IN THE COMMONWEALTH COURT OF PENNSYLVANIA

In Re: American Network Insurance Company in Rehabilitation	No. 1 ANI 2009

FORMAL COMMENT ON THE PROPOSED PLAN OF REHABILITATION FOR AMERICAN NETWORK INSURANCE COMPANY

Aetna Life Insurance Company, Cigna Corporation, UnitedHealthcare Insurance Company and WellPoint, Inc. (the "Health Insurers") through their undersigned counsel hereby submit this formal comment to the Plan of Rehabilitation (the "Plan") for American Network Insurance Company (the "Company") in accordance with the Case Management Order issued by the Court on June 5, 2013. The Health Insurers are among the largest health insurance companies in the nation.

The Health Insurers submit these comments to call the Court's attention to the fact that the Plan imposes significant risks on the public while only preserving a portion of the policyholders' coverage. The impact on the public is one of the elements which the court must consider in deciding whether to confirm the Plan.

Impact on Policyholders

The Plan is intended to equitably apportion the loss caused by the Company's insolvency across all policyholders. *See* Plan at 21. It does so by suspending certain benefits of policyholders during the term of the Plan. *See* Plan at 12-20. In the event that the Company is unable to pay both the benefits payable under the Plan and the benefits that have been suspended, the Court may enter an order terminating the rehabilitation and directing the liquidation of the Company. *See* Plan at 14 and 20. At present, the Plan does not envision a means by which the suspended benefits can be paid in full. It is only stated that "the Rehabilitator believes that the

Plan gives the rehabilitation team the time to implement longer-term remedial measures which may result in material improvements in the company's financial condition, inuring to the benefit of policyholders and creditors." *See* Plan at 21. If those further remedial measures do not succeed in restoring the Company to the point where it can pay the suspended benefits, it would appear that liquidation is the only path remaining. If liquidation follows several years of operation under the Plan, not only would there be few, if any, assets remaining to pay ongoing benefits, but issues of first impression would also be created for policyholders in jurisdictions that are outside the purview of this court.

Impact on the Public

Implementation of the Plan would impose an additional significant risk on the public by increasing the losses that will eventually have to be paid by guaranty associations if liquidation ensues. The net loss faced by the guaranty associations for future claims (not even counting the benefits that are suspended during the term of the Plan) (the "Ultimate Net Loss") is expected to grow significantly during the term of the Plan. Under the Plan, premiums and assets related to the policies will be utilized in the rehabilitation effort but the guaranty associations' limits of liability for policyholders will not be reduced by payments made to policyholders. The Health Insurers are in the process of quantifying the prospective increase in the Ultimate Net Loss, and continue to work with the rehabilitator to obtain the information necessary for them to present evidence at trial on these amounts.

Guaranty association laws are primarily designed to protect policyholders in the event that an insurer is unable to meet its contractual obligations due to impairment or insolvency. The guaranty association system was created to promote the public interest and is a publicly financed system, as the obligations of a guaranty association are redistributed back to the public in a

variety of ways. In some states, the loss is distributed back to the public through premium tax offsets. *See, e.g.*, 40 P.S. § 991.1711. In other states, the loss is distributed back to the public through surcharges on insurance policies. *See, e.g.*, Cal. Ins. Code § 1067.08(i)(1).

Some losses also could be distributed to the public under the new federal healthcare reform law. Although health insurance companies did not write long term care insurance in any significant amount, the guaranty association assessment mechanism considers long term care to be health insurance.[1] *See, e.g.*, 40 P.S. § 991.1707; Regulatory Guidance Pennsylvania Guaranty Associations - L&A and LTC (Version 13 published Aug. 6, 2012); Cal. Ins. Code §§ 1067.02(b)(1) and 1067.08. Many long term care companies and life insurance companies that wrote most of the long term care insurance have decided to exit the market, in part, due to the reluctance of regulators to grant rate increases -- precisely the issue considered by the rehabilitator in formulating the Plan. For many of such companies, long term care was their only health insurance line of business and so their contributions to health guaranty associations will diminish over time. As such, health insurers will assume an ever greater percentage of the guaranty association assessments arising out of insolvencies of long term care insurers. This will shift the burden squarely to the public as health insurance buyers.

As of January 1, 2014, all citizens are mandated by the Patient Protection and Affordable Care Act (P.L. 111-148, as amended, the "ACA) to purchase health insurance, and in some cases, the government is subsidizing that purchase. For many health companies, guaranty association assessments act as a reduction in premium revenue, through operation of the reinsurance, risk corridor and risk adjustment programs. These three programs collectively operate to put a cap on

[1] Long term care insurance is considered a sub-line of business within the overall general line of business category of health insurance for the purpose of guaranty association assessment calculation and allocation.

health insurer's capital accumulation, forcing them to redistribute assessments back to policyholders almost immediately through higher premiums.

Balancing of interests

This case has enormous precedential significance because long term care is a troubled line of business for many companies. The Plan preserves only a portion of the benefits available to policyholders while increasing the ultimate cost to the public if the companies are eventually liquidated. The Plan represents a well-intended effort by the rehabilitator and talented professionals to solve an intractable problem.

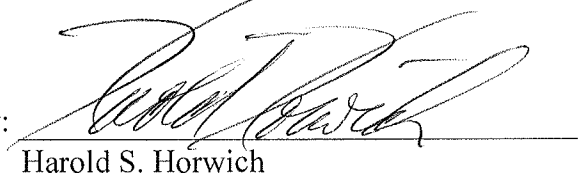
But in considering the Plan, the court must consider the interests of the public. *See Foster v. Mutual Fire, Marine & Inland Ins. Co.*, 531 Pa. 598, 613-14 (1992) ("So long as the rehabilitation properly conserves and equitably administers the assets of the involved corporation in the interest of investors, the public and others, with the main purpose being the public good the plan of rehabilitation is appropriate.") (internal quotations, citation omitted); *see also Grode v. Mutual Fire, Marine & Inland Ins. Co.*, 572 A.2d 798, 801 n.5 (Pa. Commw. Ct. 1990) ("the equitable purpose of rehabilitation and liquidation is to protect *first of all* consumers of insurance.") (emphasis in original); 40 P.S. § 221.1(c) ("The purpose of [Article V] is the protection of the interests of insureds, creditors, and the public generally...."). The Health Insurers submit that the Plan does not appropriately reconcile the interests of policyholders and the interests of the public. It places too much risk on the public for not enough benefit to the policyholders.

The Health Insurers hereby notify the Court of their intention to participate in the hearing on the Plan, to submit documentary evidence, to proffer and cross examine witnesses, and to file briefs and make argument to the Court. The Health Insurers reserve their right to supplement this formal comment as more information is provided by the rehabilitator.

Respectfully submitted,

Dated: August 29, 2013

BINGHAM MCCUTCHEN LLP

By: 

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