ever had. We remain fully committed to meeting or exceeding the 2017 outlook we previewed with you at our Investor Conference.

And as Dave Wichmann and Larry Renfro will discuss, we have solid growth momentum going into 2017. So we will turn to their commentary, beginning with Larry.

Larry Renfro

Thank you, Steve.

Customers of both UnitedHealthcare and Optum have been responding to our focused NPS, quality and value efforts. These are the building blocks of valuable, deep, long-term relationships. Customer retention was a factor in UnitedHealth Group's 2016 growth and that continues as we enter 2017.

The health care customers we serve turn to us to solve large, complex problems. UnitedHealthcare, for example, is increasingly helping states manage care for their medically complex, highly vulnerable and most costly populations. We also continue to assist employers with effective, innovative programs to support the needs of their retirees and employees challenged by chronic health issues.

For Optum, 2016 was a distinguishing year for developing and deepening relationships across health care as we deliver more value to the marketplace. In the first quarter, we announced a strategic relationship with Walgreens offering more choice and greater savings to both consumers and their sponsors. We also entered into a technology partnership with Availity, a leading health IT provider, to meaningfully improve connectivity and processing for payers, care providers and consumers.

In the second quarter, several large organizations engaged Optum to deliver pharmacy care services in 2017, in response to our progressive clinical model for whole person care.

Quest Diagnostics joined us in the third quarter in a collaboration that will span several of Optum's businesses, starting with Optum360. We were honored to receive several important, multi-year contracts from the Department of Veterans Affairs, and we partnered with Allscripts across OptumInsight and OptumHealth.

In the fourth quarter, we were pleased to announce a new relationship with CVS Health that will strengthen their retail and our pharmacy care services offerings to the benefit of consumers.

Moving into this year, last week we announced we will join with Surgical Care Affiliates, or SCA. This combination will expand the breadth of care delivery capabilities at Optum, as we continue to evolve a comprehensive ambulatory care platform, including primary, urgent, surgical and home care – all designed to deliver higher value and quality health care to consumers and payers. Surgeons operating in SCA centers perform nearly 1 million surgeries annually in over 200 locations across 33 states, with consistently high-quality, consumer satisfaction and improved value. In SCA, we will grow and build upon a leader we know well in a high growth market – a market where we have already gained meaningful market presence, experience and insight through OptumCare.

The momentum inside our businesses comes from the growth and depth of these relationships and the breadth of sustainable value we can offer.

In 2016, Optum revenues grew 24 percent to $83.6 billion, as earnings from operations grew 32 percent to more than $5.6 billion, slightly ahead of our most recent outlook. Fourth quarter 2016 was the first anniversary of the Catamaran acquisition – and we were pleased with the operating earnings growth of 18 percent in the quarter for Optum overall, led by 27 percent growth at OptumRx. Margins reached 8.1 percent in the fourth quarter and were 6.7 percent for the full year, up 40 basis points over 2015. Looking to 2017, OptumInsight's year-end backlog grew 21 percent to $12.6 billion.

As we stand back from Optum and look at our progress, we are advancing the quality and consistency of our services to customers, simplifying our business, strengthening our leadership team and focusing our resources and investments in the most important growth trends in health care. While there is more to be done, in the United States and globally, the opportunities continue to grow even faster and larger. We are optimistic

about our outlook for 2017, with revenues exceeding $90 billion and earnings from operations in the range of $6.2 billion to $6.4 billion.

In 2017, at Optum and across UnitedHealth Group, we are committed to grow by developing stronger relationships, delivering consistent value to strengthen NPS and helping make health systems work better for more people.

Now let me turn it over to Dave.

Dave Wichmann
Thank you, Larry.

UnitedHealthcare also enters 2017 with strong momentum. Fourth quarter and full year 2016 revenues were well-balanced, growing by double-digit percentages in every product category. Medical costs remained well managed, with the commercial medical cost trend ending the year in line with expectations at approximately 6 percent. 2016 was one of the strongest organic growth years in our history, with more than 2 million medical members joining. UnitedHealthcare continues to build well-diversified growth momentum, as customer and consumer retention rates continue to improve broadly, with notable strength in small and mid-sized commercial groups and in Medicare.

In the full-risk commercial group business, we grew by 205,000 people in the quarter and 375,000 people for the year, providing a positive starting point as we enter 2017. This growth was broad-based, appropriately priced and balanced across geographic regions, products and customer types.

In the self-funded segment, the market has been stable with strengthening employment rates helping us grow within existing customers. In 2016, UnitedHealthcare grew to serve an additional 335,000 commercial fee-based consumers, including 20,000 more in the fourth quarter.

As expected, individual business declined in the fourth quarter. Premium deficiency reserves taken earlier this year were sufficient, and we maintain an appropriate and prudent residual reserve for claims not yet received. Consistent with our commitments to you early in 2016, we do not believe our ACA-compliant individual business carries any financial exposure forward into 2017.

Turning to Medicare, in 2016 we grew our medical membership organically by 625,000 people, about two-thirds through Medicare Advantage. 2016 was among our best Medicare growth years, but we expect 2017 to be even stronger. Our positive Medicare Advantage performance in 2016 was driven by the combination of premium and benefits stability, rising Stars performance and improved service and clinical performance, all leading to record retention rates.

These same factors are driving 2017 growth. We expect to serve nearly 1 million more seniors with medical benefits this year, including more than three-quarters of a million seniors in Medicare Advantage, balanced and diversified, by region, channel and product.

Moving to Medicaid, adding 100,000 people in the quarter brought our full-year growth to 585,000 – once again broad-based and organic from new programs in both new and existing states. In 2017 we will introduce services in the states of Virginia and Missouri, and plan to enter Colorado via the pending partnership with Rocky Mountain Health Plan, further expanding the number of state partners we serve.

As we recap the year, UnitedHealthcare revenues of $148.6 billion grew 13 percent year-over-year, virtually all organic, as it has been over the past several years. Every business grew revenues by a double-digit percentage, in the fourth quarter and for the full-year 2016. Earnings from operations exceeded $7.6 billion and grew 13 percent or over $900 million.

UnitedHealth Group

Turning to UnitedHealth Group as a whole, our fourth quarter revenues of $47.5 billion grew 9 percent over last year. The fourth quarter consolidated medical care ratio decreased 190 basis points to 80.8 percent, slightly outperforming our recent Investor Conference outlook. The full-year care ratio of 81.2 percent improved 50 basis points year-over-year, with core businesses overcoming both the pressures in the individual market in the first half of 2016 and the higher levels of reserve development in 2015. The full-year operating cost ratio improved 30 basis points to 15.2 percent, in line with our Investor Conference forecast.

As we step into 2017, there are a number of positive indications that reflect our continuing momentum.

- Our focus on quality and NPS is intensifying and bearing results.
- Consumers continue to engage more deeply in their health, earning $255 million in healthy behavior incentives in 2016.
- We began the year crisply in customer installation and service on record levels of new and diversified growth across Optum and UnitedHealthcare.
- Optum enters the year with record backlog, people served and adjusted scripts – and with Optum Bank crossing the $7 billion mark in consumer health assets under management. Optum is pursuing a strong vision as a health services organization unlike any in existence today. We will continue to develop our business to fit that vision in 2017.
- Our merger with SCA will significantly expand our capabilities for consumers, payers and hospital partners at OptumCare, while establishing presence in new markets.
- UnitedHealthcare enters the year with strong retention rates and new business growth across all three lines of business.
- And we are seeing improving performance and earnings contribution from our hospital company and health plan in Brazil.

We should touch briefly on Penn Treaty, an industry topic we first discussed in 2010 that finally seems to be resolving. Penn Treaty is a financially distressed long-term care insurance company, with no affiliation to us. While we have never sold long-term care policies, under state laws, health insurers will be assessed a share of the guarantee funds needed to protect Penn Treaty's policyholders. We expect to accrue an approximately $350 million operating charge for our portion of the assessment. This charge will be funded over several years and the cash will be largely recovered through premium tax credits over time.

While this outcome is well known, current accounting practice only allows this charge to be recognized when a final court order of liquidation is entered. When that ultimately occurs, we will incorporate the impact in GAAP earnings, while excluding it from adjusted earnings per share.

To wrap-up, we remain committed to our outlook for 2017 revenues of $197 billion to $199 billion, adjusted net earnings of $9.30 to $9.60 per share and cash flows from operations of $11.5 billion to $12 billion. Only 17 days into the year, we think this posture strikes an appropriate balance of optimism and prudence.

Steve?

Steve Hemsley
Thank you, Dave.

You may notice a separate press release this morning announcing that Tim Flynn has joined the board of UnitedHealth Group. Tim is an exceptionally creative and solutions-oriented executive, the former global managing partner of KPMG. Tim has deep financial and global operating expertise. He is also deeply versed in corporate governance and we are thrilled to welcome Tim to our board of directors.

We'll close with a few words on the overall domestic health care landscape. To be clear, we have no better sense than anyone else concerning the timing or any ultimate actions with respect to the Affordable Care Act. So any questions and responses on that subject need to have that clear context, and as you would anticipate, we will not speculate on hypothetical or provocative questions in this area this morning.

Our posture has remained consistent for some time now. We remain positive and constructive with respect to what ultimately evolves in the next phase of health care change. We see the opportunity for:

- robust state-based health care markets offering flexible commercial benefits,
- flexible Medicaid available to eligible as well as paying beneficiaries,
- well-structured and managed high risk pools,
- exchanges where states choose to sustain them,
- and much more.

We believe, all of these, taken together, can represent effective, local, state-based coverage systems, which can well accommodate those currently in the ACA individual exchanges, as well as serve as channels for further expanding coverage if that remains the focus. We see this approach as being simpler, offering more flexibility, more choice and more affordability to both consumers and state and federal sponsors.

And as we have for many years, we remain staunch advocates for affordable coverage, infrastructure that supports a modern health care system – including a strong and diversified future-oriented health care workforce – and improvements to government sponsored benefits that incorporate better use of technology, information and care resources for Americans.

UnitedHealth Group, Optum and UnitedHealthcare remain fully committed to our mission – "to help people live healthier lives and to help make the health system work better for everyone." Today, we see more opportunities to serve and grow in the next 10 years than the past 10. We remain an adaptable, innovative and restless enterprise.

We see many ways our work can continue to improve, if we stay focused on that mission. And we are committed to pursue that goal in 2017 and the decade ahead.

Thank you for your interest today.

EXHIBIT D

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2016
OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from to
Commission file number: 001-16751

ANTHEM, INC.

(Exact name of registrant as specified in its charter)

INDIANA	**35-2145715**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification Number)**
120 MONUMENT CIRCLE INDIANAPOLIS, INDIANA	**46204**
(Address of principal executive offices)	**(Zip Code)**

Registrant's telephone number, including area code: **(317) 488-6000**
Securities registered pursuant to Section 12(b) of the Act:

Title of each class	**Name of each exchange on which registered**
Common Stock, Par Value $0.01	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See the definitions of "large accelerated filer", "accelerated filer", and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☒ Accelerated filer ☐

Non-accelerated filer ☐ (Do not check if a smaller reporting company Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant (assuming solely for the purposes of this calculation that all Directors and executive officers of the registrant are "affiliates") as of June 30, 2016 was approximately $34,510,272,302.

As of February 10, 2017, 264,378,577 shares of the Registrant's Common Stock were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Annual Report on Form 10-K incorporates by reference information from the registrant's Definitive Proxy Statement for the Annual Meeting of Shareholders to be held May 18, 2017.

be restricted. A Medicare Advantage or Medicare Part D plan contract will be terminated if the plan's MLR is below 85% for five consecutive years.

Beginning in 2014, Health Care Reform imposed an annual HIP Fee on health insurers that write certain types of health insurance on U.S. risks. The annual HIP Fee is allocated to health insurers based on the ratio of the amount of an insurer's net premium revenues written during the preceding calendar year to an adjusted amount of health insurance for all U.S. health risk for those certain lines of business written during the preceding calendar year. The HIP Fee is non-deductible for federal income tax purposes. The total amount collected from allocations to health insurers was $11,300.0 for each of 2016 and 2015 and $8,000.0 for 2014. We record our estimated liability for the HIP Fee in full at the beginning of the year with a corresponding deferred asset that is amortized on a straight-line basis to general and administrative expense. The final calculation and payment of the annual HIP Fee occurs in the third quarter each year and our portion of the HIP Fee for 2016, 2015 and 2014 was $1,176.3, $1,207.5 and $893.3, respectively. The annual HIP Fee to be allocated to all health insurers has been suspended for 2017 and is scheduled to resume and be increased to $14,300.0 for 2018, without subsequent legislative or regulatory action. For 2019 and beyond, the annual HIP Fee will equal the amount for the preceding year increased by the rate of premium growth for the preceding year less the rate of growth in the consumer price index for the preceding calendar year.

These and other provisions of Health Care Reform are likely to have significant effects on our future operations, which, in turn, could impact the value of our business model and results of operations, including potential impairments of our goodwill and other intangible assets. We will continue to evaluate the impact of Health Care Reform including any substantial changes to existing laws or regulations that may impact our business. For additional discussion regarding Health Care Reform, see Part I, Item 1 "Business—Regulation" and Part I, Item 1A "Risk Factors" in this Annual Report on Form 10-K.

Finally, federal and state regulatory agencies may further restrict our ability to obtain new product approvals, implement changes in premium rates or impose additional restrictions, under new or existing laws that could adversely affect our business, cash flows, financial condition and results of operations.

We are also subject to regulations that may result in assessments under state insurance guaranty association laws. The National Organization of Life & Health Insurance Guaranty Associations, or NOLHGA, is a voluntary organization consisting of the state life and health insurance guaranty associations located throughout the U.S. Such associations, working together with NOLHGA, provide a safety net for their state's policyholders, ensuring that they continue to receive coverage, subject to state maximum limits, even if their insurer is declared insolvent. In 2009, the Pennsylvania Insurance Commissioner placed Penn Treaty Network America Insurance Company and its subsidiary American Network Insurance Company, or collectively Penn Treaty, in rehabilitation, an intermediate action before insolvency. After failing to develop a viable rehabilitation plan, the Pennsylvania Insurance Commissioner filed a petition to convert the rehabilitation to a liquidation, with the liquidation expected to commence following the coordination of certain scheduling matters. When Penn Treaty is placed in liquidation, we and other insurers will be obligated to pay a portion of their policyholder claims through state guaranty association assessments in future periods. At December 31, 2016, we estimate our portion of the assessments for the Penn Treaty insolvency will approximate $190.0 to $220.0. In accordance with FASB guidance, the ultimate amount of the assessments will be recognized as an expense in the period in which a court ordered liquidation is entered. Payment of the assessments will be largely recovered through premium billing surcharges and premium tax credits over future years.

In addition to the external forces discussed in the preceding paragraphs, our results of operations are impacted by levels and mix of membership. In recent years, we have experienced membership growth due to the quality and pricing of our health benefits products and services, improved economic conditions, decreases in unemployment, acquisitions, entry into new markets and expansions in existing markets. In addition, we believe the self-insured portion of our group membership base will continue to increase as a percentage of total group membership. However, these membership trends could be negatively impacted by various factors that could have a material adverse effect on our future results of operations such as general economic downturns that result in business failures, failure to obtain new customers or retain existing customers, premium increases, benefit changes or our exit from a specific market. Further, our mix of membership may include more individuals with a higher acuity level obtaining coverage through our products available on the public exchanges, which may not be appropriately adjusted for in our premium rates.

EXHIBIT E

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

(Mark One)

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2016
OR
☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from _____ to _____
Commission file number 1-8323

CIGNA CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	**06-1059331**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*
900 Cottage Grove Road, Bloomfield, Connecticut	**06002**
(Address of principal executive offices)	*(Zip Code)*

(860) 226-6000
Registrant's telephone number, including area code
(860) 226-6741
Registrant's facsimile number, including area code

SECURITIES REGISTERED PURSUANT TO SECTION 12(B) OF THE ACT:	
Title of each class	Name of each exchange on which registered
Common Stock, Par Value $0.25	**New York Stock Exchange, Inc.**

SECURITIES REGISTERED PURSUANT TO SECTION 12(G) OF THE ACT:
NONE

Indicate by check mark	**Yes**	**No**
• if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.	☑	☐
• if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.	☐	☑
• whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.	☑	☐
• whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files).	☑	☐
• if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.	☑	☐
• whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See definitions of "large accelerated filer", "accelerated filer", and "smaller reporting company" in Rule 12b-2 of the Exchange Act.		
Large accelerated filer ☑	Accelerated filer ☐	Non-accelerated filer ☐	Smaller Reporting Company ☐
• whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).	☐	☑

The aggregate market value of the voting stock held by non-affiliates of the registrant as of June 30, 2016 was approximately $32.7 billion.

As of January 31, 2017, 257,052,404 shares of the registrant's Common Stock were outstanding.

Part III of this Form 10-K incorporates by reference information from the registrant's definitive proxy statement related to the 2017 annual meeting of shareholders.

The Company guarantees that separate account assets will be sufficient to pay certain life insurance or retiree benefits. The sponsoring employers are primarily responsible for ensuring that assets are sufficient to pay these benefits and are required to maintain assets that exceed a certain percentage of benefit obligations. This percentage varies depending on the asset class within a sponsoring employer's portfolio (for example, a bond fund would require a lower percentage than a riskier equity fund) and thus will vary as the composition of the portfolio changes. If employers do not maintain the required levels of separate account assets, the Company or an affiliate of the buyer of the retirement benefits business (Prudential Retirement Insurance and Annuity Company) has the right to redirect the management of the related assets to provide for benefit payments. As of December 31, 2016, employers maintained assets that exceeded the benefit obligations. Benefit obligations under these arrangements were $490 million as of December 31, 2016 and approximately 13% of these are reinsured by an affiliate of the buyer of the retirement benefits business. The remaining guarantees are provided by the Company with minimal reinsurance from third parties. There were no additional liabilities required for these guarantees as of December 31, 2016. Separate account assets supporting these guarantees are classified in Levels 1 and 2 of the GAAP fair value hierarchy. See Note 10 for further information about the fair value hierarchy.

The Company does not expect that these financial guarantees will have a material effect on the Company's consolidated results of operations, liquidity or financial condition.

B. Guaranteed Minimum Income Benefit Contracts

See Note 9 for discussion.

C. Certain Other Guarantees

The Company had financial guarantees and indemnification obligations to lenders of approximately $152 million as of December 31, 2016, related to borrowings by certain real estate joint ventures that the Company either records as an investment or consolidates. These borrowings, that are primarily nonrecourse obligations of the Company, are secured by the joint ventures' real estate properties with fair values in excess of the loan amounts and mature at various dates beginning in 2018 through 2021. The Company's indemnification obligations would require payment to lenders for any actual damages resulting from certain acts such as unauthorized ownership transfers, misappropriation of rental payments by others or environmental damages. Based on initial and ongoing reviews of property management and operations, the Company does not expect that payments will be required under these financial guarantees or indemnification obligations. Any payments that might be required could be recovered through a refinancing or sale of the assets. In some cases, the Company also has recourse to partners for their proportionate share of amounts paid. There were no liabilities required for these guarantees and indemnification obligations as of December 31, 2016.

As of December 31, 2016, the Company guaranteed that it would compensate the lessors for a shortfall of up to $42 million in the market value of certain leased equipment at the end of the lease. Guarantees of $10 million expire in 2017, $25 million expire in 2022 and $7 million expire in 2026. The Company recorded liabilities for these guarantees of $5 million as of December 31, 2016.

The Company does not expect that these guarantees will have a material adverse effect on the Company's consolidated results of operations, financial condition or liquidity.

The Company had indemnification obligations as of December 31, 2016 in connection with acquisition, disposition and reinsurance transactions. These indemnification obligations are triggered by the breach of representations or covenants provided by the Company, such as representations for the presentation of financial statements, the filing of tax returns, compliance with law or the identification of outstanding litigation. These obligations are typically subject to various time limitations, defined by the contract or by operation of law, such as statutes of limitation. In some cases, the maximum potential amount due is subject to contractual limitations based on a percentage of the transaction purchase price, while in other cases limitations are not specified or applicable. The Company does not believe that it is possible to determine the maximum potential amount due under these obligations because not all amounts due under these indemnification obligations are subject to limitation. There were no liabilities for these indemnification obligations as of December 31, 2016.

D. Guaranty Fund Assessments

The Company operates in a regulatory environment that may require the Company to participate in assessments under state insurance guaranty association laws. The Company's exposure to assessments for certain obligations of insolvent insurance companies to policyholders and claimants is based on its share of business written in the relevant jurisdictions. For the year ended December 31, 2016 and 2015, charges related to guaranty fund assessments were immaterial to the Company's results of operations.

The Company is aware that Penn Treaty Network America Insurance Company, together with its subsidiary American Network Insurance Company (collectively "Penn Treaty") is in rehabilitation. In 2012, the state court denied the regulator's amended petitions for liquidation and set forth specific requirements and a deadline for the regulator to develop a plan of rehabilitation without liquidating Penn Treaty. The regulator has appealed the court's decision. More recently, the state court has been holding settlement conferences to attempt to resolve outstanding issues with the rehabilitation plan. In July 2016, the regulator, who is the rehabilitator, filed another amended petition for liquidation with the court. Based on the developments in this matter, it is reasonably likely that a guaranty fund assessment related to Penn Treaty will be finalized in 2017. Due to the uncertainties surrounding this matter, the Company's share of this guaranty fund assessment related to Penn Treaty is uncertain, but based on current information it is estimated to approximate $85 million after-tax. The majority of this assessment is expected to be offset in the future by premium tax credits that will be recognized in the period received. The Company continues to monitor this situation.

Received 3/30/2017 3:02:56 PM Commonwealth Court of Pennsylvania

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1 PEN 2009

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

BRIEF IN OPPOSITION TO THE APPLICATION OF THE HEALTH INSURERS FOR LIMITED INTERVENTION

Teresa D. Miller, as Insurance Commissioner of Pennsylvania and in her capacity as Statutory Liquidator of Penn Treaty Network America Insurance Company ("PTNA") and American Network Insurance Company ("ANIC"), hereby submits the following Brief in Opposition to the Application of the Health Insurers for Limited Intervention. As set forth below, the Health Insurers[1] have failed to establish any direct and substantial interest in the PTNA and ANIC liquidation proceedings based on their membership in state Guaranty Associations, and this Court should therefore deny the Application.

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[1] The "Health Insurers" consist of the following companies: Aetna Life Insurance Company; Anthem, Inc.; Cigna Corporation; HM Life Insurance Company; Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey; QCC Insurance Company; United Concordia Life and Health Insurance Company; United Concordia Insurance Company; and UnitedHealthcare Insurance Company.

I. BACKGROUND

This Court is currently overseeing two related liquidation proceedings concerning two insolvent long-term care insurers, PTNA and its subsidiary ANIC (together, the "Companies"), governed by Article V of the Insurance Department Act of 1921, 40 P.S. §§ 221.1, *et seq.* ("Article V") and Pennsylvania Rules of Appellate Procedure 3771-3784. The circumstances surrounding the Companies' insolvency are well-known to the Court; this Brief in Opposition raises only those background facts necessary to the arguments herein.

On March 1, 2017, this Court entered Orders of Liquidation declaring PTNA and ANIC insolvent and appointing the Statutory Liquidator to administer the Companies' affairs. The Orders of Liquidation triggered the obligations of state Guaranty Associations to, among other things, provide benefits and coverage for the Companies' policyholders, subject to statutory limits and conditions. *E.g.*, 40 P.S. § 991.1706(c). Consistent with the foregoing, the Court directed the Statutory Liquidator to "transfer policy obligations, including the continued payment of claims and continued coverage arising under the Companies' policies, to state guaranty funds." (3/1/17 Orders ¶ 10.)

The Guaranty Associations fund their obligations through various mechanisms. In the case of life and health insurance policies, the Guaranty Associations may have the authority to collect premiums from policyholders. *E.g.*,

40 P.S. § 991.1706(d) and (g). In addition, Guaranty Associations step into the shoes of policyholders with respect to their claims against the insolvent insurer's estate to the extent of benefits provided and therefore may receive a distribution of assets from the insolvent company. *E.g.*, 40 P.S. § 991.1706(m). Finally, Guaranty Associations have the power to assess "member insurers"[2] to fund the Guaranty Associations' obligations. *See, e.g.*, 40 P.S. § 991.1707. Although state laws vary, generally a member insurer may pass the cost of its assessment obligations onto its policyholders or offset its state premium tax obligations by the amount of its assessments over time. *E.g.*, 40 P.S. §§ 991.1707(g) and 991.1711. One of the Health Insurers, UnitedHealthcare, has publicly stated that it will recover its Penn Treaty Guaranty Association assessments through the premium tax offset: "We expect to accrue an approximately $350 million operating charge for our portion of the [Penn Treaty] assessment. This charge will be funded over several years and the cash will be largely recovered through premium tax credits over time."[3] Other of the Health Insurers have similarly affirmed in regulatory

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[2] "Member insurers" consist of all insurance companies holding a certificate of authority in the state and writing the kinds of insurance covered by the guaranty association, subject to certain exceptions. 40 P.S. § 991.1702.

[3] As set forth below, the Statutory Liquidator is attaching documents addressing this issue that are subject to Judicial Notice. Pa. R.E. 201(b)(1), (2).

filings that the Guaranty Association assessments will be recovered through premium charges or premium tax credits.

Since the entry of the Orders of Liquidation, the Statutory Liquidator has advanced funds to the state Guaranty Associations pursuant to Section 536(a) of Article V, 40 P.S. § 221.36(a), to fund the payment of the Guaranty Associations' statutory obligations to the Companies' policyholders who are on claim pursuant to this Court's subsequent Orders dated March 7, 2017. The Statutory Liquidator intends to file an application pursuant to Section 536(a) of Article V, 40 P.S. § 221.36(a), to seek the Court's approval to distribute additional estate funds to the state Guaranty Associations. In connection with such application, the Statutory Liquidator also intends to seek the Court's approval of an allocation of a portion of estate assets to fund a small portion of policyholder claims that will exceed available benefits from the state Guaranty Associations ("Non-GA Benefits"). The Liquidator does not intend to provide or fund the Non-GA Benefits absent this Court's approval.[4]

The Health Insurers, who represent a tiny fraction of the state Guaranty Associations' member insurers, seek intervention to oppose the provision of Non-GA Benefits. In September 2016, this Court ruled on the Health Insurers'

[4] The Liquidator intends to seek Court approval even though she may have the right to take such action under Section 523(8) of the Act, 40 P.S. § 221.23(8), without Court approval.

objections to a potential settlement with the Companies' shareholder, Penn Treaty American Corporation ("PTAC"), that provided for the payment by the Companies of $10 million to PTAC and a settlement of certain federal tax issues (the "Settlement Objections"). This Court rejected the Health Insurers' attempt to insert themselves on an issue in which they have no interest. Addressing the Settlement Objections, this Court found:

> Conspicuously absent from Health Insurers' objections is any explanation of how they will be aggrieved by the Settlement Agreement, save for a single conclusory statement that they "will bear the burden of the assessments from the state insurance guaranty associations." Health Insurers' Revised Objection to Application for Approval of Settlement Agreement at 13, n.3. This assertion of harm does not constitute a direct or immediate interest. Although the interests of Health Insurers and individual guaranty associations are not perfectly aligned, it bears noting that the guaranty associations, which have their own counsel, have not objected to the Joint Application.

Memorandum Opinion and Order at 5, *In Re: Penn Treaty Network Am. Ins. Co.*, No. 1 PEN 2009 (Pa. Commw. Ct. Sept. 23. 2016).

The Health Insurers again seek to insert themselves into these proceedings to contest the distribution of the Companies' funds. Specifically, the Health Insurers wish to intervene to prevent policyholders from receiving the Non-GA Benefits. According to the Health Insurers, they have a direct interest in the Liquidation proceedings for the same reasons alleged in the Settlement Objections rejected by this Court:

- the set aside to pay policyholder's Non-GA Benefits will reduce the Companies' funding to state Guaranty Associations, and the Guaranty Associations will cover that reduction through increased assessments against the Health Insurers. (Application to Intervene ¶ 16.)

- the Health Insurers will "bear the burden of the assessments from the state insurance guaranty associations." (Health Insurers' Revised Objections to Application for Approval of Settlement Agreement at 13, n.3)

The Application does not address specifically the harm the Health Insurers will suffer as a result of any additional assessments resulting from the funding of Non-GA Benefits. But as explained above, each of the Health Insurers will recoup any assessments through the rates it charges on premiums or through premium tax offsets. Specifically, UnitedHealth Group stated that its exposure to the Guaranty Associations has already been "recognized" and will be "funded over several years and *affected by premium tax credits over time*." *See* UnitedHealth Group Form 10-K for the year ending December 31, 2016, p. 33 (emphasis added); UnitedHealth Group 10-K Comment. UnitedHealth adopted the same posture in its Fourth Quarter Teleconference of January 17, 2017, indicating that the assessments will be "largely recovered through premium tax credits over time" and where it also reported over $184 billion in revenue for 2016. (Relevant portions of the UnitedHealth 10-K, the 10-K Comment, and the Teleconference Report are attached, respectively, as Exhibits A, B, and C.)[5]

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[5] The exhibits are "not subject to reasonable dispute" because they "can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned." Pa. R.E.

footnote continued on next page

The other Health Insurers appear to take a similar approach. Anthem, Inc., reported on its 2016 Form 10-K that the Guaranty Association assessments arising from the Companies' liquidation will be recovered through premium billing surcharges and premium tax credits. (Relevant portions of the Anthem 10-K are attached as Exhibit D.) Cigna Corporation also reported on its 2016 Form 10-K that the majority of any assessment from the Companies' liquidation will be offset by premium tax credits. (Relevant portions of the Cigna 10-K are attached as Exhibit E.) Thus, as the Health Insurers themselves admit, the alleged harm is both derivative (from the Guaranty Associations) and recoupable (costs passed on to policyholders or the public).

For the reasons set forth below, the Liquidator thus opposes the Application to Intervene.

II. ARGUMENT

This Court should deny the Application to Intervene because the Health Insurers fail to satisfy the requirements of intervention set forth in Rule 3775 of the Pennsylvania Rules of Appellate Procedure. As this Court has held, Guaranty Association assessments do not create a direct interest in the distribution of the

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201(b)(1), (2). The Form 10-K filings are on file with the SEC, and the statements by UnitedHealth are available on its website, http://www.unitedhealthgroup.com/Investors/FinancialReports.aspx. This Court is thus requested to take Judicial Notice of these documents. Pa. R.E. 201(c)(2).

Companies' assets. The Health Insurers' due process argument is similarly not persuasive, as the Health Insurers have no grounds to claim that they have any recognizable interest or that they are entitled to additional process beyond the administrative remedies which they have failed to pursue. In addition, the Health Insurers have presumed they have standing, launching into a discussion of the merits of their putative objection as if the Court had already granted their Application. That discussion should be struck and wholly ignored by the Court because it has no place in this proceeding unless and until the Health Insurers are found to have standing to assert it. For the reasons set forth herein, they do not satisfy applicable standing requirements. Even if the Court were to consider the merits of the premature objection, the Liquidator respectfully submits that it is based on a specious and twisted interpretation of applicable law, the only virtue of which is to enable the transfer of money from the policyholders of these failed insurers to the Health Insurers.

A. This Court Need Not Consider the Application Because the Health Insurers' Lack of Standing is the Law of the Case

The Application to Intervene is not the first time the Health Insurers have objected to the use or distribution of the Companies' assets for a purpose with which they disagree. This Court previously rejected the Health Insurers' position that standing may be found on conclusory allegations regarding the burden of Guaranty Association assessments. This holding, which the Health Insurers never

challenged, is the law of the case and should be adopted with respect to the Health Insurers' current Application.

Prior to entering Liquidation, the Statutory Liquidator negotiated a settlement with the Companies' parent that included the making of certain payments and the allocation of certain tax attributes to PTAC, and thereafter sought this Court's approval. The Health Insurers opposed the settlement, relying (as they do in the instant Application) on their derivative interest from future assessments by the Guaranty Associations to establish standing to challenge the settlement and planned distribution of PTNA and ANIC assets.

In denying the Objections, this Court rejected the Health Insurers' argument that the "burden of the assessments from the state insurance guaranty associations" could establish standing with respect to the distribution of PTNA's and ANIC's assets. Memorandum Opinion and Order at 5, *In Re: Penn Treaty Network Am. Ins. Co.*, No. 1 PEN 2009 (Pa. Commw. Ct. Sept. 23. 2016) (quoting Health Insurers' Objections) (quotation marks omitted). Indeed, the Health Insurers' objections were devoid of "any explanation of how they will be aggrieved … save for a single conclusory statement" asserting the "burden" of those assessments. *Id.* at 6. This, the Court concluded, "does not constitute a direct or immediate interest." *Id.*

In their Application, the Health Insurers again complain that they will bear the burden of Guaranty Association assessments. Application, ¶¶ 2, 16, 19, 20. This Court's unchallenged finding that conclusory statements regarding the potential impact of Guaranty Association assessments do not qualify as a direct or immediate interest is now the law of the case, and the Health Insurers should not be permitted to revisit this issue. *See Dep't of Corr. v. Workers' Comp. Appeal Bd. (Wagner-Stover)*, 6 A.3d 603, 614 n. 20 (Pa. Commw. Ct. 2010) (Leavitt, J.) (law of the case doctrine bars second review of an issue already decided by the court in the same case). As a matter not "of right but of grace," the Court is competent to correct decisions that are "palpably erroneous", but that is not the case here. *Merkel v. W.C.A.B. (Hoffman Indus.)*, 918 A.2d 190, 194 (Pa. Commw. Ct. 2007). The Health Insurers merely re-argue the same position, adding only speculative claims about the *extent* of the assessment by Guaranty Associations after the *possibility* of Non-GA Benefits payments.[6] This Court should rest on its prior holding declaring that the Health Insurers' derivative interest from the Guaranty Associations is insufficient to establish standing.

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[6] It is worth noting that the Health Insurers did not verify the Application because, allegedly, "[e]ach of the Health Insurers lacks sufficient knowledge or information to verify the foregoing Application . . . ." *See* Verification of Howard S. Horwich. It is startling that the Health Insurers cannot verify the alleged assessment burden when they are simultaneously reporting the assessment burden (or lack thereof) in public filings. (*See* Exs. A-E (statements regarding assessment burden).)

B. The Health Insurers Cannot Establish a Right to Intervene under Rule 3775

This Court should deny the Application because, even without considering the prior decision, the Health Insurers cannot satisfy their burden under Rule 3775.

1. Applicable Intervention Standard

Intervention is at heart a question of standing, and the Pennsylvania Supreme Court has held that direct harm is the threshold issue in the intervention and standing analysis. *See Johnson v. Am. Standard*, 8 A.3d 318, 333 (Pa. 2010) ("[A] party must be aggrieved in order to possess standing to pursue litigation."). Unless adversely affected, an entity is not aggrieved and thus "has no standing to obtain a judicial resolution of that challenge." *Hosp. & Health Sys. Ass'n of Pennsylvania v. Dep't of Pub. Welfare*, 888 A.2d 601, 607 (Pa. 2005). The specific rules governing intervention in insurer receivership proceedings mirror these standards. *See* Pa.R.A.P. 3775(a) ("A person not named as a respondent in a formal proceeding who has a direct and substantial interest in the administration of the insurer's business or estate may request leave of court to intervene."); Pa.R.A.P. 3775(c) ("Intervention in a formal proceeding shall be allowed" only if the putative intervenor "establish[es] a sufficient interest in the proceedings.").

Thus, the Health Insurers have the burden of establishing two key elements. First, "[o]ne who seeks to challenge governmental action must show a direct and substantial interest." *Wm. Penn Parking Garage, Inc. v. City of Pittsburgh*, 464 Pa.

168, 202 (1975). Second, "they must show a sufficiently close causal connection between the challenged action and the asserted injury to qualify the interest as 'immediate' rather than 'remote.'" *Id.*

Where a government rule or action is at issue, the Court begins by asking whether "'the interest sought to be protected by the complainant is arguably within the zone of interests to be protected or regulated by the statute or constitutional guarantee in question.'" *Johnson v. Am. Std.*, 607 Pa. 492, 511 (2010) (quoting *Ass'n of Data Processing Serv. Orgs. v. Camp*, 397 U.S. 150, 153 (1970)). The "zone of interests" query is a guidepost, not an absolute determinant of standing. *See id.* at 517. Thus, "it is clear that the possibility that an interest will suffice to confer standing grows less as the causal connection grows more remote." *Wm. Penn*, 464 Pa. at 197. Harm is not "direct or immediate" if it is based on pure speculation. *Crosby Valve v. Dep't of Ins.*, 131 A.3d 1087, 1097 (Pa. Commw. Ct. 2015).

For the reasons set forth below, the Health Insurers fail to show that they will suffer any harm, or that their imagined harm is so immediate that intervention is required.

2. Article V Places the Health Insurers Outside of the Scope of Protected Interests

The Health Insurers are a group of independent health insurance companies with no contractual, ownership, or other relationship with the Companies.

Importantly, they are outside of the zone of interests protected by Article V. The Health Insurers are neither the object of the challenged action in this case, nor are they listed among the types of parties that receivership proceedings are designed to protect under Article V: *i.e.*, "insureds, creditors, and the public generally . . . ." 40 P.S. § 221.1. Accordingly, the Health Insurers' interest is already considered remote for purposes of liquidation. The legislature has not seen fit to recognize or take action to protect any interest they may hold in Guaranty Association assessments.

The Health Insurers are attempting to expand their role and their influence, seeking to cut out the Guaranty Associations as well as their boards and other members. But they have no direct interest here. They will never have a claim against the estates. They are nine insurers ***out of hundreds*** who may bear temporarily some unquantified amount of responsibility for Guaranty Association assessments, and they continue to seek to intervene in and interfere with these proceedings only to benefit their own self interests.

In so doing, the Health Insurers invite this Court to open the floodgates on intervention by those with derivative claims. The Health Insurers are in a position similar to that of the shareholder of a creditor with no direct interest in the PTNA and ANIC estates. Like a shareholder claiming that a contemplated action will diminish the value of the company's stock, the Health Insurers allege only that

they may suffer a loss as a result of their interest in the Guaranty Associations. It is well-settled that a shareholder has no standing to intervene unless it has a "direct, personal injury" to the "shareholder as an individual", rather than the corporation. *Morrison Informatics, Inc. v. Members 1st Credit Union*, 97 A.3d 1233, 1237-38 (Pa. Super. Ct. 2014); *Hill v. Ofalt*, 85 A.3d 540, 548-49 (Pa. Super. Ct. 2014). Other receivership courts have therefore unsurprisingly held that insolvent insurers' independent shareholders lack standing to participate in liquidation proceedings. *See Cohen v. State ex rel. Stewart*, 89 A.3d 65, 74 & n.33, 94 & n.127 (Del. 2014); *Metcalf v. Investors Equity Life Ins. Co. of Hawai'i, Ltd.*, 910 P.2d 110, 111 (Haw. 1996); *State ex rel. Holland v. Heritage Nat'l Ins. Co.*, 184 P.3d 1093, 1097 (Okla. Civ. App. 2008); *Hartnett v. S. Am. Fire Ins. Co.*, 495 So.2d 902, 903 (Fla. Dist. Ct. App. 1986). These Courts properly recognize that derivative claimants have no role to play in receivership proceedings.

This Court should not allow the Health Insurers to intervene where they are outside of the zone of interests protected by Article V and bring nothing more than a derivative claim arising from their interest in the Guaranty Associations. To do so would ignore the statutory receivership scheme as well as settled common-law principles governing derivative claims. The Health Insurers' emphasis on their own interests over those protected by Article V (the Companies' creditors and policyholders, and the general public) should not be overlooked.

3. The Health Insurers Fail to Establish Any Harm Outside the Protected Zone of Interests That Would Warrant Intervention

The Health Insurers come before this Court already burdened by their diminished interest under Article V. But as this Court previously recognized, their alleged harm is insufficient on its face to establish standing even if their views could be considered in the liquidation analysis.

The Health Insurers' Application is supported only by speculation, assumptions, and conclusory statements regarding potential harm. *See*, *e.g.*, Application Introduction, ¶ 1 ("the anticipated allocation of estate assets"), ¶ 8 ("the uncertainty as to whether the Receiver intends to seek Court approval"), ¶ 16 ("if the [allegedly] illegal distribution is allowed to occur"), ¶ 19 ("[a]ssuming that the Receiver intends to utilize an allocation formula similar to that in the Second Amended Plan…"). The Application is also admittedly filed before the Health Insurers' potential putative interests are set. *See* Application, ¶ 8 ("[b]ecause of … the uncertainty as to whether the Receiver intends to seek Court approval for that allocation or transfer, the Health Insurers present this application in advance of the entry of the liquidation orders"). The Statutory Liquidator has yet to file an application concerning the allocation or distribution of assets for the provision of the Non-GA Benefits, but, as noted herein, she intends to seek approval for any such distribution.

Even if the Application were filed, of course, the Health Insurers' claims would arise from purely speculative and remote harm. This Court rejected the derivative-exposure approach taken by the Health Insurers, but, even if it had not, the Application is pure speculation with regard to the alleged interest arising from the potential exposure the Health Insurers may have. This is simply not enough to show a direct and substantial interest. *Crosby Valve*, 131 A.3d at 1097.

The Health Insurers are, simply put, guessing. At each stage, the purported "interest" is based on unsupported allegations concerning a possible loss and assumptions regarding the Liquidator's allocation formula for the Non-GA Benefits.[7] The Application begins by citing to an alleged "$100 million" figure in order to suggest the Health Insurers may suffer a significant harm if the Non-GA Benefits are paid in Liquidation. *See* Application, ¶¶ 7, 16, 19, 20. But the Application reflects that this figure is based upon an assumption as to the Statutory Liquidator's allocation formula. Application, ¶ 19.

After relying upon this headline number, the Health Insurers admit that the alleged exposure is not directly suffered by the Health Insurers. According to the Application, their collective potential exposure would be "nearly half" of that, or somewhere "over $40 million." *See* Application, ¶¶ 16, 20. Even if the Health

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[7] Indeed, the alleged harm is pure legal fiction that only counsel could verify. *See* Verification of Howard S. Horwich (noting that "[e]ach of the Health Insurers lacks sufficient knowledge or information to verify the foregoing Application....")

Insurers accurately identified the assessment value arising from the Non-GA Benefits, the $40 million exposure would split amongst the nine parties seeking to intervene.

Importantly, these speculative assessment figures do not actually reflect possible losses to the Health Insurers, and thus cannot be a "substantial" interest. *See Penn Parking*, 464 Pa. at 191-195 (requiring substantial and specific adverse pecuniary effect). The Health Insurers complain in their Application that the Guaranty Associations will pass through to their members any assessments as a result of the Liquidation. Several of the Health Insurers, however, have publicly disclosed how they will pass through the same costs to their policyholders or will recoup them through premium tax offsets. For example, UnitedHealth Group disclosed that its exposure to the Guaranty Associations has already been "recognized" and will be "funded over several years and *affected by premium tax credits over time*." *See* UnitedHealth Group Form 10-K for the year ending December 31, 2016, p. 33 (emphasis added); UnitedHealth Group 10-K Comment. UnitedHealth adopted the same posture in its Fourth Quarter Teleconference of January 17, 2017, where it indicated that the assessments will be "largely recovered through premium tax credits over time" and also reported over $184 billion in revenue for 2016. (Exs. A-C.) Thus, even if UnitedHealth were forced to pay the entire alleged $40 million assessment for Non-GA Benefits, the direct

harm claimed in the Application amounts to less than 0.05% of its revenue last year.

The other Health Insurers appear to take a similar approach. Anthem, Inc., reported on its 2016 Form 10-K that the Guaranty Association assessments arising from the Companies' liquidation will be recovered through premium billing surcharges and premium tax credits. (Ex. D.) Cigna Corporation also reported on its 2016 Form 10-K that the majority of any assessment from the Companies' liquidation will be offset by premium tax credits. (Ex. E.)

The Application fails to disclose that the allegations of harm are contradicted by the Health Insurers' statements to the public and to regulators. The Health Insurers' purported interests are speculative at best and any potential losses are likely to be recouped. This is not a "direct and substantial interest" in the proceedings that warrants intervention.

The Health Insurers' lack of standing reflects an additional reason to deny the Application. Given the speculative nature of the relief sought, the Application represents nothing more than an attempt to elicit an impermissible advisory opinion. *See Stuckley v. Zoning Hearing Bd.*, 79 A.3d 510, 519 (Pa. 2013) (when no justiciable case or controversy exists, "any opinion would be merely advisory, and therefore, inappropriate"). There is no current case or controversy among the

parties. This Court should reject the Application as an attempt to secure an advisory opinion where no dispute exists. *Stuckley*, 79 A.3d at 519.

C. The Health Insurers Failed to Exhaust Their Administrative Remedies

Even if the Health Insurers had standing to intervene in the Liquidation — and they do not — this Court would lack jurisdiction to entertain the Health Insurers' objections because they have failed to exhaust available administrative remedies. Statutory law makes clear that the Health Insurers must rely on state Guaranty Associations to speak on their behalf, and those same statutes prescribe a system of administrative remedies should the Guaranty Associations fail to do so.

Put another way, if either state Guaranty Associations or the National Organization of Life and Health Insurance Guaranty Associations ("NOLHGA") do not take what the Health Insurers deem to be appropriate actions, then the state life and health insurance guaranty association acts prescribe mandatory administrative procedures that the Health Insurers must follow in order to challenge an "action of the board of directors or the association." *E.g.*, 40 P.S. § 991.1709(c); Model GA Act § 11C.[8]

[8] Moreover, the state and model Guaranty Association statutes are evidence that the industry and state legislatures have concluded that the Guaranty Associations and NOLHGA adequately represent the interests of member insurers in liquidation proceedings, further demonstrating that the Health Insurers have no direct and substantial interest that warrants intervention.

Specifically, the Pennsylvania Life and Health Insurance Guaranty Association Act provides that:

> ***Any action of the board of directors or the association may be appealed to the commissioner by any member insurer*** if such appeal is taken within sixty (60) days of the final action being appealed. If a member company is appealing an assessment, the amount assessed shall be paid to the association and available to meet association obligations during the pendency of an appeal. If the appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member company. ***Any final action or order of the commissioner shall be subject to judicial review in a court of competent jurisdiction***.

40 P.S. § 991.1709(c) (emphasis added).[9] Thus, the Guaranty Association statutes expressly contemplate that member insurers may wish to challenge actions of their Guaranty Association or its board, and they provide a fully adequate procedure and remedy for that specific purpose: within 60 days after the action becomes final, the member may appeal the action to the Commissioner, and the Commissioner's decision is appealable to a court of competent jurisdiction in the state in which the

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[9] Section 991.1709(c) of the Pennsylvania Life and Health Insurance Guaranty Association Act is based on § 11C of the Model Act, which provides:

> A final action of the board of directors or the Association may be appealed to the commissioner by a member insurer if the appeal is taken within sixty (60) days of its receipt of notice of the final action being appealed. A final action or order of the commissioner shall be subject to judicial review in a court of competent jurisdiction in accordance with the laws of this State that apply to the actions or orders of the commissioner.

challenge is made. The Health Insurers have not appealed any action of any Guaranty Association or Guaranty Association board to the Commissioner, or to the Liquidator's knowledge the commissioner of any other state. Because they have denied the Commissioner (and her contemporaries) the opportunity to reach a final action on any of the issues that they raise, the Health Insurers cannot raise related claims in this Court. *Id.*[10]

Exhaustion of the remedies set forth in 40 P.S. § 991.1709(c) (and similar statutes of other states) is a prerequisite to the Health Insurers coming before this Court and asking for any relief that is contrary to that sought by NOLHGA or the state Guaranty Associations. "It is fundamental that prior to resorting to judicial remedies, litigants must exhaust all the adequate and available administrative remedies which the legislature has provided." *Ohio Cas. Grp. v. Argonaut Ins. Co.,* 514 Pa. 430, 435 (1987). Such exhaustion is a strict requirement of both the common law and the Pennsylvania Statutory Construction Act. *See id.* ("The doctrine of exhaustion of administrative remedies is founded on judicial recognition of the mandate of the legislature that statutorily prescribed remedies

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[10] For this reason, the wait-and-see approach adopted by the Virginia Life, Accidental & Sickness Guaranty Association ("VAGA") completely inverts the administrative scheme governing Guaranty Associations. (*See* Exhibit 1 to the Application.) According to the VAGA letter, if the Health Insurers are rightfully denied intervention, VAGA *may* then seek to intervene but it is not guaranteed to do so. (Ex. 1. to App.) If it does not, the Health Insurers will have a new opportunity to challenge the Non-GA Benefits by contesting VAGA's decision. Rather than ignore administrative law, the Health Insurers should instead exhaust their remedies as required.

are to be strictly pursued."); 1 Pa.C.S. § 1504 ("In all cases where a remedy is provided or a duty is enjoined or anything is directed to be done by any statute, the directions of the statute shall be strictly pursued.").

Because the Health Insurers have not pursued an administrative appeal, there can be no judicial review. They have raised their concerns prematurely, rendering them not "ripe," and the Court should not excuse them from statutorily mandated procedures. And because no "final action" has been taken here, the Health Insurers have not suffered a direct and immediate injury that could justify departure from this well-settled principle of administrative law. 40 P.S. § 991.1709(c).

D. The Health Insurers' Decision to Leapfrog Their Administrative Remedies Does Not Entitle Them to Additional "Due Process" Rights

The Health Insurers also contend that their "due process rights would be violated if their application for limited intervention were denied." (Brief in Support of Intervention at 10.) This argument wrongfully suggests that the Health Insurers do not have any other remedy, or that they have a right to intervene outside of the requirements under the Rules of Appellate Procedure.

The Health Insurers purport to invoke the fundamental right to due process, declaring that "i[f] denied intervention, the Health Insurers will have no other opportunity to be heard on this issue…." This claim is simply untrue. As set forth above, if the Guaranty Associations or NOLHGA support or do not act to oppose

the Non-GA Benefits, state statute provides a process for the Health Insurers to be heard on the merits of their claim. Whatever interest the Health Insurers think they have, the legislature has already established administrative and judicial remedies for them to pursue prior to the assessments and after.

The Health Insurers also make no showing of some independent due process right even if they cannot establish a right to intervene. Contrary to the Health Insurers' arguments, not every party that may be affected by a decision has a right to participate in the proceedings. *Cf. Petty v. Hosp. Serv. Ass'n of Ne. Pa.*, 611 Pa. 119, 135 (2011) (observing that interest warranting intervention must be "other than that of the general citizenry.") The cases cited by the Health Insurers, *Fulton v. Bedford County Tax Claim Bureau*, *Pa. Coal Mining Ass'n v. Ins. Dep't*, and *Larock v. Sugarloaf Twp. Zoning H'g Bd.* are not to the contrary.

Importantly, unlike the speculative and derivative harm claimed by the Health Insurers, both *Fulton* and *Larock* involved established, settled property interests. *See Fulton*, 942 A.2d 240, 243 (Pa. Commw. Ct. 2008) (sheriff's sale purchaser held legal title to property at issue and thus was entitled to due process before a forced transfer); *Larock*, 740 A.2d 308, 313 (Pa. Commw. Ct. 1999) (recognizing settled common-law principles that property owners in "immediate vicinity of property involved in zoning litigation" were entitled to intervene (internal quotation marks omitted)). Here, the Health Insurers have only a

derivative interest, recoupable against their policyholders or premium taxes, that is neither settled nor substantial like the real property interests in *Fulton* and *Larock*.

Pa. Coal Mining Ass'n is similarly inapposite. There, the appellants established an interest protected by the due process clause based on an analysis of "the nature of the government activity and the citizen's dependency and reliance on that activity." 370 A.2d 685, 690 (Pa. 1977). The Health Insurers assume without establishing that their claimed "harm" from the assessments represents a property right to be protected by due process. As set forth herein, the Health Insurers lack *any* cognizable interest, given the derivative nature of their claim as well as the ability to pass through any costs to policyholders or recover them through tax offsets. Moreover, *Pa. Coal Mining Ass'n* does not address the intervention standard; instead, it asked whether a party has received sufficient due process where it has a right to contest rate increases as opposed to receiving notice and an opportunity to be heard before those rates go into effect. The Health Insurers already have an opportunity to be heard through the administrative procedures established to challenge decisions by the Guaranty Associations or NOLHGA.

The Health Insurers make no argument showing that their interests are entitled to the protections of due process and completely ignore the administrative process available to them. To the extent the Health Insurers suffer any injury

(which they do not), that interest is sufficiently protected by the Guaranty Associations, NOLHGA, and the procedures established for their operations.

E. The Objection of The Health Insurers Is Without Merit

Though they lacked standing to do so, the Health Insurers nonetheless included in their Application the substance of the objection they would pursue if granted that standing. That objection is not now before the Court and the Liquidator will therefore reserve any substantive response for the unlikely eventuality that the issue will be lawfully raised. Suffice it at this juncture to observe that the argument of the Health Insurers is premised on inapplicable cases subjected to tortuous interpretations aimed solely at reducing policyholder benefits so that the Health Insurers might avoid a portion of any burden imposed on them by statute (which they have largely admitted does not exist) effectively as a cost of doing the lucrative business in which they are engaged.

III. CONCLUSION

For the reasons set forth herein, this Court should deny the Application to Intervene.

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Respectfully submitted,

/s/ James R. Potts

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