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SC Court of Appeals

**THE STATE OF SOUTH CAROLINA
In the Court of Appeals**

**APPEAL FROM RICHLAND COUNTY
Court of Common Pleas**

L. Casey Manning, Chief Administrative Judge, Fifth Judicial Circuit

2020-CP-4005802

Raymond G. Farmer, as Director of the
South Carolina Department of Insurance,
and the South Carolina Department of
Insurance,

Respondents,

v.

Jessica K. Altman, as Rehabilitator of
Senior Health Insurance Company of
Pennsylvania, Patrick H. Cantilo, as Special
Deputy Rehabilitator of Senior Health
Insurance Company of Pennsylvania, and
Senior Health Insurance Company of
Pennsylvania in Rehabilitation,

Appellants

AMENDED RECORD ON APPEAL

VOLUME II

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**APPENDIX B
SELECTED FINANCIAL INFORMATION**



**SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
*IN REHABILITATION***

THE ATTACHED PAGES ARE SELECTED EXCERPTS FROM THE COMPANY'S UNFILED 2019 STATUTORY FINANCIAL STATEMENT AND INTERNAL 2020 FINANCIAL INFORMATION. NO REPRESENTATION, EXPRESS OR IMPLIED, IS MADE AS TO THEIR ACCURACY OR COMPLETENESS.

THIS INFORMATION IS PROVIDED SOLELY FOR INFORMATION AND CONTAINS STATEMENTS THAT ARE, OR MAY BE DEEMED TO BE, "FORWARD-LOOKING STATEMENTS" WITHIN THE MEANING OF THE PRIVATE SECURITIES LITIGATION REFORM ACT OF 1995. ANY SUCH FORWARD-LOOKING STATEMENTS ARE BASED UPON A VARIETY OF ESTIMATES AND ASSUMPTIONS THAT, THOUGH CONSIDERED REASONABLE BY THE REHABILITATOR, MAY NOT BE REALIZED, AND ARE INHERENTLY SUBJECT TO SIGNIFICANT BUSINESS, ECONOMIC AND OTHER UNCERTAINTIES AND CONTINGENCIES.

SOME ASSUMPTIONS INEVITABLY WILL NOT MATERIALIZE AND EVENTS AND CIRCUMSTANCES OCCURRING SUBSEQUENT TO THE DATE ON WHICH THE INFORMATION WAS PREPARED MAY BE SIGNIFICANTLY DIFFERENT FROM THOSE ASSUMED, OR MAY BE UNANTICIPATED, AND THUS MAY AFFECT FINANCIAL OR OTHER RESULTS IN A MATERIAL AND POSSIBLY ADVERSE MANNER. THE INFORMATION, THEREFORE, SHOULD NOT BE RELIED UPON AS A GUARANTY OR OTHER ASSURANCE OF THE ACTUAL RESULTS THAT WILL OCCUR.

ASSETS

ELECTRONICALLY FILED - 2021 Aug 23 4:56 PM - RICHLAND - COMMON PLEAS - CASE#2020CP4005802

	Current Year			Prior Year
	1	2	3	4
	Assets	Nonadmitted Assets	Net Admitted Assets (Cols. 1 - 2)	Net Admitted Assets
1. Bonds (Schedule D).....	1,721,888,236		1,721,888,236	2,006,961,967
2. Stocks (Schedule D):				
2.1 Preferred stocks.....	86,271,292		86,271,292	109,432,792
2.2 Common stocks.....	3,578,386		3,578,386	1,813,578
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens.....	12,681,751		12,681,751	17,540,853
3.2 Other than first liens.....			0	
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less \$.....0 encumbrances).....			0	
4.2 Properties held for the production of income (less \$.....0 encumbrances).....			0	
4.3 Properties held for sale (less \$.....0 encumbrances).....			0	
5. Cash (\$.....(6,955,915), Schedule E-Part 1), cash equivalents (\$.....53,638,393, Schedule E-Part 2) and short-term investments (\$.....0, Schedule DA).....	46,682,478		46,682,478	20,755,355
6. Contract loans (including \$.....0 premium notes).....			0	
7. Derivatives (Schedule DB).....			0	
8. Other invested assets (Schedule BA).....	25,617,716	9,916,628	15,701,088	11,834,651
9. Receivables for securities.....	135,570		135,570	10,149
10. Securities lending reinvested collateral assets (Schedule DL).....			0	
11. Aggregate write-ins for invested assets.....	0	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11).....	1,896,855,429	9,916,628	1,886,938,801	2,168,349,345
13. Title plants less \$.....0 charged off (for Title insurers only).....			0	
14. Investment income due and accrued.....	12,081,945		12,081,945	15,264,664
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection.....	929,722	1,699	928,023	1,071,261
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including \$.....0 earned but unbilled premiums).....			0	
15.3 Accrued retrospective premiums (\$.....0) and contracts subject to redetermination (\$.....0).....			0	
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers.....	22,002		22,002	13,421
16.2 Funds held by or deposited with reinsured companies.....			0	
16.3 Other amounts receivable under reinsurance contracts.....	(48)		(48)	
17. Amounts receivable relating to uninsured plans.....			0	
18.1 Current federal and foreign income tax recoverable and interest thereon.....	2,364,433		2,364,433	(138,737)
18.2 Net deferred tax asset.....			0	
19. Guaranty funds receivable or on deposit.....	1,208,738		1,208,738	1,448,680
20. Electronic data processing equipment and software.....			0	
21. Furniture and equipment, including health care delivery assets (\$.....0).....			0	
22. Net adjustment in assets and liabilities due to foreign exchange rates.....			0	
23. Receivables from parent, subsidiaries and affiliates.....	49,541		49,541	49,639
24. Health care (\$.....0) and other amounts receivable.....	30,700	30,700	0	
25. Aggregate write-ins for other-than-invested assets.....	3,587,702	0	3,587,702	0
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25).....	1,917,130,164	9,949,027	1,907,181,137	2,186,058,273
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts.....			0	
28. TOTAL (Lines 26 and 27).....	1,917,130,164	9,949,027	1,907,181,137	2,186,058,273

DETAILS OF WRITE-INS

1101.			0	
1102.			0	
1103.			0	
1198. Summary of remaining write-ins for Line 11 from overflow page.....	0	0	0	0
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above).....	0	0	0	0
2501. Reimbursement from Insurance Carrier.....	3,587,702		3,587,702	
2502.			0	
2503.			0	
2598. Summary of remaining write-ins for Line 25 from overflow page.....	0	0	0	0
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above).....	3,587,702	0	3,587,702	0

Annual Statement for the year 2019 of the

Senior Health Insurance Company of Pennsylvania

LIABILITIES, SURPLUS AND OTHER FUNDS

	1	2
	Current Year	Prior Year
1. Aggregate reserve for life contracts \$.....0 (Exhibit 5, Line 9999999) less \$.....0 included in Line 6.3 (including \$.....0 Modco Reserve).....		
2. Aggregate reserve for accident and health contracts (including \$.....0 Modco Reserve).....	2,766,443,751	2,608,580,249
3. Liability for deposit-type contracts (Exhibit 7, Line 14, Col. 1) (including \$.....0 Modco Reserve).....		
4. Contract claims:		
4.1 Life (Exhibit 8, Part 1, Line 4.4, Col. 1 less sum of Cols. 9, 10 and 11).....		
4.2 Accident and health (Exhibit 8, Part 1, Line 4.4, sum of Cols. 9, 10 and 11).....	37,734,617	35,658,115
5. Policyholders' dividends/refunds to members \$.....0 and coupons \$.....0 due and unpaid (Exhibit 4, Line 10).....		
6. Provision for policyholders' dividends, refunds to members and coupons payable in following calendar year - estimated amounts:		
6.1 Policyholders' dividends and refunds to members apportioned for payment (including \$.....0 Modco).....		
6.2 Policyholders' dividends and refunds to members not yet apportioned (including \$.....0 Modco).....		
6.3 Coupons and similar benefits (including \$.....0 Modco).....		
7. Amount provisionally held for deferred dividend policies not included in Line 6.....		
8. Premiums and annuity considerations for life and accident and health contracts received in advance less \$.....0 discount; including \$....1,462,254 accident and health premiums (Exhibit 1, Part 1, Col. 1, sum of Lines 4 and 14).....	1,462,254	1,655,613
9. Contract liabilities not included elsewhere:		
9.1 Surrender values on canceled contracts.....		
9.2 Provision for experience rating refunds, including the liability of \$.....0 accident and health experience rating refunds of which \$.....0 is for medical loss ratio rebate per the Public Health Service Act.....		
9.3 Other amounts payable on reinsurance, including \$....16,032 assumed and \$....1,910 ceded.....	17,942	35,513
9.4 Interest Maintenance Reserve (IMR, Line 6).....	4,746,341	1,564,805
10. Commissions to agents due or accrued - life and annuity contracts \$.....0, accident and health \$.....0 and deposit-type contract funds \$.....0.....	580,812	699,815
11. Commissions and expense allowances payable on reinsurance assumed.....		
12. General expenses due or accrued (Exhibit 2, Line 12, Col. 7).....	6,629,583	3,792,089
13. Transfers to Separate Accounts due or accrued (net) (including \$.....0 accrued for expense allowances recognized in reserves, net of reinsured allowances).....		
14. Taxes, licenses and fees due or accrued, excluding federal income taxes (Exhibit 3, Line 9, Col. 6).....	414,345	603,113
15.1 Current federal and foreign income taxes, including \$.....0 on realized capital gains (losses).....		(2,573,218)
15.2 Net deferred tax liability.....		
16. Unearned investment income.....		
17. Amounts withheld or retained by reporting entity as agent or trustee.....		
18. Amounts held for agents' account, including \$.....0 agents' credit balances.....		
19. Remittances and items not allocated.....	329,763	336,270
20. Net adjustment in assets and liabilities due to foreign exchange rates.....		
21. Liability for benefits for employees and agents if not included above.....		
22. Borrowed money \$.....0 and interest thereon \$.....0.....		
23. Dividends to stockholders declared and unpaid.....		
24. Miscellaneous liabilities:		
24.01 Asset valuation reserve (AVR Line 16, Col. 7).....	206,126	58,113
24.02 Reinsurance in unauthorized and certified (\$.....0) companies.....		
24.03 Funds held under reinsurance treaties with unauthorized and certified (\$.....0) reinsurers.....		
24.04 Payable to parent, subsidiaries and affiliates.....		
24.05 Drafts outstanding.....		
24.06 Liability for amounts held under uninsured plans.....		
24.07 Funds held under coinsurance.....		
24.08 Derivatives.....		
24.09 Payable for securities.....	1,975,610	
24.10 Payable for securities lending.....		
24.11 Capital notes \$.....0 and interest thereon \$.....0.....		
25. Aggregate write-ins for liabilities.....	2,738,221	2,519,689
26. Total liabilities excluding Separate Accounts business (Lines 1 to 25).....	2,823,279,366	2,652,931,248
27. From Separate Accounts Statement.....		
28. Total liabilities (Line 26 and 27).....	2,823,279,366	2,652,931,248
29. Common capital stock.....	2,500,005	2,500,005
30. Preferred capital stock.....	5,000,000	5,000,000
31. Aggregate write-ins for other-than-special surplus funds.....	0	0
32. Surplus notes.....	50,000,000	50,000,000
33. Gross paid in and contributed surplus (Page 3, Line 33, Col. 2 plus Page 4, Line 51.1, Col. 1).....	1,198,824,011	1,196,326,042
34. Aggregate write-ins for special surplus funds.....	0	0
35. Unassigned funds (surplus).....	(2,172,422,245)	(1,720,699,022)
36. Less treasury stock, at cost:		
36.1 0.000 shares common (value included in Line 29 \$.....0).....		
36.2 0.000 shares preferred (value included in Line 30 \$.....0).....		
37. Surplus (Total Lines 31 + 32 + 33 + 34 + 35 - 36) (including \$.....0 in Separate Accounts Statement).....	(923,598,234)	(474,372,980)
38. Totals of Lines 29, 30 and 37 (Page 4, Line 55).....	(916,098,229)	(466,872,975)
39. Totals of Lines 28 and 38 (Page 2, Line 28, Col. 3).....	1,907,181,137	2,186,058,273
DETAILS OF WRITE-INS		
2501. Unclaimed funds.....	2,738,221	2,519,689
2502.		
2503.		
2598. Summary of remaining write-ins for Line 25 from overflow page.....	0	0
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above).....	2,738,221	2,519,689
3101.		
3102.		
3103.		
3198. Summary of remaining write-ins for Line 31 from overflow page.....	0	0
3199. Totals (Lines 3101 through 3103 plus 3198) (Line 31 above).....	0	0
3401.		
3402.		
3403.		
3498. Summary of remaining write-ins for Line 34 from overflow page.....	0	0
3499. Totals (Lines 3401 through 3403 plus 3498) (Line 34 above).....	0	0

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	1	2
	Current Year	Prior Year
1. Premiums and annuity considerations for life and accident and health contracts (Exhibit 1, Part 1, Line 20.4, Col. 1, less Col. 11)	78,564,611	1,237,392,658
2. Considerations for supplementary contracts with life contingencies.....		
3. Net investment income (Exhibit of Net Investment Income, Line 17).....	69,898,620	81,934,412
4. Amortization of Interest Maintenance Reserve (IMR) (Line 5).....	497,421	192,717,772
5. Separate Accounts net gain from operations excluding unrealized gains or losses.....		
6. Commissions and expense allowances on reinsurance ceded (Exhibit 1, Part 2, Line 26.1, Col. 1).....	244	945,401
7. Reserve adjustments on reinsurance ceded.....		
8. Miscellaneous Income:		
8.1 Income from fees associated with investment management, administration and contract guarantees from Separate Accounts		
8.2 Charges and fees for deposit-type contracts.....		
8.3 Aggregate write-ins for miscellaneous income.....	0	0
9. Totals (Lines 1 to 8.3).....	148,960,896	1,512,990,242
10. Death benefits.....		
11. Matured endowments (excluding guaranteed annual pure endowments).....		
12. Annuity benefits (Exhibit 8, Part 2, Line 6.4, Cols. 4 + 8).....		
13. Disability benefits and benefits under accident and health contracts.....	371,758,091	390,323,186
14. Coupons, guaranteed annual pure endowments and similar benefits.....		
15. Surrender benefits and withdrawals for life contracts.....		
16. Group conversions.....		
17. Interest and adjustments on contract or deposit-type contract funds.....		
18. Payments on supplementary contracts with life contingencies.....		
19. Increase in aggregate reserves for life and accident and health contracts.....	157,863,106	1,391,115,603
20. Totals (Lines 10 to 19).....	529,621,197	1,781,438,788
21. Commissions on premiums, annuity considerations and deposit-type contract funds (direct business only) (Exhibit 1, Part 2, Line 31, Col. 1).....	5,172,110	6,133,056
22. Commissions and expense allowances on reinsurance assumed (Exhibit 1, Part 2, Line 26.2, Col. 1).....	482,173	569,135
23. General insurance expenses and fraternal expenses (Exhibit 2, Line 10, Columns 1, 2, 3, 4 and 6).....	29,395,680	34,197,614
24. Insurance taxes, licenses and fees, excluding federal income taxes (Exhibit 3, Line 7, Cols. 1 + 2 + 3 + 5).....	3,889,989	2,640,964
25. Increase in loading on deferred and uncollected premiums.....		
26. Net transfers to or (from) Separate Accounts net of reinsurance.....		
27. Aggregate write-ins for deductions.....	0	12,570,929
28. Totals (Lines 20 to 27).....	568,561,149	1,837,550,486
29. Net gain from operations before dividends to policyholders, refunds to members and federal income taxes (Line 9 minus Line 28).....	(419,600,253)	(324,560,244)
30. Dividends to policyholders and refunds to members.....		
31. Net gain from operations after dividends to policyholders, refunds to members and before federal income taxes (Line 29 minus Line 30)....	(419,600,253)	(324,560,244)
32. Federal and foreign income taxes incurred (excluding tax on capital gains).....	(1,632,614)	(463,908)
33. Net gain from operations after dividends to policyholders, refunds to members and federal income taxes and before realized capital gains or (losses) (Line 31 minus Line 32).....	(417,967,639)	(324,096,336)
34. Net realized capital gains (losses) (excluding gains (losses) transferred to the IMR) less capital gains tax of \$.....2,815,978 (excluding taxes of \$.....(977,935) transferred to the IMR).....	(44,066,405)	(175,822,458)
35. Net income (Line 33 plus Line 34).....	(462,034,044)	(499,918,794)
CAPITAL AND SURPLUS ACCOUNT		
36. Capital and surplus, December 31, prior year (Page 3, Line 38, Col. 2).....	(466,872,971)	12,649,170
37. Net income (Line 35).....	(462,034,044)	(499,918,794)
38. Change in net unrealized capital gains (losses) less capital gains tax of \$.....0.....	842,233	131,852
39. Change in net unrealized foreign exchange capital gain (loss)		
40. Change in net deferred income tax.....		
41. Change in nonadmitted assets.....	9,616,707	(19,510,668)
42. Change in liability for reinsurance in unauthorized and certified companies.....		11,626,473
43. Change in reserve on account of change in valuation basis (increase) or decrease.....		
44. Change in asset valuation reserve	(148,123)	28,148,996
45. Change in treasury stock, (Page 3, Lines 36.1 and 36.2 Col. 2 minus Col. 1).....		
46. Surplus (contributed to) withdrawn from Separate Accounts during period.....		
47. Other changes in surplus in Separate Accounts Statement.....		
48. Change in surplus notes.....		
49. Cumulative effect of changes in accounting principles.....		
50. Capital changes:		
50.1 Paid in.....		
50.2 Transferred from surplus (Stock Dividend).....		
50.3 Transferred to surplus.....		
51. Surplus adjustment:		
51.1 Paid in.....	2,497,969	0
51.2 Transferred to capital (Stock Dividend).....		
51.3 Transferred from capital.....		
51.4 Change in surplus as a result of reinsurance.....		
52. Dividends to stockholders.....		
53. Aggregate write-ins for gains and losses in surplus.....	0	0
54. Net change in capital and surplus for the year (Lines 37 through 53).....	(449,225,258)	(479,522,141)
55. Capital and surplus, December 31, current year (Lines 36 + 54) (Page 3, Line 38).....	(916,098,229)	(466,872,971)
DETAILS OF WRITE-INS		
08.301.		
08.302.		
08.303.		
08.398. Summary of remaining write-ins for Line 8.3 from overflow page.....	0	0
08.399. Totals (Lines 08.301 through 08.303 plus 08.398) (Line 8.3 above).....	0	0
2701. Termination of Roebbling Reinsurance Agreement.....		12,570,929
2702.		
2703.		
2798. Summary of remaining write-ins for Line 27 from overflow page.....	0	0
2799. Totals (Lines 2701 through 2703 plus 2798) (Line 27 above).....	0	12,570,929
5301.		
5302.		
5303.		
5398. Summary of remaining write-ins for Line 53 from overflow page.....	0	0
5399. Totals (Lines 5301 through 5303 plus 5398) (Line 53 above).....	0	0

	1	2
	Current Year	Prior Year
CASH FROM OPERATIONS		
1. Premiums collected net of reinsurance.....	62,752,519	73,765,461
2. Net investment income.....	75,782,728	91,432,001
3. Miscellaneous income.....	244	1,057
4. Total (Lines 1 through 3).....	138,535,491	165,198,519
5. Benefit and loss related payments.....	353,928,567	351,102,177
6. Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts.....		
7. Commissions, expenses paid and aggregate write-ins for deductions.....	36,182,999	42,838,983
8. Dividends paid to policyholders.....		
9. Federal and foreign income taxes paid (recovered) net of \$.....0 tax on capital gains (losses).....	135,301	(671,176)
10. Total (Lines 5 through 9).....	390,246,866	393,269,984
11. Net cash from operations (Line 4 minus Line 10).....	(251,711,376)	(228,071,464)
CASH FROM INVESTMENTS		
12. Proceeds from investments sold, matured or repaid:		
12.1 Bonds.....	432,428,356	452,604,302
12.2 Stocks.....	1,474,442	15,714,528
12.3 Mortgage loans.....	4,859,102	14,266,387
12.4 Real estate.....		
12.5 Other invested assets.....	5,040,743	283,790
12.6 Net gains or (losses) on cash, cash equivalents and short-term investments.....		(1,834)
12.7 Miscellaneous proceeds.....	1,975,610	728,906
12.8 Total investment proceeds (Lines 12.1 to 12.7).....	445,778,253	483,596,079
13. Cost of investments acquired (long-term only):		
13.1 Bonds.....	158,454,700	651,406,627
13.2 Stocks.....	67,901	77,189,849
13.3 Mortgage loans.....		
13.4 Real estate.....		
13.5 Other invested assets.....	5,900,000	
13.6 Miscellaneous applications.....	125,421	0
13.7 Total investments acquired (Lines 13.1 to 13.6).....	164,548,022	728,596,476
14. Net increase (decrease) in contract loans and premium notes.....		
15. Net cash from investments (Line 12.8 minus Lines 13.7 minus Line 14).....	281,230,231	(245,000,397)
CASH FROM FINANCING AND MISCELLANEOUS SOURCES		
16. Cash provided (applied):		
16.1 Surplus notes, capital notes.....		
16.2 Capital and paid in surplus, less treasury stock.....		0
16.3 Borrowed funds.....		
16.4 Net deposits on deposit-type contracts and other insurance liabilities.....		
16.5 Dividends to stockholders.....		
16.6 Other cash provided (applied).....	(3,591,732)	(2,264,237)
17. Net cash from financing and miscellaneous sources (Lines 16.1 to 16.4 minus Line 16.5 plus Line 16.6).....	(3,591,732)	(2,264,237)
RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS		
18. Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17).....	25,927,123	(475,336,098)
19. Cash, cash equivalents and short-term investments:		
19.1 Beginning of year.....	20,755,358	496,091,456
19.2 End of year (Line 18 plus Line 19.1).....	46,682,481	20,755,358
Note: Supplemental disclosures of cash flow information for non-cash transactions:		
20.0001		

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EXHIBIT 6 - AGGREGATE RESERVES FOR ACCIDENT AND HEALTH CONTRACTS - ACCIDENT AND HEALTH (a)

	1	Comprehensive		4	5	6	7	8	9	10	11	12	13
		2	3										
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Credit A&H	Disability Income	Long-Term Care	Other Health
ACTIVE LIFE RESERVE													
1. Unearned premium reserves.....	12,003,829											12,003,829	
2. Additional contract reserves (b).....	1,223,633,993											1,223,633,993	
3. Additional actuarial reserves - Asset/Liability analysis.....	636,536,764											636,536,764	
4. Reserve for future contingent benefits.....	0												
5. Reserve for rate credits.....	0												
6. Aggregate write-ins for reserves.....	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Totals (Gross).....	1,872,174,585	0	0	0	0	0	0	0	0	0	0	1,872,174,585	0
8. Reinsurance ceded.....	806,876											806,876	
9. Totals (Net).....	1,871,367,710	0	0	0	0	0	0	0	0	0	0	1,871,367,710	0
CLAIM RESERVE													
10. Present value of amounts not yet due on claims.....	895,879,794											895,879,794	
11. Additional actuarial reserves - Asset/Liability analysis.....	0												
12. Reserve for future contingent benefits.....	0												
13. Aggregate write-ins for reserves.....	0	0	0	0	0	0	0	0	0	0	0	0	0
14. Totals (Gross).....	895,879,794	0	0	0	0	0	0	0	0	0	0	895,879,794	0
15. Reinsurance ceded.....	803,753											803,753	
16. Totals (Net).....	895,076,042	0	0	0	0	0	0	0	0	0	0	895,076,042	0
17. TOTALS (Net).....	2,766,443,751	0	0	0	0	0	0	0	0	0	0	2,766,443,751	0
18. TABULAR FUND INTEREST.....	94,796,751											94,796,751	

DETAILS OF WRITE-INS

0601.	0												
0602.	0												
0603.	0												
0698. Summary of remaining write-ins for Line 6 from overflow page.....	0	0	0	0	0	0	0	0	0	0	0	0	0
0699. Totals (Lines 0601 through 0603 plus 0698) (Line 6 above).....	0	0	0	0	0	0	0	0	0	0	0	0	0
1301.	0												
1302.	0												
1303.	0												
1398. Summary of remaining write-ins for Line 13 from overflow page.....	0	0	0	0	0	0	0	0	0	0	0	0	0
1399. Totals (Lines 1301 through 1303 + 1398) (Line 13 above).....	0	0	0	0	0	0	0	0	0	0	0	0	0

(a) Indicate if blocks of business in run-off that comprise less than 5% of premiums and less than 5% of reserve and loans liability are aggregated with material blocks of business and which columns are affected.

(b) Attach statement as to valuation standard used in calculating this reserve, specifying reserve bases, interest rates and methods.

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EXHIBIT 8 - CLAIMS FOR LIFE AND ACCIDENT AND HEALTH CONTRACTS

PART 1 - Liability End of Current Year

	1	2	Ordinary			6	Group		Accident and Health		
			3	4	5		7	8	9	10	11
	Total	Industrial Life	Life Insurance	Individual Annuities	Supplementary Contracts	Credit Life (Group and Individual)	Life Insurance	Annuities	Group	Credit (Group and Individual)	Other
1. Due and unpaid:											
1.1 Direct.....	0	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
1.2 Reinsurance assumed.....	0	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
1.3 Reinsurance ceded.....	0	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
1.4 Net.....	0	0	0	0	0	0	0	0	0	0	0
2. In course of settlement:											
2.1 Resisted:											
2.11 Direct.....	0	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
2.12 Reinsurance assumed.....	0	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
2.13 Reinsurance ceded.....	0	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
2.14 Net.....	0	0	(b).....0	(b).....0	0	(b).....0	(b).....0	0	0	0	0
2.2 Other:											
2.21 Direct.....	31,934,537	.....	.....	.....	.....	.....	.....	.....	470,450	.....	31,464,087
2.22 Reinsurance assumed.....	2,601,162	.....	.....	.....	.....	.....	.....	.....	373,231	.....	2,227,931
2.23 Reinsurance ceded.....	28,754	.....	.....	.....	.....	.....	.....	.....	.....	.....	28,754
2.24 Net.....	34,506,945	0	(b).....0	(b).....0	0	(b).....0	(b).....0	0	(b).....843,682	(b).....0	(b).....33,663,264
3. Incurred but unreported:											
3.1 Direct.....	2,875,720	.....	.....	.....	.....	.....	.....	.....	72,350	.....	2,803,370
3.2 Reinsurance assumed.....	352,675	.....	.....	.....	.....	.....	.....	.....	49,835	.....	302,840
3.3 Reinsurance ceded.....	723	.....	.....	.....	.....	.....	.....	.....	.....	.....	723
3.4 Net.....	3,227,672	0	(b).....0	(b).....0	0	(b).....0	(b).....0	0	(b).....122,185	(b).....0	(b).....3,105,486
4. Totals:											
4.1 Direct.....	34,810,257	0	0	0	0	0	0	0	542,801	0	34,267,457
4.2 Reinsurance assumed.....	2,953,837	0	0	0	0	0	0	0	423,066	0	2,530,771
4.3 Reinsurance ceded.....	29,477	0	0	0	0	0	0	0	0	0	29,477
4.4 Net.....	37,734,617	(a).....0	(a).....0	0	0	0	(a).....0	0	965,867	0	36,768,750

(a) Including matured endowments (but not guaranteed annual pure endowments) unpaid amounting to \$.....0 in Column 2, \$.....0 in Column 3 and \$.....0 in Column 7.

(b) Include only portion of disability and accident and health claim liabilities applicable to assumed "accrued" benefits. Reserves (including reinsurance assumed and net of reinsurance ceded) for unaccrued benefits for Ordinary Life Insurance \$.....0, Individual Annuities \$.....0, Credit Life (Group and Individual) \$.....0, and Group Life \$.....0, are included in Page 3, Line 1, (See Exhibit 5, Section on Disability Disabled Lives); and for Group Accident and Health \$.....19,896,545, Credit (Group and Individual) Accident and Health \$.....0 and Other Accident and Health \$.....875,179,497 are included in Page 3, Line 2, (See Exhibit 6, Claim Reserve).

EXHIBIT 8 - CLAIMS FOR LIFE AND ACCIDENT AND HEALTH CONTRACTS

PART 2 - Incurred During the Year

	1	2	Ordinary			6	Group		Accident and Health		
			3	4	5		7	8	9	10	11
	Total	Industrial Life (a)	Life Insurance (b)	Individual Annuities	Supplementary Contracts	Credit Life (Group and Individual)	Life Insurance (c)	Annuities	Group	Credit (Group and Individual)	Other
1. Settlements during the year:											
1.1 Direct.....	343,343,970								4,931,883		338,412,086
1.2 Reinsurance assumed.....	26,475,718								4,222,270		22,253,448
1.3 Reinsurance ceded.....	129,258								-		129,258
1.4 Net.....(d).....	369,690,430	0	0	0	0	0	0	0	9,154,153	0	360,536,277
2. Liability December 31, current year from Part 1:											
2.1 Direct.....	34,810,257	0	0	0	0	0	0	0	542,801	0	34,267,457
2.2 Reinsurance assumed.....	2,953,837	0	0	0	0	0	0	0	423,066	0	2,530,771
2.3 Reinsurance ceded.....	29,477	0	0	0	0	0	0	0	0	0	29,477
2.4 Net.....	37,734,617	0	0	0	0	0	0	0	965,867	0	36,768,750
3. Amounts recoverable from reinsurers Dec. 31, current year.....	22,002										22,002
4. Liability December 31, prior year:											
4.1 Direct.....	32,821,419								486,861		32,334,558
4.2 Reinsurance assumed.....	2,881,635								488,252		2,393,383
4.3 Reinsurance ceded.....	44,679										44,679
4.4 Net.....	35,658,375	0	0	0	0	0	0	0	975,112	0	34,683,262
5. Amounts recoverable from reinsurers Dec. 31, prior year.....	13,421										13,421
6. Incurred benefits:											
6.1 Direct.....	345,332,808	0	0	0	0	0	0	0	4,987,823	0	340,344,985
6.2 Reinsurance assumed.....	26,547,920	0	0	0	0	0	0	0	4,157,084	0	22,390,836
6.3 Reinsurance ceded.....	122,637	0	0	0	0	0	0	0	0	0	122,637
6.4 Net.....	371,758,091	0	0	0	0	0	0	0	9,144,908	0	362,613,183

(a) Including matured endowments (but not guaranteed annual pure endowments) amounting to \$.0 in Line 1.1, \$.0 in Line 1.4, \$.0 in Line 6.1 and \$.0 in Line 6.4.
(b) Including matured endowments (but not guaranteed annual pure endowments) amounting to \$.0 in Line 1.1, \$.0 in Line 1.4, \$.0 in Line 6.1 and \$.0 in Line 6.4.
(c) Including matured endowments (but not guaranteed annual pure endowments) amounting to \$.0 in Line 1.1, \$.0 in Line 1.4, \$.0 in Line 6.1 and \$.0 in Line 6.4.
(d) Includes \$.0 (15,834,951) premiums waived under total and permanent disability benefits.

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	1 Current Year Total Nonadmitted Assets	2 Prior Year Total Nonadmitted Assets	3 Change in Total Nonadmitted Assets (Col. 2 - Col. 1)
1. Bonds (Schedule D).....			
2. Stocks (Schedule D):			
2.1 Preferred stocks.....			
2.2 Common stocks.....			
3. Mortgage loans on real estate (Schedule B):			
3.1 First liens.....			
3.2 Other than first liens.....			
4. Real estate (Schedule A):			
4.1 Properties occupied by the company.....			
4.2 Properties held for the production of income.....			
4.3 Properties held for sale.....			
5. Cash (Schedule E-Part 1), cash equivalents (Schedule E-Part 2) and short-term investments (Schedule DA).....			
6. Contract loans.....			
7. Derivatives (Schedule DB).....			
8. Other invested assets (Schedule BA).....	9,916,628	19,513,439	9,596,811
9. Receivables for securities.....			
10. Securities lending reinvested collateral assets (Schedule DL).....			
11. Aggregate write-ins for invested assets.....	0	0	
12. Subtotals, cash and invested assets (Lines 1 to 11).....	9,916,628	19,513,439	9,596,811
13. Title plants (for Title insurers only).....			
14. Investment income due and accrued.....			
15. Premiums and considerations:			
15.1 Uncollected premiums and agents' balances in the course of collection.....	1,699	19,216	17,517
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due.....			
15.3 Accrued retrospective premiums and contracts subject to redetermination.....			
16. Reinsurance:			
16.1 Amounts recoverable from reinsurers.....			
16.2 Funds held by or deposited with reinsured companies.....			
16.3 Other amounts receivable under reinsurance contracts.....			
17. Amounts receivable relating to uninsured plans.....			0
18.1 Current federal and foreign income tax recoverable and interest thereon.....			0
18.2 Net deferred tax asset.....			0
19. Guaranty funds receivable or on deposit.....			0
20. Electronic data processing equipment and software.....			0
21. Furniture and equipment, including health care delivery assets.....			0
22. Net adjustment in assets and liabilities due to foreign exchange rates.....			0
23. Receivables from parent, subsidiaries and affiliates.....			0
24. Health care and other amounts receivable.....	30,700	33,079	2,379
25. Aggregate write-ins for other-than-invested assets.....	0	0	0
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 through 25).....	9,949,027	19,565,734	9,616,707
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts.....			0
28. TOTALS (Lines 26 and 27).....	9,949,027	19,565,734	9,616,707

DETAILS OF WRITE-INS

1101.			0
1102.			0
1103.			0
1198. Summary of remaining write-ins for Line 11 from overflow page.....	0	0	0
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above).....	0	0	0
2501.			0
2502.			0
2503.			0
2598. Summary of remaining write-ins for Line 25 from overflow page.....	0	0	0
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above).....	0	0	0

NOTES TO FINANCIAL STATEMENTS

Note #	Description	Page #
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3	Business Combinations and Goodwill	19.2
4	Discontinued Operations	19.2
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NOTES TO FINANCIAL STATEMENTS

1. Summary of Significant Accounting Policies

A. Accounting Practices

The financial statements of Senior Health Insurance Company of Pennsylvania ("Company") are presented on the basis of accounting practices prescribed or permitted by the Pennsylvania Commissioner of Insurance ("Commissioner").

The Commissioner recognizes only statutory accounting practices prescribed or permitted by the Commonwealth of Pennsylvania for reporting the financial condition and results of operations of an insurance company and determining its solvency under Pennsylvania Insurance Law. The *Accounting Practices and Procedures* manual ("NAIC SAP") has been adopted as a component of prescribed or permitted practices by the Commonwealth of Pennsylvania. However, Pennsylvania may adopt certain prescribed accounting practices that differ from NAIC SAP. In addition, the Commissioner has the right to permit other specific practices that deviate from prescribed practices. The Company received a permitted practice for a one-time release of the Interest Maintenance Reserve ("IMR") prescribed by NAIC Statement of Statutory Accounting Principles (SSAP) No. 7 – Asset Valuation and Interest Maintenance Reserve effective January 1, 2018. The effect of this permitted practice was a release of the amortized IMR of \$192,502,234 which increased the Company's 2018 reported Net Income and negative Surplus balances by \$72,502,234. As a result of the IMR release, the Company established a premium deficiency reserve of \$120,000,000. The effect of the permitted practice in 2019 was an increase in net income and negative surplus balances of \$116,228,684. A reconciliation of the Company's net income and capital & surplus is shown below.

	SSAP #	F/S Page	F/S Line #	2019	2018
NET INCOME					
(1) Senior Health Insurance Company of Pennsylvania state basis	XXX	XXX	XXX	\$ (465,369,419)	\$ (499,918,794)
(2) State Prescribed Practices that are an increase/decrease from NAIC SAP					
(3) State Permitted Practices that are an increase/decrease from NAIC SAP: Amortization of Interest Maintenance Reserve	7	4	4	161,958,913	176,638,177
Increase in Aggregate Reserves for Life and Accident and Health Company	54R	4	19	(45,730,229)	(68,622,724)
(4) NAIC SAP (1 – 2 – 3 = 4)	XXX	XXX	XXX	\$ (581,598,103)	\$ (607,934,244)
SURPLUS					
(5) Senior Health Insurance Company of Pennsylvania state basis	XXX	XXX	XXX	\$ (919,285,952)	\$ (466,872,975)
(6) State Prescribed Practices that increase/decrease from NAIC SAP					
(7) State Permitted Practices that increase/decrease from NAIC SAP: Amortization of Interest Maintenance Reserve	7	4	37	161,958,913	176,638,177
Increase in Aggregate Reserves for Life and Accident and Health Company	54R	4	37	(45,730,229)	(68,622,724)
(8) NAIC SAP (5 – 6 – 7 = 8)	XXX	XXX	XXX	\$ (1,035,514,636)	\$ (574,888,428)

B. Use of Estimates in the Preparation of the Financial Statements

The preparation of financial statements in conformity with Statutory Accounting Principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities. It also requires disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the period. Actual results could differ from those estimates.

C. Accounting Policy

Health premiums are earned ratably over the terms of the related insurance and reinsurance contracts or policies.

In addition, the Company uses the following accounting policies:

- (1) Short-term investments are stated at amortized cost.
- (2) Bonds are stated at amortized cost using the scientific interest method, except those rated NAIC class 6, which are stated at the lower of amortized cost or fair value.
- (3) Common stocks are stated at market value.
- (4) Preferred stocks are stated at amortized cost, except those rated NAIC class 4 or lower quality, which are carried at the lower of cost or fair value.
- (5) Mortgage loans on real estate are stated at the aggregate unpaid balance, excluding accrued interest.
- (6) Loan-Backed securities are stated at amortized cost using the interest method including anticipated prepayments at the date of purchase; significant changes in estimated cash flows from the original purchase assumptions are accounted for using the retrospective method. These assumptions are generally consistent with the current interest rate and economic environment.
- (7) The Company reports Fuzion Analytics, Inc., a non-insurance company, at audited GAAP equity.
- (8) Ownership interests in joint ventures are classified as other invested assets on the balance sheet. The Company carries these interests based on its proportionate share of the underlying audited GAAP equity of the investee, adjusted for any distributions received.

NOTES TO FINANCIAL STATEMENTS

1.

Summary of Significant Accounting Policies, continued
- (9)

The Company has no investments in derivatives.
- (10)

The Company anticipates investment income as a factor in the premium deficiency calculation, in accordance with SSAP No. 54R—Individual and Group Accident and Health Contracts.
- (11)

Unpaid losses and loss adjustment expenses include amounts determined from individual case estimates and loss reports and amounts, based on experience, for losses incurred but not reported. Such liabilities are necessarily based on assumptions and estimates. The ultimate liability may be greater or less than the amount reported. The methods for making such estimates and for establishing the resulting liabilities are continually reviewed. Any adjustments to these liabilities are reflected in the period determined.
- (12)

The Company has not modified its capitalization policy from the prior period.
- (13)

The Company receives no pharmaceutical rebates.
- D.

The Company has suffered recurring losses from operations and has a net capital and surplus deficit. The Company is actively working with the Pennsylvania Insurance Department to develop a corrective action plan.
2.

Accounting Changes and Corrections of Errors
- A.

There are no material changes in accounting principles or corrections of errors.
3.

Business Combinations and Goodwill
- A.

During 2019, the Company did not purchase any interest in another company.
- B.

During 2019, the Company did not merge with any other insurance company.
- C.

During 2019, the Company did not participate in an assumption reinsurance agreement.
- D.

During 2019, the Company did not recognize an impairment loss on the transactions described above.
4.

Discontinued Operations
- During 2019, the Company did not discontinue any operations.

NOTES TO FINANCIAL STATEMENTS

5. Investments

A. Mortgage Loans, including Mezzanine Real Estate Loans

(1)	The Company originated no new loans in 2019.			
(2)	The maximum percentage of any one loan to the value of the security at the time of the loan, exclusive of insured, guaranteed or purchase money mortgages, was 65.00%.			
(3)	Taxes, assessments and any amounts advanced and not included in the mortgage loan total:	<u>Current Year</u>	<u>Prior Year</u>	
		\$ -	\$ -	
(4)	Age Analysis of Mortgage Loans:			
a.	Current Year	<u>Insured</u>	<u>Commercial All Other</u>	<u>Total</u>
1.	Recorded Investment			
a)	Current	\$ -	\$ 12,681,751	\$ 12,681,751
b)	30-59 Days Past Due	-	-	-
c)	60-89 Days Past Due	-	-	-
d)	90-179 Days Past Due	-	-	-
e)	180+ Days Past Due	-	-	-
2.	Accruing Interest 90-179 Days Past Due			
a)	Recorded Investment	-	-	-
b)	Interest Accrued	-	-	-
3.	Accruing Interest 180+ Days Past Due			
a)	Recorded Investment	-	-	-
b)	Interest Accrued	-	-	-
4.	Interest Reduced			
a)	Recorded Investment	-	-	-
b)	Number of Loans	-	-	-
c)	Percent Reduced	-	-	-
b.	Prior Year			
1.	Recorded Investment			
(a)	Current	\$ -	\$ 17,540,853	\$ 17,540,853
(b)	30-59 Days Past Due	-	-	-
(c)	60-89 Days Past Due	-	-	-
(d)	90-179 Days Past Due	-	-	-
(e)	180+ Days Past Due	-	-	-
2.	Accruing Interest 90-179 Days Past Due			
a)	Recorded Investment	-	-	-
b)	Interest Accrued	-	-	-
3.	Accruing Interest 180+ Days Past Due			
a)	Recorded Investment	-	-	-
b)	Interest Accrued	-	-	-
4.	Interest Reduced			
a)	Recorded Investment	-	-	-
b)	Number of Loans	-	-	-
c)	Percent Reduced	-	-	-
(5)	Investment in Impaired Loans With or Without Allowance for Credit Losses:			
a.	Current Year	<u>Insured</u>	<u>Commercial All Other</u>	<u>Total</u>
1.	With Allowance for Credit Losses	\$ -	\$ -	\$ -
2.	No Allowance for Credit Losses	-	-	-
b.	Prior Year			
1.	With Allowance for Credit Losses	-	-	-
2.	No Allowance for Credit Losses	-	-	-
(6)	Investment in Impaired Loans – Average Recorded Investment, Interest Income Recognized, Recorded Investment on Nonaccrual Status and Amt of Interest Income Recognized Using a Cash-Basis Method			
a.	Current Year	<u>Insured</u>	<u>Commercial All Other</u>	<u>Total</u>
1.	Average Recorded Investment	\$ -	\$ -	\$ -
2.	Interest Income Recognized	-	-	-
3.	Recorded Investments on Nonaccrual Status	-	-	-
4.	Amt of Int Inc recognized Using Cash Basis	-	-	-
b.	Prior Year			
1.	Average Recorded Investment	-	-	-
2.	Interest Income Recognized	-	-	-
3.	Recorded Investments on Nonaccrual Status	-	-	-
4.	Amt of Int Inc recognized Using Cash Basis	-	-	-
(7)	Allowance for Credit Losses:	<u>Current Year</u>	<u>Prior Year</u>	
a.	Balance at beginning of period	\$ -	\$ -	
b.	Additions charged to operations	-	-	
c.	Direct write-downs charged against the allowances	-	-	
d.	Recoveries of amounts previously charged off	-	-	
e.	Balance at end of period	-	-	
(8)	The Company has no mortgage loans derecognized because of foreclosure.			
(9)	Interest income on impaired loans is reported as collected when cash is received			

NOTES TO FINANCIAL STATEMENTS

5. Investments, continued

B. Debt Restructuring

The Company has no investments involving troubled debt restructurings.

C. Reverse Mortgages

The Company has no investment in reverse mortgages.

D. Loan-Backed Securities

- (1) The Company uses a proprietary model for loss assumptions and widely accepted models for prepayment assumptions in valuing mortgage-backed and asset-backed securities with inputs from major third-party data providers. It combines the effects of interest rates, volatility, and pre-payment speeds based on various scenario simulations (Monte Carlo) with credit loss analysis and resulting effective analytics (spreads, duration, convexity) and cash-flows on a monthly basis. Credit sensitive cash flows are calculated using a proprietary model which estimates future loan defaults in terms of timing and severity. Model assumptions are specific to asset class and collateral types and are regularly evaluated and adjusted where appropriate.
- (2) The Company has no loan-backed securities with a recognized other-than-temporary impairment due to the intent to sell or the inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis.
- (3) The Company has no loan-backed securities with a recognized other-than-temporary impairments for which the present value of cash flows expected to be collected is less than amortized cost as of December 31, 2019.
- (4) Impaired loan-backed securities for which an other-than-temporary impairment has not been recognized in earnings as a realized loss are as follows:

	Amortized	Fair	Unrealized
	Cost	Value	Loss
			Position
In a continuous loss position less than 12 months	\$ 44,288,723	\$ 44,126,191	\$ (162,532)
In a continuous loss position 12 months or longer	15,051,325	14,926,301	(125,024)
Total	\$ 59,340,048	\$ 59,052,492	\$ (287,556)

- (5) There are several factors that are considered in determining whether an “other-than-temporary” impairment exists, including but not limited to debt burden, credit ratings, sector, liquidity, financial flexibility, company management, expected earnings and cash flow stream, and economic prospects associated with the investment.

E. Dollar Repurchase Agreements and/or Securities Lending Transactions

The Company has no dollar repurchase agreements and/or securities lending transactions at December 31, 2019.

F. Repurchase Agreements Transactions Accounted for as Secured Borrowing

The Company has no repurchase agreements transactions accounted for as a secured borrowing at December 31, 2019.

G. Reverse Repurchase Agreements Transactions Accounted for as Secured Borrowing

The Company has no reverse repurchase agreements transactions accounted for as a secured borrowing at December 31, 2019.

H. Repurchase Agreements Transactions Accounted for as a Sale

The Company has no repurchase agreements transactions accounted for as a sale at December 31, 2019.

I. Reverse Repurchase Agreements Transactions Accounted for as a Sale

The Company has no reverse repurchase agreements transactions accounted for as a sale at December 31, 2019.

J. Real Estate

The Company has no investment in real estate at December 31, 2019.

K. Low Income Housing Tax Credits (“LIHTC”)

The Company holds no LIHTC property investments at December 31, 2019.

NOTES TO FINANCIAL STATEMENTS

5. Investments, continued

L. Restricted Assets

1) Restricted Assets (including Pledged)

Restricted Asset Category	Gross (Admitted & Nonadmitted) Restricted							Current Year			
	Current Year					6	7	8	9	Percentage	
	1	2	3	4	5	6	7	8	9	10	11
	Total General Account (G/A)	G/A Supporting S/A Activity (a)	Total Separate Account (S/A) Restricted Assets	S/A Assets Supporting G/A Activity (b)	Total (1 plus 3)	Total From Prior Year	Increase/ (Decrease) (5 minus 6)	Total Nonadmitted Restricted	Total Admitted Restricted (5 minus 8)	Gross (Admitted & Nonadmitted) Restricted to Total Assets (c)	Admitted Restricted to Total Admitted Assets (d)
a. Subject to contractual obligation for which liability is not shown											
b. Collateral held under security lending arrangements											
c. Subject to repurchase agreements											
d. Subject to reverse repurchase agreements											
e. Subject to dollar repurchase agreements											
f. Subject to dollar reverse repurchase agreements											
g. Placed under option contracts											
h. Letter stock or securities restricted as to sale – excluding FHLB capital stock											
i. FHLB capital stock					513,300		67,900		513,300	0.027	27
j. On deposit with states	18,726,442				18,726,442	19,834,582	(1,108,140)		18,726,442	0.979	0.979
k. On deposit with other regulatory bodies											
l. Pledged as collateral to FHLB (including assets backing funding agreements)											
m. Pledged as collateral not captured in other categories											
n. Other restricted assets											
o. Total Restricted Assets	\$ 19,239,742	\$	\$	\$	\$ 19,239,742	\$ 20,279,982	\$ (1,040,240)		\$ 19,239,742	1.006	.006

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NOTES TO FINANCIAL STATEMENTS

5. Investments, continued

2. Detail of Assets Pledged as Collateral Not Captured in Other Categories (Contracts that Share Similar Characteristics, Such as Reinsurance and Derivatives, Are Reported in the Aggregate)

Description of Assets	Gross (Admitted & Nonadmitted) Restricted							8	Percentage	
	Current Year					6	7		9	10
	1	2	3	4	5					
	Total General Account (G/A)	G/A Supporting S/A Activity (a)	Total Separate Account (S/A) Restricted Assets	S/A Assets Supporting G/A Activity (b)	Total (1 plus 3)	Total From Prior Year	Increase/ (Decrease) (5 minus 6)	Total Current Year Admitted Restricted	Gross (Admitted & Nonadmitted) Restricted to Total Assets	Admitted Restricted to Total Admitted Assets
	\$	\$	\$	\$	\$	\$	\$			
Total (c)	\$	\$	\$	\$	\$	\$	\$			

3. Detail of Other restricted Assets (Contracts that Share Similar Characteristics, Such as Reinsurance and Derivatives, Are Reported in the Aggregate)

Description of Assets	Gross (Admitted & Nonadmitted) Restricted							8	Percentage	
	Current Year					6	7		9	10
	1	2	3	4	5					
	Total General Account (G/A)	G/A Supporting S/A Activity (a)	Total Separate Account (S/A) Restricted Assets	S/A Assets Supporting G/A Activity (b)	Total (1 plus 3)	Total From Prior Year	Increase/ (Decrease) (5 minus 6)		Total Current Year Admitted Restricted	Gross (Admitted & Nonadmitted) Restricted to Total Assets
	\$	\$	\$	\$	\$	\$	\$	\$		
Total (c)	\$	\$	\$	\$	\$	\$	\$	\$		

4. The Company has no collateral received and reflected as assets within the financial statements.

M. Working Capital Finance Investments

The Company has no working capital finance investments.

N. Offsetting and Netting of Assets and Liabilities

The Company has no derivatives, repurchase and reverse repurchases, securities borrowing and securities lending assets and liabilities that are offset per SSAP No. 64—Offsetting and Netting of Assets and Liabilities.

O. 5GI Securities

The Company had no 5GI securities at December 31, 2019 or 2018.

Investment	Number of 5GI Securities		Aggregate BACV		Aggregate Fair Value	
	Current Year	Prior Year	Current Year	Prior Year	Current Year	Prior Year
Bonds – Actual Cost			\$	\$	\$	\$
Bonds – Fair Value						
Preferred Stock–Actual Cost						
Preferred Stock – Fair Value						
Total			\$	\$	\$	\$

P. Short Sales

The Company had no short sales during 2019.

Q. Prepayment Penalty and Acceleration Fees

The Company had 30 CUSIPs that were called prior to their maturity date in 2019. The securities received proceeds of \$21,082,846 and a book/ adjusted carrying value of \$20,383,245 resulting in a net realized gain of \$699,601.

	General Account
Number of CUSIPs	30
Aggregate Amount of Insurance Income	\$692,010

NOTES TO FINANCIAL STATEMENTS

6. Joint Ventures, Partnerships and Limited Liability Companies

- M. The Company has no investment in joint ventures, partnerships or limited liability companies that exceeds 10% of its admitted assets.
- N. In 2018, the Company recognized other-than-temporary impairments of \$43,264,419 on bond securities, common stock, joint venture, partnerships and limited liability companies within its portfolio. These assets are illiquid private placement investments that are in bankruptcy or work out status for which the fair value was determined based on a liquidation analysis. All the assets in the table below have been nonadmitted as of December 31, 2019.

CUSIP	Description	Actual Cost	Fair Value	Book/Adjusted Carrying Value	Current Year's OTTI Recognized
99Y800BE6	Agera Holdings LLC Equity Interest	\$ 2,978,104	\$ 0	\$ 0	\$ 2,978,104
00119@AA4	Agera	7,500,000	0	0	7,500,000
00119@114	Agera	17,500,000	0	0	17,500,000
99Y801WR2	Agera Parent LLC	2,500,000	0	0	2,500,000
99Y802HM8	Agera Parent LLC	470,000	0	0	470,000
99Y802ZP1	Agera Parent LLC	5,661,500	0	0	5,661,500
76016VAB9	RentPath LLC	2,213,829	0	0	2,213,829
99Y795QL6	Platinum Partners Value Arbitrage	500,000	0	0	500,000
99Y800JH1	Platinum Partners Master Fund	399,548	0	0	399,548
99Y801VN2	Platinum Partners Master Fund	51,000	0	0	51,000
99Y797TA3	Montsant Partners LLC	1,621,035	0	0	1,621,035
99Y798K13	Montsant Partners LLC	378,965	0	0	378,965
99Y802IJ4	Kingdom Energy Resources LLC	930,000	930,000	930,000	489,748
99Y802FD0	Equipment Finance SPE V LLC	7,010,089	7,010,089	7,010,089	1,000,000
608753109	Molycorp Inc	690	0	0	690
TOTAL		\$ 49,714,760	\$ 7,940,089	\$ 7,940,089	\$ 43,264,419

7. Investment Income

The Company did not exclude any due and accrued income from investment income in 2019.

8. Derivative Instruments

The Company did not utilize derivatives in 2018 or 2019.

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NOTES TO FINANCIAL STATEMENTS

9. Income Taxes

A. The Company adopted SSAP 101, a replacement of SSAP No. 10R, effective 1/1/2013. Balances and related disclosures are presented pursuant to SSAP 101.

1. Components of Net Deferred Tax Asset

	Ordinary	2019 Capital	Total	Ordinary	2018 Capital	Total	Ordinary	Change Capital	Total
a. Gross deferred tax assets	283,857,446		328,751,544	200,637,758		246,804,351	83,219,688	(1,272,496)	81,947,192
b. Statutory valuation allowance adjustment		44,894,098			46,166,594				
c. Adjusted gross deferred tax assets	278,854,808	44,894,098	323,748,907	192,106,517	46,166,594	238,273,110	86,748,291	(1,272,496)	85,475,795
d. Deferred tax assets non-admitted	5,002,637	0	5,002,637	8,531,241	0	8,531,241	(3,528,603)	0	(3,528,603)
e. Net deferred tax asset	0	0	0	0	0	0	0	0	0
f. Deferred tax liabilities	5,002,637	0	5,002,637	8,531,241	0	8,531,241	(3,528,603)	0	(3,528,603)
g. Net admitted deferred tax asset/(liability)	5,002,637	0	5,002,637	8,531,241	0	8,531,241	(3,528,603)	0	(3,528,603)
	0	0	0	0	0	0	0	0	0

2. Admission Calculation Components

	Ordinary	2019 Capital	Total	Ordinary	2018 Capital	Total	Ordinary	Change Capital	Total
a. Federal income taxes paid in prior years recoverable through loss carrybacks	0	0	0	0	0	0	0	0	0
b. Adjusted gross deferred tax assets expected to be realized	0	0	0	0	0	0	0	0	0
c. Adjusted gross deferred tax assets offset by gross deferred tax liabilities	0	0	0	0	0	0	0	0	0
g. Deferred tax assets admitted as the result of SSAP No 101	0	0	0	0	0	0	0	0	0

3.		2019	2018
(a) Ratio Percentage Used to Determine Recovery Period and Threshold Limitation Amount		(1,533%)	(909%)
(b) Amount of Adjusted Capital and Surplus Used to Determine Recovery Period and Threshold Limitation	\$	(915,731,212)	\$ (466,814,972)

4. Tax planning strategies did not have an effect on the Company's net admitted deferred tax assets for 2019 or 2018.

B. There are no temporary differences for which deferred tax liabilities are not recognized

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NOTES TO FINANCIAL STATEMENTS

9. Income Taxes, continued

C. Current income taxes incurred consist of the following major components:

	2019		2018		Change
1. Current Income Tax					
(a) Federal	\$	(1,632,614)	\$	(463,908)	\$ (1,168,706)
(b) Foreign					
(c) Subtotal	\$	(1,632,614)	\$	(463,908)	\$ (1,168,706)
(d) Federal income tax on net capital gains		-		-	
(e) Utilization of capital loss carryforwards		-		-	
(f) Other		-		-	
(99) Subtotal	\$	(1,632,614)	\$	(463,908)	\$ (1,168,706)
2. Deferred Tax Assets:					
(a) Ordinary					
(1) Discounting of unpaid losses	\$	-	\$	-	\$ -
(2) Unearned premium reserve		-		-	
(3) Policyholder reserves		165,654,143		112,796,962	52,857,181
(4) Investments		-		-	
(5) Deferred acquisition costs		9,654,853		11,110,674	(1,455,821)
(6) Policyholder dividends accrual		-		-	
(7) Fixed assets		-		-	
(8) Compensation and benefits accrual		-		-	
(9) Pension accrual		-		-	
(10) Nonadmitted Assets		2,089,296		4,108,804	(2,019,508)
(11) Net operating loss carry-forward		106,397,361		72,533,393	33,863,967
(12) Tax credit carry-forward		-		-	
(13) Other (including items <5% of total ordinary tax assets)		61,793		87,925	(26,132)
(99) Subtotal	\$	283,857,446	\$	200,637,758	\$ 83,219,688
(b) Statutory valuation allowance adjustment		(278,854,808)		(192,106,517)	(86,748,282)
(c) Non-admitted		-		-	-
(d) Admitted ordinary deferred tax assets	\$	5,002,637	\$	8,531,241	\$ (3,528,604)
(e) Capital:					
(1) Investments		44,759,823		36,718,851	8,040,972
(2) Net capital loss carry-forward		0		6,723,864	(6,723,864)
(3) Partnerships		134,276		2,723,879	(2,589,603)
(4) Other (including items <5% of total capital tax assets)		-		-	-
(99) Subtotal	\$	44,894,098	\$	46,166,594	\$ (1,272,495)
(f) Statutory valuation allowance adjustment		(44,894,098)		(46,166,594)	1,272,495
(g) Non-admitted		-		-	-
(h) Admitted capital deferred tax assets	\$	-	\$	-	\$ -
(i) Admitted deferred tax assets	\$	5,002,637	\$	8,531,241	\$ (3,528,604)
3. Deferred Tax Liabilities:					
(a) Ordinary:					
(1) Reserves – Transition Adjustment TCJA	\$	4,783,378	\$	7,305,785	\$ (2,522,408)
(2) Accrued dividends		24,375		1,000,491	(976,116)
(3) Deferred and uncollected premium		194,885		224,965	(30,080)
(4) Policyholder reserves		-		-	-
(5) Other (including items <5% of total ordinary tax liabilities)		-		-	-
(99) Subtotal	\$	5,002,637	\$	8,531,241	\$ (3,528,604)
(b) Capital:					
(1) Investments	\$	-	\$	-	\$ -
(2) Real estate		-		-	-
(3) Other (including items <5% of total capital tax liabilities)		-		-	-
(99) Subtotal	\$	-	\$	-	\$ -
(c) Deferred tax liabilities	\$	5,002,637	\$	8,531,241	\$ (3,528,604)
4. Net Deferred tax assets/liabilities:	\$	-	\$	-	\$ -

NOTES TO FINANCIAL STATEMENTS

9. Income Taxes, continued

The valuation allowance adjustments to gross deferred tax assets as of December 31, 2019 and 2018 were \$323,748,907 and \$238,273,110 respectively. The net change in the total valuation allowance adjustments for the year(s) ended December 31, 2019 was \$85,475,796. The AMT Credits will be fully refunded in future periods, due to the Tax Cuts and Jobs Act ("TJCA") that eliminated the corporate AMT for 2018 and future years. As the Company is going to receive a refund for its AMT credits by 2021, the amount is presented in income tax receivable.

D. Among the more significant book to tax adjustments were the following:

The Company's income tax incurred and change in deferred income tax differs from the amount obtained by applying the federal statutory rate of 35% to income before taxes as follows:

	Current Year	Prior Year
(1) Current Income Taxes Incurred	\$ (1,632,614)	\$ (463,908)
(2) Change In Deferred Income Tax (Without Tax on Unrealized Gains and Losses)	-	-
Tax on Capital Gain	1,838,060	
(3) Total Income Tax Reported	\$ 205,446	\$ (463,908)
(4) Income Before Taxes	\$(465,163,973) 21%	\$(496,806,89) 21%
(5) Expected Income Tax Expense (Benefit) at Statutory Rate	(97,684,434)	(104,329,448)
(6) Increase (Decrease) In Actual Tax Reported Resulting From:		
b. Amortization of IMR	668,110	(40,844,617)
c. Section 382 Adjustment	-	-
d. Deferred Tax Benefit on Nonadmitted Assets	2,019,508	696
e. Return to provision	205,446	(9,760,491)
f. Impact of tax reform rate change	-	53,355,419
g. AMT Credit Sequestration	85,475,796	149,480
h. Change in Valuation Allowance	9,521,020	(80,732,174)
i. Other		(652,144)
(7) Total Income Tax Reported	\$ 205,446	\$ (463,908)

E. Operating Loss Carryforwards and Income Taxes Available for Recoupment

- (1) As of December 31, 2019, the Company has a \$256,523,608 operating loss carryforward which will begin to expire in 2031, an \$250,130,490 operating loss carryforward with an indefinite carryforward period and a \$2,060,618 AMT tax credit carryforward, which will be fully refunded by 2021. The Company also has a \$32,018,399 capital loss carryforward, which will begin to expire in 2023.
- (2) The amount of Federal income taxes incurred that are available for recoupment in the event of future net losses are \$0 as the TCJA eliminated loss carrybacks for life insurance companies.
- (3) The aggregate amount of deposits admitted under Section 6603 of the Internal Revenue Code are \$0.

F. Consolidated Federal Income Tax Return

- (1) The Company files a consolidated return with the following entities:

Senior Health Oversight Trust
Fuzion Analytics, Inc.

- (2) The Company is included in a consolidated federal income tax return with its parent company, Senior Health Care Oversight Trust and subsidiary, Fuzion Analytics, Inc. The Company has a written tax sharing agreement, approved by the Pennsylvania Insurance Department, which sets forth the manner in which the total combined federal tax income is allocated to each entity which is a party to the consolidation.

G. The Company does not believe that it is reasonably possible that the liability related to any federal or foreign tax loss contingency will significantly increase within the next 12 months.

NOTES TO FINANCIAL STATEMENTS

10. Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties

- A. Effective August 20, 2019, Senior Health Oversight Trust (“Oversight Trust”) contributed all of its issued and outstanding stock in its wholly-owned subsidiary, Fuzion Analytics, Inc. (“Fuzion”), to the capital of the Company, resulting in Fuzion becoming a wholly-owned subsidiary of the Company. The Company’s affiliated investment, Fuzion, has a current equity position of \$2,975,269 for December 31, 2019, but is in draft form and could potentially increase by approximately \$1.1 million after the filing of the Company’s Annual Statement.
- B. See Notes 10 F. and 10 I. below.
- C. As of December 31, 2019, the Company recognizes an equity valuation for Fuzion of \$2,975,269.
- D. At December 31, 2019, the Company reported a net receivable from Fuzion of \$49,541.
- At December 31, 2019, the Company reported no receivable or payable from/to Oversight Trust.
- Intercompany payables and receivables are settled on a monthly basis.
- E. There are no guarantees or undertakings concerning parent, subsidiaries, affiliates or other related parties.
- F. On March 1, 2014, the employees and operating assets of the Company were transferred to Fuzion in connection with the execution of a management services agreement under which Fuzion is responsible for the management of the Company’s closed block of long-term care insurance business. First year fees under this agreement were fixed based on expenses the Company would have been expected to incur in the absence of the agreement. In the second and subsequent years of the agreement, fees decline based on the attrition of the Company’s runoff block of long-term care business, subject to minimum and maximum annual decreases. The Company paid Fuzion \$12,778,644 and \$15,477,760 for services under this agreement in 2019 and 2018, respectively.
- G. See note 10A and 10F. above.
- H. See note 10A and 10F. above.
- I. The Company has no investments in SCA entities that exceeds 10 percent of admitted assets.
- J. The Company did not recognize any impairment write down for its investments in SCA entities during the statement period
- K. The Company has no investments in foreign insurance subsidiaries.
- L. The Company has an investment in downstream noninsurance holding companies, Fuzion Analytics, Inc.

M.

Balance Sheet Value of All SCA Entities				
SCA Entity	Percentage of SCA Ownership	Gross Amount	Admitted Amount	Nonadmitted Amount
a. SSAP No. 97 8a Entities				
b. SSAP No. 97 8b(ii) Entities Fuzion Analytics, Inc	100%	\$ 2,975,269	\$ 2,975,269	\$ -
Total SSAP No 97 8b(ii) Entities		\$ 2,975,269	\$ 2,975,269	\$ -
c. SSAP No. 97 8b(iii) Entities				
d. SSAP No. 97 8b(iv) Entities				
e. Total SSAP No. 97 8b Entities		\$ 2,975,269	\$ 2,975,269	\$ -
f. Aggregate Total (a + e)		\$ 2,975,269	\$ 2,975,269	\$ -

- N. The Company has no investments in Insurance SCA entities.
- O. The Company has no share of losses in SCA entities that exceeds its investment.

11. Debt

- A. The Company has no debt.
- B. In 2015, the Company became a member of the Federal Home Loan Bank (FHLB) of Pittsburgh. To date, the Company has no borrowings with the FHLB.

NOTES TO FINANCIAL STATEMENTS

12. Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and Other Postretirement Benefit Plans

A. Defined Benefit Plan

The Company has no defined benefit plan.

B. Not applicable

C. Not applicable

D. Not applicable

E. Not applicable

F. Multiemployer Plans

The Company does not participate in a multiemployer plan.

G. Consolidated/Holding Company Plans

The Company does not participate in consolidated/holding company plans.

H. Postemployment Benefits and Compensated Absences

The Company does not offer post-employment benefits but, pursuant to a contract entered into by Conseco Life, provided health insurance coverage in 2019 for three retirees. This cost of this coverage has not been accrued because these benefits are life-contingent, non-accumulating and cannot be reasonably estimated.

I. Impact of Medicare Modernization Act on Postretirement Benefits

The FASB issued FASB Staff Position ("FSP") FAS 106-2, "Accounting and Disclosure Requirements Related to the Medicare Prescription Drug, Improvement and Modernization Act of 2003" ("FSP FAS 106-2") in May 2004. FSP FAS 106-2 provides guidance on accounting for the effects of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the "Modernization Act"). The Modernization Act provides, among other things, a federal subsidy to plan sponsors who maintain postretirement health care plans that provide prescription drug benefits and meet certain equivalency criteria. FSP FAS 106-2 superseded FSP SAS 106-1, "Accounting and Disclosure Requirements Related to the Medicare Prescription Drug, Improvement and Modernization Act of 2003". The adoption of FSP FAS 106-2 did not have any impact on the Company's financial statements.

13. Capital and Surplus, Shareholders' Dividend Restrictions and Quasi-Reorganizations

- (1) The Company's capital consists of 200,000 common shares authorized and 166,667 issued and outstanding with a par value of \$15 per share.
- (2) The Company has 20,000 preferred shares authorized and 5,000 issued and outstanding, with a stated value of \$1,000 per share.
- (3) The Company may not pay any dividends without the prior written approval of the Pennsylvania Insurance Department.
- (4) The Company paid no dividends to shareholders during 2019.
- (5) See Note No.13 (3) above.
- (6) The Company's parent, the Oversight Trust, is governed by an independent Board of Trustees comprised of former insurance regulators and financial experts. The Oversight Trust's purpose is to support the solvency of the Company and the interests of its policyholders. The Company and the Oversight Trust are subject to the oversight of the Pennsylvania Insurance Department in accordance with an order issued by the Pennsylvania Insurance Department on November 12, 2008.
- (7) During 2019, the Company had no advances to surplus.
- (8) During 2019, the Company held no stock for special purposes.
- (9) During 2019, the Company had no special surplus funds.
- (10) As of December 31, 2019, the portion of unassigned funds (surplus) represented or increased by cumulative net unrealized gains was \$828,998.
- (11) The Company issued a surplus note ("Note") on February 19, 2015 to Beechwood Re Investments, LLC for cash. Payment of principal and interest on the Note is not guaranteed and such payment is subordinated to claims of all policyholders, creditors, and other liabilities of the Company. Interest and principal payments on the Note require prior approval of the Commissioner.

Date Issued	Interest Rate	Par Value	Carrying Value	Interest And Principal Paid Current Year	Total Interest and/or Principal Paid	Unapproved Interest and/or Principal	Date of Maturity
2/19/2015	6.0%	\$50,000,000	\$50,000,000	-	-	\$11,550,000	04/01/2020

(12,13) The Company has not restated surplus due to a quasi-reorganization.

NOTES TO FINANCIAL STATEMENTS

14. Liabilities, Contingencies and Assessments

A. Contingent Commitments

- (1) The Company has not made any guarantees or undertakings for the benefit of an affiliate that would result in a material contingent exposure of the Company’s or any affiliated insurer’s assets to liability.
- (2) The Company does not have any credit facility commitments at December 31, 2019.
- (3) The Company has two credit facilities with Alliance Bernstein Private Credit Investors Middle Market Direct Lending Fund, L.P. The Company currently has investments of \$22,500,000 and remaining commitments of \$2,250,000 as of December 31, 2019. The Company no longer participates in new investments after December 31, 2018, however, the existing credit facilities may continue to have capital commitments according to the terms of the applicable loan documents. Alliance Bernstein anticipates full repayment of the debt obligations under the existing facilities over the next two years.

B. Assessments

- (1) The Company has recorded a liability of \$52,739 for guaranty fund assessments on several insolvencies as of December 31, 2019. This amount represents estimated obligations to state guaranty funds to provide for covered claims and other insurance obligations of insolvent insurers, net of the estimated offset to future premium taxes. The period over which the assessments are anticipated to be funded varies by insolvency and is difficult to predict.

The Company’s estimate of probable recoveries of prior payments through premium tax credits is \$967,227 and is recorded as an asset. The period over which the credits are realized varies by state but typically ranges from five to ten years.

- (2) Assessments:

Assets recognized from paid and accrued premium tax offsets and policy surcharges, prior year end	\$	1,448,680
Increases:		
Premium tax offsets recognized from current year assessments paid	\$	79,112
Decreases:		
Premium tax offsets applied	\$	201,761
Change in accrued assessment liability	\$	117,292
Assets recognized from paid and accrued premium tax offsets and policy surcharges, current year end	\$	1,208,738

- (3) Guaranty Fund Liabilities and Assets Related to Assessments from Insolvencies of Entities that Write Long-Term Care
 - a. Discount Rate Applied: Not Applicable
 - b. The Undiscounted and Discounted Amount of the Guaranty Fund Assessment and Related Assets by Insolvency are presented in the following table:

Name of the Insolvency	Guaranty Fund Assessment		Related Assets	
	Undiscounted	Discounted	Undiscounted	Discounted
Penn Treaty Network American Insurance Co	\$ 1,156,420	\$ -	\$ 890,073	\$ -
American Network Insurance Co	65,885	-	53,631	-
Senior American Insurance Co	6,830	-	6,584	-
Total	\$ 1,229,136	\$ -	\$ 950,288	\$ -

- c. Number of Jurisdictions, Ranges of Years Used to Discount and Weighted Average Number of Years of the Discounting Time Period for Payables and Recoverables by Insolvency: Not Applicable

C. Gain Contingencies

The Company has not reported all benefits from an Investment Management Services agreement that had a guaranteed return of 5.85% on all assets due to the counterparties inability to fulfill their obligation to pay the interest. However, management continues to proceed in collecting the interest owed to the Company.

D. Claims Related Extra Contractual Obligation (“ECO”) and Bad Faith Losses Stemming From Lawsuits

The Company has no ECO and Bad Faith Losses Stemming from Lawsuits.

E. Joint and Several Liabilities

The Company has no joint and several liability arrangements.

NOTES TO FINANCIAL STATEMENTS

14. Liabilities, Contingencies and Assessments, continued

F. All Other Contingencies

- (1) Various lawsuits against the Company arise in the course of the Company's business. On December 19, 2018, the Receiver for Platinum Partners Credit Opportunities Funds filed an action against the Company, its affiliate Fuzion Analytics, Inc., Beechwood entities and others in the United States District Court for the Southern District of New York captioned *Melanie L. Cyganowski, as Equity Receiver for Platinum Partners Credit Opportunities Master Fund LP, et al. v. Beechwood RE Ltd., et al* ("PPCO Receiver Action"). The Company believes that this claim is not estimable at this time and has been tendered to the Company's insurance carrier. The Company is vigorously defending this matter. SHIP's motion for Summary Judgement was filed on February 14, 2020, which remains pending. In a related action, Company filed third party claims and crossclaims against a number of Beechwood and Platinum individuals and entities on April 19, 2019. Company has reached a settlement in principle for those third party claims and crossclaims. Notwithstanding the foregoing, an unfavorable resolution in the larger PPCO Receiver Action could have an adverse impact on the Company's financial position. The Company has a recorded value of \$3.3 million for the PPCO asset, which could change as a result of the pending litigation.
- (2) On June 24, 2019 the Company was served with a complaint filed on June 7, 2019 by the Joint Official Liquidators of Platinum Partners Value Arbitrage Fund against the Company in Delaware State Court captioned Principal Growth Strategies, LLC, a Delaware limited liability company; Platinum Partners Value Arbitrage Fund L.P. (in Official Liquidation), a Cayman Islands exempted limited partnership; and Martin Trott & Christopher Smith, Joint Official Liquidators of Platinum Partners Value Arbitrage Fund, L.P. (in official liquidation) v. AGH Parent LLC; Senior Health Insurance Company of Pennsylvania, et al. (the "PPVA Action"). Plaintiffs allege that several transactions involving Agera Energy resulted plaintiff Principal Growth Strategies losing its interests in Agera Energy in exchange for worthless Platinum Funds. Plaintiffs allege the Agera-related transactions were conceived by Beechwood and Platinum Partners insiders to benefit alleged Beechwood preferred investor clients, including the Company. The lawsuit has been removed to Delaware federal court, but a motion to remand is pending. The Company believes that this claim is not estimable at this time and it has been tendered to the Company's insurance carrier. The Company plans to vigorously defend this matter. Nevertheless, an unfavorable resolution could have an adverse impact on the Company's financial position.
- (2) On April 10, 2019, David Levy filed a complaint against the Company in the United States District Court for the Southern District of New York captioned David Levy v. Senior Health Insurance Company of Pennsylvania ("Levy advancement action") seeking indemnification and advancement for his legal fees incurred in connection with various third-party actions filed against him, including the above-referenced PPCO Action and PPVA Action, pursuant to provisions in the Investment Management Agreements entered into between the Company and Beechwood entities. Contemporaneously with filing the complaint, Levy also filed a Motion for a Preliminary Injunction seeking the immediate advancement of legal fees incurred by him in connection with the third-party actions. On May 13, 2019, in the preliminary injunction, the court found that Levy is entitled to advancement of third-party claims, but limited fees to only those incurred in defending allegations of conduct by Levy in his role as investment adviser to the Company while an officer of Beechwood. On July 9, 2019, Levy was convicted of fraud and conspiracy to commit fraud in connection with the same scheme for which the court ordered the Company to advance litigation expenses. Following the jury's verdict, the Company moved for and was granted summary judgment in the Levy advancement action on the basis that Levy's criminal conduct eliminated any entitlement to indemnification or advancement. In light of the criminal conviction, on August 7, 2019, the Company filed its notice of appeal of the Preliminary Injunction ruling regarding advancement and posted a bond with the registry of the court in the amount of \$765,630. In late September 2019, the judge in Levy's criminal trial granted Levy a post-trial acquittal, which the government has appealed. In light of the appeal of the criminal action, on January 22, 2020, the parties filed a Joint Motion to Stay the Appeal of the Preliminary Injunction Pending Outcome of Pending Criminal Appeal. On February 20, 2020, the court granted the Company's voluntary dismissal and request to withdraw the \$765,360 from the registry of the Court, plus interest, less any administrative fees. This settlement has not been reflected in the December 31, 2019 financial statement and will be recorded in 2020.
- (3) On May 16, 2019, several Beechwood entities and individuals filed an action for advancement and indemnification for third-party expenses, along with a motion for summary judgment on the advancement claim in the United States District Court of the Southern District of New York captioned BAM et al. v. Senior Health Insurance Company. Similar to the Levy action, the court granted the Beechwood Parties' motion for summary judgment for third-party expenses, which the Company appealed. The parties have reached a settlement in principle which makes the appeal moot. By Order dated February 22, the court ordered that the Company's deposit of \$519,252.81, plus interest, less any administrative fees, be returned. This settlement has not been reflected in the December 31, 2019 financial statement and will be recorded in 2020.
- (4) Under an assignment agreement effective October 1, 2008 with Consec Life Insurance Company ("Consec Life"), all the assets and liabilities pertaining to the Company's non-long-term care business were assigned and assumed by Consec Life. The Company remains contingently liable for the assigned business in the event Consec Life fails to perform its obligations under the assignment agreement. In recognition of this liability, Consec Life is required to maintain assets in a trust account of which the Company is beneficiary, with an aggregate fair market value equal to the estimated reserves of the assigned business. Assets are deposited or withdrawn from the trust on a quarterly basis as needed to maintain the aggregate market value of the trust assets. As of December 31, 2019, the required trust amount was \$152,701,732. The market value of trust assets was \$154,131,222.

15. Leases

A. Lessee Leasing Arrangements

- (1) The Company has no lessee leasing arrangements.
- (2) The Company has no initial or remaining noncancelable lessee terms in excess of one year.
- (3) The Company has no sale-leaseback transactions.

B. Lessor Leasing Arrangements

- (1) The Company has no operating leases as a significant part of its business activity.

NOTES TO FINANCIAL STATEMENTS

(2) The Company has no leveraged leases.

16. Information About Financial Instruments with Off-Balance Sheet Risk and Financial Instruments with Concentrations of Credit Risk

The Company does not have any financial instruments with off-balance sheet risk.

17. Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

- A. During 2019, the Company had no transfers of receivables reported as sales.
- B. Transfer and Servicing of Financial Assets
 - (1) During 2019, the Company had no transfers or servicing of financial assets.
 - (2) During 2019, the Company had no transfers or servicing of financial assets and liabilities.
 - (3) During 2019, the Company had no transfers or servicing of financial assets and liabilities.
 - (4) During 2019, the Company had no asset-backed financing arrangements and similar transfers accounted for as sales.
 - (5) During 2019, the Company had no transfers of financial assets accounted for as secured borrowing.
 - (6) During 2019, the Company had no transfers of receivables with recourse.
 - (7) During 2019, the Company had no securities subject to repurchase and reverse repurchase agreements.
- C. Wash Sales

During 2019, the Company had no securities with NAIC designation 3 or below which were sold and reacquired within 30 days of the sale date.

18. Gain or Loss to the Reporting Entity from Uninsured Plans and the Portion of Partially Insured Plans

- A. The Company does not serve as administrator of any ASO plans.
- B. The Company does not serve as administrator of any ASC plans.
- C. The Company has no Medicare or similarly structured cost-based reimbursement contracts.

19. Direct Premium Written/Produced by Managing General Agents/Third Party Administrators

The Company does not have any direct premiums written by managing general agents or third-party administrators.

NOTES TO FINANCIAL STATEMENTS

20. Fair Value Measurement

A. The Company's valuation techniques and the inputs used to develop the fair value measurements are as follows:

Pricing Level 1 – Valuations are based on unadjusted quoted prices in active markets for identical assets that our pricing sources have the ability to access. Since the valuations are based on quoted prices that are readily and regularly available in an active market, valuation of these securities does not entail a significant amount or degree of judgment.

Pricing Level 2 – Valuations based upon quoted prices for similar assets in active markets, quoted prices for identical or similar assets in inactive markets, or valuations based on models where the significant inputs are observable (e.g. interest rates, yield curves, prepayment speeds, default rates, loss severities), or can be corroborated by observable market data.

Pricing Level 3 – Valuations that are derived from techniques in which one or more of the significant inputs are unobservable, including broker quotes which are non-binding.

(1) Fair Value Measurement as of December 31, 2019.

Description for each class of asset or liability	Level 1	Level 2	Level 3	Net Asset Value (NAV)	Total
a. Assets carried at fair value					
Bonds					
Industrial & Misc.	\$ -	\$ -	\$ -	\$ -	\$ -
Total Bonds	\$ -	\$ -	\$ -	\$ -	\$ -
Common Stock					
Industrial & Misc. Other	\$ -	\$ 513,300	\$ -	\$ -	\$ 513,300
Industrial & Misc. Publicly Traded	\$ -	\$ -	\$ 89,817	\$ -	\$ 89,817
Parent, Subs, & Affiliates	\$ -	\$ -	\$ 2,975,269	\$ -	\$ 2,975,269
Total Common Stock	\$ -	\$ 513,300	\$ 3,065,086	\$ -	\$ 3,578,386
Money Market Funds					
Exempt Money Market Funds	\$ 41,843,393	\$ -	\$ -	\$ -	\$ 41,843,393
Other Money Market Funds	11,795,000	-	-	-	11,795,000
Total Money Market Funds	\$ 53,638,393	\$ -	\$ -	\$ -	\$ 53,638,393
Total Assets carried at fair value	\$ 53,638,393	\$ 513,300	\$ 3,065,086	\$ -	\$ 57,216,779

(2) Following is a reconciliation of the opening balances to the closing balances for fair value measurements categorized within Level 3 of the fair value hierarchy.

Description	Beginning Balance at 01/01/2019	Transfers into Level 3	Transfers out of Level 3	Total gains and (losses) included in Net Income	Total gains and (losses) included in Surplus	Purchases	Issuances	Sales	Settlements	Ending Balance at 12/31/2019
Assets										
Bonds	\$ -	-	-	-	-	-	-	-	-	-
Common Stock	106,627	-	-	(690)	461,179	2,497,970	-	-	-	3,065,086
Total	\$106,627	-	-	\$(690)	\$461,179	\$2,497,970	-	-	-	\$3,065,086

(3) Pricing level changes are infrequent and occur when the Company's widely accepted pricing service provider is not able to determine a price on observable inputs, in which case the Company uses broker quotes which may use unobservable inputs.

(4) See Note 20 A.

(5) The Company had no derivative activity in 2019 or 2018.

B. The Company reports only on a statutory basis, hence there are no other fair value disclosures.

NOTES TO FINANCIAL STATEMENTS

20. Fair Value Measurement, continued

C. Aggregate fair value for all financial instruments.

Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)
Bonds	1,803,159,678	1,721,888,231	2,299,806	1,756,233,799	44,626,073	
Common Stock	3,578,386	3,578,386	-	513,300	3,065,086	-
Perpetual Preferred Stock	86,859,728	86,271,292	-	14,716,228	72,143,500	-
Mortgage Loans	13,530,338	12,681,751	-	-	13,530,338	-
Cash Equivalents	53,638,393	53,638,393	53,638,393	-	-	-
Surplus Notes	1,712,669	1,645,981	-	1,712,669	-	-
Other Invested Assets	20,188,946	10,719,726	-	-	20,188,946	-

- D. Not applicable
- E. At December 31, 2019, the Company did not hold any investments using the NAV practical expedient pursuant to SSAP No. 100R – Fair Value.

21. Other Items

A. Unusual or Infrequent Items

During 2019 and 2018, there were no unusual or infrequent items.

B. Troubled Debt Restructuring

The Company had no troubled debt restructuring.

C. Other Disclosures

- (1) Assets with statement values totaling \$18,726,442 and \$19,834,582 at December 31, 2019 and 2018, respectively, were on deposit with government authorities or trustees as required by law.
- (2) The Pennsylvania Department of Insurance has approved a permitted practice to a one-time release of the Interest Maintenance Reserve ("IMR") of \$192,502,234 million effective January 1, 2018. This permitted practice also created a premium deficiency reserve of \$120,000,000 million which ultimately increased surplus a net \$72,576,741 million between the two transactions.
- (3) On September 28, 2018, the Bruckner Investment Trust Class A and Class B Notes were terminated in exchange for the transfer to the Company of Sutton Capital Trust securities and a cash payment. The termination of the Bruckner Class A and B Notes resulted in a net loss to the Company of \$9,916,628.
- (4) In order to meet the Equity Limited Partnership threshold according to the Pennsylvania Investment statute, the Company nonadmitted \$9,916,628 of its holdings in Alliance Bernstein Private Credit Investors Middle Market Direct Lending Fund, L.P. The Company holds this investment at \$19,435,088 based upon the October 31, 2019 statements at fair market value (FMV). The December 31, 2019 financial statements received late February reflect a FMV of \$17,706,269 and the change in value of \$1.7 million will be recorded in 2020.
- (5) On July 24, 2018, Senior Health Insurance Company of Pennsylvania ("SHIP") filed a Complaint in the United States District Court for the Southern District of New York entitled Senior Health Insurance Company of Pennsylvania v. Beechwood Re Ltd., B Asset Manager, L.P., Beechwood Bermuda International, Ltd., Beechwood Re Investments, LLC a/k/a Beechwood Re Investors, LLC, Illumin Capital Management, LP, Moshe M. Feuer a/k/a Mark Feuer, Scott A. Taylor, David I. Levy, Dhruv Narain, and John Does 1-20, Case No. 1:18-cv-6658 (JSR) seeking damages for breach of three Investment Management Agreements, fraud, gross negligence, unjust enrichment, and conspiracy (the "SHIP Action"). SHIP filed amended complaints in the SHIP Action on December 14, 2018 and December 28, 2018. The action is currently stayed as to defendant David Levy due to a pending criminal matter. Fact and expert discovery in the SHIP Action as to the remaining parties is now complete. The final pretrial conference is set for April 2, 2020.

NOTES TO FINANCIAL STATEMENTS

21. Other Items, continued

- (6) On July 31, 2019 the Company filed litigation in the United States District Court for the Southern District of New York captioned Senior Health Insurance Company of Pennsylvania v. Lincoln International LLC, Lincoln Advisors LLC. The Company filed a Second Amended Complaint on October 31, 2019 seeking damages for aiding and abetting fraud, aiding and abetting breach of fiduciary duty, conspiracy and contribution and indemnity and unjust enrichment/constructive trust. On February 14, 2020, Defendants moved for Summary Judgement. Company's opposition to Defendants Motion for Summary Judgement is due March 6, 2020.
- D. The Company had no business interruption insurance recoveries.
- E. The Company had no state transferable or non-transferable tax credits at December 31, 2019.
- F. Subprime Mortgage Related Risk Exposure
- (1) The company has exposure to subprime lending in the fixed maturity (bond) investment portfolio, which contains securities collateralized by mortgages that have characteristics of subprime lending such as low FICO score, adjustable rate mortgages and alternative documentation mortgages. These investments are in the form of asset-backed securities and collateralized mortgage obligations which are collateralized by subprime mortgages. The Company reviews its mortgage-backed investments for other than temporary impairments and records losses to the extent it believes it is probable that not all payments due under these investments will be collected subject to the Company's ability and intent to hold these investments to a point of recovery. The risk to subprime mortgage investments is mitigated through portfolio diversification.
- (2) The Company had no direct investments in subprime mortgage loans at December 31, 2019.
- (3) At December 31, 2019, the Company had subprime mortgage related risk exposure through mortgage-backed securities as presented below:
- Direct Exposure Through Other Investments:
- | | Actual Cost | Book/Adjusted Carrying Value (excluding interest) | Fair Value | OTTI Losses Recognized |
|--|-------------|---|------------|------------------------|
| Residential mortgage-backed securities | \$ 868,704 | \$ 854,534 | \$ 886,263 | \$ - |
- (4) The Company does not write Mortgage Guaranty or Financial Guaranty insurance.
- G. The Company has no retained assets for 2019 and 2018.
- H. Insurance-Linked Securities (ILS) Contracts
- The Company has no insurance-linked securities (ILS) contracts.

22. Events Subsequent

- (A) On February 27, 2019, as required under 40 P.S. §443 (a), SHIP filed its Risk-Based Capital ("RBC") report reflecting total adjusted capital of -\$466,814,972, placing the Company below the "mandatory control level." As a result, on July 30, 2019, a majority of the Oversight Trust Trustees voted to give consent to rehabilitation of the Company and to waive the hearing contemplated by 40 P.S. §221.15. On that same date, a majority of the directors of the Company voted to give consent to rehabilitation of the Company and to waive the hearing contemplated by 40 P.S. §221.15. On January 23, 2020, the Insurance Commissioner of the Commonwealth of Pennsylvania filed an Application in the Commonwealth Court of Pennsylvania seeking to place the Company in rehabilitation pursuant to 40 P.S. §221.1 to §221.63 on the ground that rehabilitation was consented to by the Trustees of the Oversight Trust Trustees and directors of the Company. By Order dated January 29, 2020, the Commonwealth Court of Pennsylvania granted the Application and the Company was placed into rehabilitation.

NOTES TO FINANCIAL STATEMENTS

23. Reinsurance

A. Ceded Reinsurance Report
Section 1 - General Interrogatories

1.

Are any of the reinsurers, listed in Schedule S as non-affiliated, owned in excess of 10% or controlled, either directly or indirectly, by the Company or by any representative, officer, trustee, or director of the Company?
Yes (☐) No (☒) If yes, give full details.
-
2.

Have any policies issued by the Company been reinsured with a company chartered in a country other than the United States (excluding U.S. Branches of such companies) that is owned in excess of 10% or controlled directly or indirectly by an insured, a beneficiary, a creditor or an insured or any other person not primarily engaged in the insurance business?
Yes (☐) No (☒) If yes, give full details.
-

Section 2 - Ceded Reinsurance Report - Part A

1.

Does the Company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayment of premium or other similar credits?
Yes (☐) No (☒)

a.

If yes, what is the estimated amount of the aggregate reduction in surplus of a unilateral cancellation by the reinsurer as of the date of this statement, for those agreements in which cancellation results in a net obligation of the Company to the reinsurer, and for which such obligation is not presently accrued? Where necessary, the Company may consider the current or anticipated experience of the business reinsured in making this estimate.

b.

What is the total amount of reinsurance credits taken, whether as an asset or as a reduction of liability, for these agreements in this statement?
2.

Does the Company have any reinsurance agreements in effect such that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premium collected under the reinsured policies?
Yes (☐) No (☒)
If yes, give full details.
-

Section 3 - Ceded Reinsurance Report - Part B

1.

What is the estimated amount of the aggregate reduction in surplus, (for agreements other than those under which the reinsurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2 above) of termination of ALL reinsurance agreements, by either party, as of the date of the statement? Where necessary, the Company may consider the current or anticipated experience of the business reinsured in making the estimate. \$0
2.

Have any new agreements been executed, or existing agreements amended, since January 1 of the year of this statement, to include policies or contracts that were in force or which had existing reserves established by the Company as of the effective date of the agreement?
Yes (☐) No (☒)

If yes, what is the amount of reinsurance credits, whether an asset or a reduction of liability, taken for such new agreements or amendments? \$ 0

B. Uncollectible Reinsurance

Effective January 1, 2018, the Roebling reinsurance treaty was terminated, resulting in a write-off of \$11,626,473, all of which was unauthorized in 2017.

C. Commutation of Ceded Reinsurance

During 2019, the Company did not report any income or expenses as a result of commutation of reinsurance.

D. Reporting Entity Ceding to Certified Reinsurer Whose Rating was Downgraded or Status Subject to Revocation

The Company has had no certified reinsurers ratings downgraded or status subject to revocation.

E. The Company has no reinsurance of variable annuity contracts with an affiliated captive reinsurer.

F. The Company has no reinsurance agreements with an affiliated captive reinsurer.

G. The Company does not utilize captives to assume reserves.

24. Retrospectively Rated Contracts & Contracts Subject to Redetermination

The Company has no retrospectively rated contracts or contracts subject to redetermination.

NOTES TO FINANCIAL STATEMENTS

25. Change in Incurred Losses and Loss Adjustment Expenses

Gross of Reinsurance
Reserves as of December 31, 2018 were \$959,644,499. As of December 31, 2019, gross payments of \$317,253,364, discounted to December 31, 2018, have been made for incurred losses and estimated waiver of premium to insured events of prior years. Reserves remaining for prior years are now \$634,244,696, discounted to December 31, 2018, as a result of re-estimation of unpaid claims and claim adjustment expenses on the long- term care line of insurance. Thus, there has been an \$8,146,439 favorable prior year development on an annual basis from December 31, 2018 to December 31, 2019. As additional information becomes known on individual claims experience, the original estimates are adjusted accordingly. None of the Company's accident and health contracts are subject to retrospective rating or experience refunds.

26. Intercompany Pooling Arrangements

The Company is not part of an affiliated intercompany pooling arrangement.

27. Structured Settlements

The Company has not reduced reserves through the purchase of an annuity as part of a structured settlement.

28. Health Care Receivables

The Company has no pharmaceutical rebate receivables or risk sharing receivables.

29. Participating Policies

The Company has no participating policies.

30. Premium Deficiency Reserves

Premium deficiency reserves were necessary.

1) Liability carried for premium deficiency reserves	\$ 636,536,749
2) Date of most recent evaluation of this liability	12/31/2019
3) Was anticipated investment income utilized in the calculation?	Yes ☒ No ☐

31. Reserves for Life Contracts and Deposit-type Contracts

The Company had no life contracts or annuity contracts in force as of December 31, 2019.

32. Analysis of Annuity Actuarial Reserves and Deposit Liabilities by Withdrawal Characteristics

The Company had no annuity contracts in force and had no deposit-type liabilities as of December 31, 2019.

33. Premium and Annuity Considerations Deferred and Uncollected

The Company had no life contracts or annuity contracts in force as of December 31, 2019.

34. Separate Accounts

The Company had no separate accounts at December 31, 2019.

35. Loss/Claim Adjustment Expenses

The balance in the liability for unpaid accident and health claim adjustment expenses as of December 31, 2019 and 2018 was \$20,947,086 and \$21,543,776, respectively. The Company incurred \$10,305,677 on a net basis and paid \$11,090,455 of net claim adjustment expenses in the current year, of which \$1,260,431 of the paid amount was attributable to insured or covered events of prior years. The Company did not increase or decrease the provision for insured events of prior years. The Company does not take into account any anticipated salvage and subrogation in its determination of the liability for unpaid claims/losses.

Annual Statement for the year 2019 of the **Senior Health Insurance Company of Pennsylvania**

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

GENERAL

1.1

Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer?
If yes, complete Schedule Y, Parts 1, 1A and 2.

Yes [X] No []

1.2

If yes, did the reporting entity register and file with its domiciliary State Insurance Commissioner, Director or Superintendent or with such regulatory official of the state of domicile of the principal insurer in the Holding Company System, a registration statement providing disclosure substantially similar to the standards adopted by the National Association of Insurance Commissioners (NAIC) in its Model Insurance Holding Company System Regulatory Act and model regulations pertaining thereto, or is the reporting entity subject to standards and disclosure requirements substantially similar to those required by such Act and regulations?

Yes [X] No [] N/A []

1.3

State regulating? PENNSYLVANIA

1.4

Is the reporting entity publicly traded or a member of publicly traded group?

Yes [] No [X]

1.5

If the response to 1.4 is yes, provide the CIK (Central Index Key) code issued by the SEC for the entity/group.

2.1

Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity?

Yes [] No [X]

2.2

If yes, date of change:

3.1

State as of what date the latest financial examination of the reporting entity was made or is being made.

12/31/2018

3.2

State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released.

12/31/2018

3.3

State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date).

12/31/2018

3.4

By what department or departments?
PENNSYLVANIA

3.5

Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with departments?

Yes [] No [] N/A [X]

3.6

Have all of the recommendations within the latest financial examination report been complied with?

Yes [X] No [] N/A []

4.1

During the period covered by this statement, did any agent, broker, sales representative, non-affiliated sales/service organization or any combination thereof under common control (other than salaried employees of the reporting entity) receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:

4.11

sales of new business?

Yes [] No [X]

4.12

renewals?

Yes [] No [X]

4.2

During the period covered by this statement, did any sales/service organization owned in whole or in part by the reporting entity or an affiliate, receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:

4.21

sales of new business?

Yes [] No [X]

4.22

renewals?

Yes [] No [X]

5.1

Has the reporting entity been a party to a merger or consolidation during the period covered by this statement?
If the answer is YES, complete and file the merger history data file with the NAIC.

Yes [] No [X]

5.2

If yes, provide the name of entity, NAIC company code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.

1	2	3
Name of Entity	NAIC Company Code	State of Domicile

6.1

Has the reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period?

Yes [X] No []

6.2

If yes, give full information:
Subsequent to the 2018 Annual Statement filing, certificates of authority in the following states have been suspended: Alaska, Arizona, Idaho, Iowa, Kentuck, Oregon, Virginia, Washington, West Virginia, and Wyoming.

7.1

Does any foreign (non-United States) person or entity directly or indirectly control 10% or more of the reporting entity?

Yes [] No [X]

7.2

If yes,

7.21

State the percentage of foreign control

7.22

State the nationality(s) of the foreign person(s) or entity(s); or if the entity is a mutual or reciprocal, the nationality of its manager or attorney-in-fact and identify the type of entity(s) (e.g., individual, corporation, government, manager or attorney-in-fact).

1	2
Nationality	Type of Entity

8.1

Is the company a subsidiary of a bank holding company regulated with the Federal Reserve Board?

Yes [] No [X]

8.2

If response to 8.1 is yes, please identify the name of the bank holding company.

8.3

Is the company affiliated with one or more banks, thrifts or securities firms?

Yes [] No [X]

8.4

If the response to 8.3 is yes, please provide below the names and locations (city and state of the main office) of any affiliates regulated by a federal financial regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify the affiliate's primary federal regulator.

1	2	3	4	5	6
Affiliate Name	Location (City, State)	FRB	OCC	FDIC	SEC

9.

What is the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit?
Eide Bailly, LLP, 800 Nicollet Mall, Ste. 1300, Minneapolis, MN 55402-7033

10.1

Has the insurer been granted any exemptions to the prohibited non-audit services provided by the certified independent public accountant requirements as allowed in Section 7H of the Annual Financial Reporting Model Regulation (Model Audit Rule), or substantially similar state law or regulation?

Yes [] No [X]

10.2

If the response to 10.1 is yes, provide information related to this exemption:

10.3

Has the insurer been granted any exemptions related to other requirements of the Annual Financial Reporting Model Regulation as allowed for in Section 18A of the Model Regulation, or substantially similar state law or regulation?

Yes [] No [X]

10.4

If the response to 10.3 is yes, provide information related to this exemption:

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Annual Statement for the year 2019 of the **Senior Health Insurance Company of Pennsylvania**

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

10.5Has the reporting entity established an Audit Committee in compliance with the domiciliary state insurance laws?Yes [X]No []N/A []

10.6If the response to 10.5 is no or n/a, please explain:

11.What is the name, address and affiliation (officer/employee of the reporting entity or actuary/consultant associated with an actuarial consulting firm) of the individual providing the statement of actuarial opinion/certification?
Allen J Schmitz, F.S.A. M.A.A.A. Actuary/Consultant with Milliman, Inc., 15800 West Bluemound Road Suite 100, Brookfield, WI 53005

12.1Does the reporting entity own any securities of a real estate holding company or otherwise hold real estate indirectly?Yes []No [X]

12.11Name of real estate holding company

12.12Number of parcels involved

12.13Total book/adjusted carrying value\$

12.2If yes, provide explanation

13.FOR UNITED STATES BRANCHES OF ALIEN REPORTING ENTITIES ONLY:

13.1What changes have been made during the year in the United States manager or the United States trustees of the reporting entity?

13.2Does this statement contain all business transacted for the reporting entity through its United States Branch on risks wherever located?Yes []No [X]

13.3Have there been any changes made to any of the trust indentures during the year?Yes []No [X]

13.4If answer to (13.3) is yes, has the domiciliary or entry state approved the changes?Yes []No []N/A [X]

14.1Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards?Yes [X]No []

14.1(a)Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;

14.1(b)Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;

14.1(c)Compliance with applicable governmental laws, rules and regulations;

14.1(d)The prompt internal reporting of violations to an appropriate person or persons identified in the code; and

14.1(e)Accountability for adherence to the code.

14.11If the response to 14.1 is no, please explain:

14.2Has the code of ethics for senior managers been amended?Yes []No [X]

14.21If the response to 14.2 is yes, provide information related to amendment(s).

14.3Have any provisions of the code of ethics been waived for any of the specified officers?Yes []No [X]

14.31If the response to 14.3 is yes, provide the nature of any waiver(s).

15.1Is the reporting entity the beneficiary of a Letter of Credit that is unrelated to reinsurance where the issuing or confirming bank is not on the SVO Bank List?Yes []No [X]

15.2If the response to 15.1 is yes, indicate the American Bankers Association (ABA) Routing Number and the name of the issuing or confirming bank of the Letter of Credit and describe the circumstances in which the Letter of Credit is triggered.

1 American Bankers Association (ABA) Routing Number	2 Issuing or Confirming Bank Name	3 Circumstances That Can Trigger the Letter of Credit	4 Amount
			\$

BOARD OF DIRECTORS

16.Is the purchase or sale of all investments of the reporting entity passed upon either by the Board of Directors or a subordinator committee thereof?Yes [X]No []

17.Does the reporting entity keep a complete permanent record of the proceedings of its Board of Directors and all subordinate committees thereof?Yes [X]No []

18.Has the reporting entity an established procedure for disclosure to its Board of Directors or trustees of any material interest or affiliation on the part of any of its officers, directors, trustees or responsible employees that is in conflict or is likely to conflict with the official duties of such person?Yes [X]No []

FINANCIAL

19.Has this statement been prepared using a basis of accounting other than Statutory Accounting Principles (e.g., Generally Accepted Accounting Principles)?Yes []No [X]

20.1Total amount loaned during the year (inclusive of Separate Accounts, exclusive of policy loans):

20.11To directors or other officers\$0

20.12To stockholders not officers\$0

20.13Trustees, supreme or grand (Fraternal only)\$0

20.2Total amount of loans outstanding at the end of year (inclusive of Separate Accounts, exclusive of policy loans):

20.21To directors or other officers\$0

20.22To stockholders not officers0

20.23Trustees, supreme or grand (Fraternal only)0

21.1Were any assets reported in this statement subject to a contractual obligation to transfer to another party without the liability for such obligation being reporting in the statement?Yes []No [X]

21.2If yes, state the amount thereof at December 31 of the current year:

21.21Rented from others\$0

21.22Borrowed from others\$0

21.23Leased from others\$0

21.24Other\$0

22.1Does this statement include payments for assessments as described in the Annual Statement Instructions other than guaranty fund or guaranty association assessments?Yes []No [X]

22.2If answer is yes:

22.21Amount paid as losses or risk adjustment\$0

22.22Amount paid as expenses\$0

22.23Other amounts paid\$0

23.1Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement?Yes [X]No []

Annual Statement for the year 2019 of the **Senior Health Insurance Company of Pennsylvania**

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

23.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount: \$ _____

INVESTMENT

24.01 Were all the stocks, bonds and other securities owned December 31 of current year, over which the reporting entity has exclusive control, in the actual possession of the reporting entity on said date (other than securities lending programs addressed in 24.03)? Yes ☒ No ☐

24.02 If no, give full and complete information, relating thereto:

24.03 For security lending programs, provide a description of the program including value for collateral and amount of loaned securities, and whether collateral is carried on or off-balance sheet (an alternative is to reference Note 17 where this information is also provided).

24.04 Does the company's security lending program meet the requirements for a conforming program as outlined in the *Risk-Based Capital Instructions*? Yes ☐ No ☐ N/A ☐

24.05 If answer to 24.04 is yes, report amount of collateral for conforming programs. \$ _____

24.06 If answer to 24.04 is no, report amount of collateral for other programs \$ _____

24.07 Does your securities lending program require 102% (domestic securities) and 105% (foreign securities) from the counterparty at the outset of the contract? Yes ☐ No ☐ N/A ☐

24.08 Does the reporting entity non-admit when the collateral received from the counterparty falls below 100%? Yes ☐ No ☐ N/A ☐

24.09 Does the reporting entity or the reporting entity's securities lending agent utilize the Master Securities Lending Agreement (MSLA) to conduct securities lending? Yes ☐ No ☐ N/A ☐

24.10 For the reporting entity's security lending program, state the amount of the following as of December 31 of the current year:

24.101 Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2: \$ _____

24.102 Total book adjusted/carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2: \$ _____

24.103 Total payable for securities lending reported on the liability page: \$ _____

25.1 Were any of the stocks, bonds or other assets of the reporting entity owned at December 31 of the current year not exclusively under the control of the reporting entity or has the reporting entity sold or transferred any assets subject to a put option contract that is current in force? (Exclude securities subject to Interrogatory 21.1 and 24.03.) Yes ☒ No ☐

25.2 If yes, state the amount thereof at December 31 of the current year:

25.21 Subject to repurchase agreements \$ _____

25.22 Subject to reverse repurchase agreements \$ _____

25.23 Subject to dollar repurchase agreements \$ _____

25.24 Subject to reverse dollar repurchase agreements \$ _____

25.25 Placed under option agreements \$ _____

25.26 Letter stock or securities restricted as sale – excluding FHLB Capital Stock \$ _____

25.27 FHLB Capital Stock \$ 513,300

25.28 On deposit with states \$ 18,762,440

25.29 On deposit with other regulatory bodies \$ _____

25.30 Pledged as collateral – excluding collateral pledged to an FHLB \$ _____

25.31 Pledged as collateral to FHLB – including assets backing funding agreements \$ _____

25.32 Other \$ 0

25.3 For category (25.26) provide the following:

1 Nature of Restriction	2 Description	3 Amount
		\$ _____

26.1 Does the reporting entity have any hedging transactions reported on Schedule DB? Yes ☐ No ☒

26.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state? Yes ☐ No ☐ N/A ☒
If no, attach a description with this statement.

Lines 26.3 through 26.5: FOR LIFE/FRATERNAL REPORTING ENTITIES ONLY:

26.3 Does the reporting entity utilize derivatives to hedge variable annuity guarantees subject to fluctuations as a results of interest rate sensitivity? Yes ☐ No ☒

26.4 If the response to 26.3 is yes, does the reporting entity utilize:

26.41 Special accounting provision of SSAP No. 108 Yes ☐ No ☐

26.42 Permitted accounting practice Yes ☐ No ☐

26.43 Other accounting guidance Yes ☐ No ☐

26.5 By responding yes to 26.41 regarding utilizing the special accounting provisions of SSAP No. 108, the reporting entity attests to the following: Yes ☐ No ☐

- The reporting entity has obtained explicit approval from the domiciliary state.
- Hedging strategy subject to the special accounting provisions is consistent with the requirements of VM-21.
- Actuarial certification has been obtained which indicates that the hedging strategy is incorporated within the establishment of VM-21 reserves and provides the impact of the hedging strategy within the Actuarial Guidance Conditional Tail Expectation Amount.
- Financial Officer Certification has been obtained which indicates that the hedging strategy meets the definition of a Clearly Defined Hedging Strategy within VM-21 and the Clearly Defined Hedging Strategy is the hedging strategy being used by the company in its actual day-to-day risk mitigation efforts.

27.1 Were any preferred stocks or bonds owned as of December 31 of the current year mandatorily convertible into equity, or, at the option of the issuer, convertible into equity? Yes ☐ No ☒

27.2 If yes, state the amount thereof at December 31 of the current year: \$ _____ 0

28. Excluding items in Schedule E-Part 3-Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III - General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC *Financial Condition Examiners Handbook*? Yes ☒ No ☐

28.01 For agreements that comply with the requirements of the NAIC *Financial Condition Examiners Handbook*, complete the following:

1 Name of Custodian(s)	2 Custodian's Address
The Bank of New York Mellon	1 Wall Street, 14th Floor, New York, NY 10286

28.02 For all agreements that do not comply with the requirements of the NAIC *Financial Condition Examiners Handbook*, provide the name, location and a complete explanation

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GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

1	2	3
Name(s)	Location(s)	Complete Explanation(s)

28.03 Have there been any changes, including name changes, in the custodian(s) identified in 28.01 during the current year? Yes [] No [X]

28.04 If yes, give full and complete information relating thereto:

1	2	3	4
Old Custodian	New Custodian	Date of Change	Reason

28.05 Investment management – Identify all investment advisors, investment managers, broker/dealers, including individuals that have the authority to make investment decisions on behalf of the reporting entity. For assets that are managed internally by employees of the reporting entity, note as such. ["...that have access to the investment accounts", "... handle securities"].

1	2
Name of Firm or Individual	Affiliation
New England Asset Management	U
Conning Asset Management Company	U
John Robison, Chief Investment Officer	I

28.0597 For those firms/individuals listed in the table for Question 28.05, do any firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") manage more than 10% of the reporting entity's invested assets? Yes [X] No []

28.0598 For firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") listed in the table for Question 28.05, does the total assets under management aggregate to more than 50% of the reporting entity's invested assets? Yes [X] No []

28.06 For those firms or individuals listed in the table for 28.05 with an affiliation code of "A" (affiliated) or "U" (unaffiliated), provide the information for the table below.

1	2	3	4	5
Central Registration Depository Number	Name of Firm or Individual	Legal Entity Identifier (LEI)	Registered With	Investment Management Agreement (IMA) File
105900	New England Asset Management	JR85E5PS4GQFZTFC1	SEC	No
107423	Conning Asset Management Company	49300Z0GMKK37BDV4	SEC	No

29.1 Does the reporting entity have any diversified mutual funds reported in Schedule D-Part 2 (diversified according to the Securities and Exchange Commission (SEC) in the Investment Company Act of 1940 [Section 5 (b) (1)])? Yes [] No [X]

29.2 If yes, complete the following schedule:

1	2	3
CUSIP	Name of Mutual Fund	Book/Adjusted Carrying Value
		\$
29.2999	TOTAL	\$

29.3 For each mutual fund listed in the table above, complete the following schedule:

1	2	3	4
Name of Mutual Fund (from above table)	Name of Significant Holding of the Mutual Fund	Amount of Mutual Fund's Book/Adjusted Carrying Value Attributable to the Holding	Date of Valuation
		\$	

30. Provide the following information for all short-term and long-term bonds and all preferred stocks. Do not substitute amortized value or statement value for fair value.

		1	2	3
		Statement (Admitted) Value	Fair Value	Excess of Statement over Fair Value (-), or Fair Value over Statement (+)
30.1	Bonds	\$ 1,721,888,236	\$ 1,803,159,706	\$ 81,271,470
30.2	Preferred Stocks	\$ 86,271,292	\$ 86,859,728	\$ 588,436
30.3	Totals	\$ 1,808,159,528	\$ 1,890,019,434	\$ 81,859,906

30.4 Describe the sources or methods utilized in determining the fair values:

See Fair Value Disclosure in Note 20.A of Notes to Financial Statement

31.1 Was the rate used to calculate fair value determined by a broker or custodian for any of the securities in Schedule D? Yes [X] No []

31.2 If the answer to 31.1 is yes, does the reporting entity have a copy of the broker's or custodian's pricing policy (hard copy or electronic copy) for all brokers or custodians used as a pricing source? Yes [] No [X]

31.3 If the answer to 31.2 is no, describe the reporting entity's process for determining a reliable pricing source for purposes of disclosure of fair value for Schedule D: Prices are obtained from the dealer/market makers for these securities. These prices are non-binding but represent the best estimate of fair value per market conditions.

32.1 Have all the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office been followed? Yes [X] No []

32.2 If no, list exceptions:

33. By self-designating 5GI securities, the reporting entity is certifying the following elements for each self-designation 5GI security:
a. Documentation necessary to permit a full credit analysis of the security does not exist or an NAIC CRP credit rating for an FE or PL security is not available.
b. Issuer or obligor is current on all contracted interest and principal payments.
c. The insurer has an actual expectation of ultimate payment of all contracted interest and principal.
Has the reporting entity self-designated 5GI securities? Yes [] No [X]

34. By self-designating PLGI securities, the reporting entity is certifying the following elements of each self-designated PLGI security:
a. The security was purchased prior to January 1, 2018.
b. The reporting entity is holding capital commensurate with the NAIC Designation reported for the security.
c. The NAIC Designation was derived from the credit rating assigned by an NAIC CRP in its legal capacity as an NRSRO which is shown on a current private letter rating held by the insurer and available for examination by state insurance regulators.

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

d.

The reporting entity is not permitted to share this credit rating of the PL security with the SVO.

Has the reporting entity self-designated PLGI securities?

Yes [☐] No [☒]

35.

By assigning FE to a Schedule BA non-registered private fund, the reporting entity is certifying the following elements of each self-designated FE fund:

a.

The shares were purchased prior to January 1, 2019.

b.

The reporting entity is holding capital commensurate with the NAIC Designation reported for the security.

c.

The security had a public credit rating(s) with annual surveillance assigned by an NAIC CRP in its legal capacity as an NRSRO prior to January 1, 2019.

d.

The fund only or predominantly holds bonds in its portfolio.

e.

The current reported NAIC Designation was derived from the public credit rating(s) with annual surveillance assigned by an NAIC CRP in its legal capacity as an NRSRO.

f.

The public credit rating(s) with annual surveillance assigned by an NAIC CRP has not lapsed.

Has the reporting entity assigned FE to Schedule BA non-registered private funds that complied with the above criteria?

Yes [☐] No [☐]

OTHER

36.1

Amount of payments to trade associations, service organizations and statistical or rating bureaus, if any?

\$

0

36.2

List the name of the organization and the amount paid if any such payment represented 25% or more of the total payments to trade associations, service organizations and statistical or rating bureaus during the period covered by this statement.

1 Name	2 Amount Paid
	\$

37.1

Amount of payments for legal expenses, if any?

\$

1,182,188

37.2

List the name of the firm and the amount paid if any such payment represented 25% or more of the total payments for legal expenses during the period covered by this statement.

1 Name	2 Amount Paid
Stradley Ronon Stevens & Young LLP	\$ 486,351

38.1

Amount of payments for expenditures in connection with matters before legislative bodies, officers or departments of government, if any?

\$

38.2

List the name of the firm and the amount paid if any such payment represented 25% or more of the total payment expenditures in connection with matters before legislative bodies, officers or departments of government during the period covered by this statement.

1 Name	2 Amount Paid
	\$

GENERAL INTERROGATORIES

PART 2 – LIFE, ACCIDENT AND HEALTH COMPANIES/FRATERNAL BENEFIT SOCIETIES INTERROGATORIES

Life, Accident and Health Companies/Fraternal Benefit Societies:

1.1

Does the reporting entity have any direct Medicare Supplement Insurance in force?

Yes [☐]

No [☒]

1.2

If yes, indicate premium earned on U.S. business only.

\$

1.3

What portion of Item (1.2) is not reported on the Medicare Supplement Insurance Experience Exhibit?

\$

1.3

Reason for excluding:

1.4

Indicate amount of earned premium attributable to Canadian and/or Other Alien not included in Item (1.2) above.

\$

1.5

Indicate total incurred claims on all Medicare Supplement insurance.

\$

1.6

Individual policies:

Most current three years:

1.61

Total premium earned

\$

1.62

Total incurred claims

\$

1.63

Number of covered lives

\$

All years prior to most current three years:

1.64

Total premium earned

\$

1.65

Total incurred claims

\$

1.66

Number of covered lives

\$

1.7

Group policies:

Most current three years:

1.71

Total premium earned

\$

1.72

Total incurred claims

\$

1.73

Number of covered lives

\$

All years prior to most current three years:

1.74

Total premium earned

\$

1.75

Total incurred claims

\$

1.76

Number of covered lives

\$

2.

Health Test:

1

Current Year

2

Prior Year

2.1

Premium Numerator

\$

0

\$

0

2.2

Premium Denominator

\$

78,564,611

\$

1,237,392,658

2.3

Premium Ratio (2.1/2.2)

0.0%

0.0%

2.4

Reserve Numerator

\$

49,738,445

\$

49,770,059

2.5

Reserve Denominator

\$

2,167,641,605

\$

2,270,616,300

2.6

Reserve Ratio (2.4/2.5)

2.3%

2.2%

3.1

Does the reporting entity have Separate Accounts?

Yes [☐]

No [☒]

3.2

If yes, has a Separate Accounts statement been filed with this Department

Yes [☐]

No [☐]

N/A [☐]

3.3

What portion of capital and surplus funds of the reporting entity covered by assets in the Separate Accounts statement, is not currently distributable from the Separate Accounts to the general account for use by the general account?

\$

0

3.4

State the authority under which Separate Accounts are maintained:

3.5

Was any of the reporting entity's Separate Accounts business reinsured as of December 31?

Yes [☐]

No [☐]

3.6

Has the reporting entity assumed by reinsurance any Separate Accounts business as of December 31?

Yes [☐]

No [☐]

3.7

If the reporting entity has assumed Separate Accounts business, how much, if any, reinsurance assumed receivable for reinsurance of Separate Accounts reserve expense allowances is included as a negative amount in the liability for "Transfers to Separate Accounts due or accrued (net)?"

\$

0

4.

For reporting entities having sold annuities to another insurer where the insurer purchasing the annuities has obtained a release of liability from the claimant (payee) as the result of the purchase of an annuity from the reporting entity only:

4.1

Amount of loss reserves established by these annuities during the current year:

\$

0

4.2

List the name and location of the insurance company purchasing the annuities and the statement value on the purchase date of the annuities.

1 P&C Insurance Company and Location	2 Statement Value on Purchase Date of Annuities (i.e., Present Value)

5.1

Do you act as a custodian for health savings accounts?

Yes [☐]

No [☒]

5.2

If yes, please provide the amount of custodial funds held as of the reporting date.

\$

0

5.3

Do you act as an administrator for health savings accounts?

Yes [☐]

No [☒]

5.4

If yes, please provide the balance of the funds administered as of the reporting date.

\$

0

6.1

Are any of the captive affiliates reported on Schedule S, Part 3, authorized reinsurers?

Yes [☐]

No [☐]

N/A [☒]

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GENERAL INTERROGATORIES

PART 2 – LIFE, ACCIDENT AND HEALTH COMPANIES/FRATERNAL BENEFIT SOCIETIES INTERROGATORIES

6.2 If the answer to 6.1 is yes, please provide the following:

1 Company Name	2 NAIC Company Code	3 Domiciliary Jurisdiction	4 Reserve Credit	Assets Supporting Reserve Credit		
				5 Letters of Credit	6 Trust Agreements	7 Other
			\$	\$	\$	\$

7. Provide the following for individual ordinary life insurance* policies (U.S. business only) for the current year (prior to reinsurance assumed or ceded).

7.1	Direct premiums written	\$
7.2	Total incurred claims	\$
7.3	Number of covered lives	

*Ordinary Life Insurance Includes
Term (whether full underwriting, limited underwriting, jet issue, "short form app")
Whole Life (whether full underwriting, limited underwriting, jet issue, "short form app")
Variable Life (with or without secondary guarantee)
Universal Life (with or without secondary guarantee)
Variable Universal Life (with or without secondary guarantee)

8. Is the reporting entity licensed or chartered, registered, qualified, eligible or writing business in at least two states? Yes [X] No []

8.1 If no, does the reporting entity assume reinsurance business that covers risks residing in at least one state other than the state of domicile of the reporting entity? Yes [] No []

Life, Accident and Health Companies Only:

9.1 Are personnel or facilities of this reporting entity used by another entity or entities or are personnel or facilities of another entity or entities used by this reporting entity (except for activities such as administration of jointly underwritten group contracts and joint mortality or morbidity studies)? Yes [X] No []

9.2 Net reimbursement of such expenses between reporting entities:

9.21	Paid	\$	12,778,644
9.22	Received	\$	
10.1	Does the reporting entity write any guaranteed interest contracts?	Yes []	No [X]

10.2 If yes, what amount pertaining to these items is included in:

10.21	Page 3, Line 1	\$
10.22	Page 4, Line 1	\$

11. For stock reporting entities only:

11.1	Total amount paid in by stockholders as surplus funds since organization of the reporting entity:	\$	1,198,824,014
12.	Total dividends paid stockholders since organization of the reporting entity:		
12.11	Cash	\$	217,094,932
12.12	Stock	\$	140,004

13.1 Does the reporting entity reinsure any Workers' Compensation Carve-Out business defined as:

Reinsurance (including retrocessional reinsurance) assumed by life and health insurers of medical, wage loss and death benefits of the occupational illness and accident exposures, but not the employers liability exposures, of business originally written as workers' compensation insurance.

13.2 If yes, has the reporting entity completed the *Workers' Compensation Carve-Out Supplement* to the Annual Statement? Yes [] No [X]

13.3 If 13.1 is yes, the amounts of earned premiums and claims incurred in this statement are:

	1 Reinsurance Assumed	2 Reinsurance Ceded	3 Net Retained
13.31	Earned premium	\$ 0	\$ 0
13.32	Paid claims	\$ 0	\$ 0
13.33	Claim liability and reserve (beginning of year)	\$ 0	\$ 0
13.34	Claim liability and reserve (end of year)	\$ 0	\$ 0
13.35	Incurred claims	\$ 0	\$ 0

13.4 If reinsurance assumed included amounts with attachment points below \$1,000,000, the distribution of the amounts reported in Lines 13.31 and 13.34 for Column (1) are:

	1 Earned Premium	2 Claim Liability and Reserve
13.41	<\$25,000	\$ 0
13.42	\$25,000 — 99,999	\$ 0
13.43	\$100,000 — 249,999	\$ 0
13.44	\$250,000 — 999,999	\$ 0
13.45	\$1,000,000 or more	\$ 0

13.5 What portion of earned premium reported in 13.31, Column 1 was assumed from pools? \$ 0

Fraternal Benefit Societies Only:

14. Is the reporting entity organized and conducted on the lodge system, with ritualistic form of work and representative form of government? Yes [] No [X]

15. How often are meetings of the subordinate branches required to be held?

16. How are the subordinate branches represented in the supreme or governing body?

17. What is the basis of representation in the governing body?

Annual Statement for the year 2019 of the **Senior Health Insurance Company of Pennsylvania**
FIVE-YEAR HISTORICAL DATA

Show amounts in whole dollars only, no cents; show percentages to one decimal place, i.e., 17.6.

\$000 omitted for amounts of life insurance

	1 2019	2 2018	3 2017	4 2016	5 2015
Life Insurance in Force (Exhibit of Life Insurance)					
1. Ordinary - whole life and endowment (Line 34, Col. 4).....					
2. Ordinary - term (Line 21, Col. 4, less Line 34, Col. 4).....					
3. Credit life (Line 21, Col. 6).....					
4. Group, excluding FEGLI/SGLI (Line 21, Col. 9 less Lines 43 & 44, Col. 4).....					
5. Industrial (Line 21, Col. 2).....					
6. FEGLI/SGLI (Lines 43 & 44, Col. 4).....					
7. Total (Line 21, Col. 10).....	0	0	0	0	
7.1 Total in force for which VM-20 deterministic/stochastic reserves are calculated.....				XXX.....	XXX.....
New Business Issued (Exhibit of Life Insurance)					
8. Ordinary - whole life and endowment (Line 34, Col. 2).....					
9. Ordinary - term (Line 2, Col. 4, less Line 34, Col. 2).....					
10. Credit life (Line 2, Col. 6).....					
11. Group (Line 2, Col. 9).....					
12. Industrial (Line 2, Col. 2).....					
13. Total (Line 2, Col. 10).....	0	0	0	0	
Premium Income - Lines of Business (Exhibit 1-Part 1)					
14. Industrial life (Line 20.4, Col. 2).....					
15.1 Ordinary life insurance (Line 20.4, Col. 3).....					
15.2 Ordinary individual annuities (Line 20.4, Col. 4).....					
16. Credit life (group and individual) (Line 20.4, Col. 5).....					
17.1 Group life insurance (Line 20.4, Col. 6).....					
17.2 Group annuities (Line 20.4, Col. 7).....					
18.1 A&H - group (Line 20.4, Col. 8).....	1,422,165	25,442,802	1,042,753	(25,926,020)	2,790,822
18.2 A&H - credit (group and individual) (Line 20.4, Col. 9).....					
18.3 A&H - other (Line 20.4, Col. 10).....	77,142,447	1,211,949,856	44,419,490	(1,127,056,295)	133,931,988
19. Aggregate of all other lines of business (Line 20.4, Col. 11).....					
20. Total.....	78,564,611	1,237,392,658	45,462,243	(1,152,982,315)	136,722,810
Balance Sheet (Pages 2 and 3)					
21. Total admitted assets excluding Separate Accounts business (Page 2, Line 26, Col. 3)....	1,907,181,137	2,186,058,273	2,688,468,510	2,744,535,287	2,879,794,716
22. Total liabilities excluding Separate Accounts business (Page 3, Line 26).....	2,823,279,366	2,652,931,248	2,675,819,343	2,716,512,099	2,824,037,145
23. Aggregate life reserves (Page 3, Line 1).....					
23.1 Excess VM-20 deterministic/stochastic reserve over NPR related to Line 7.1.....				XXX.....	XXX.....
24. Aggregate A&H reserves (Page 3, Line 2).....	2,766,443,751	2,608,580,649	1,217,465,047	1,296,352,123	2,635,480,160
25. Deposit-type contract funds (Page 3, Line 3).....					
26. Asset valuation reserve (Page 3, Line 24.01).....	206,126	58,003	28,206,999	32,191,000	37,970,000
27. Capital (Page 3, Lines 29 & 30).....	7,500,005	7,500,005	7,500,005	7,500,005	7,500,005
28. Surplus (Page 3, Line 37).....	(923,598,234)	(474,372,980)	5,149,161	20,523,182	48,257,565
Cash Flow (Page 5)					
29. Net cash from operations (Line 11).....	(251,697,543)	(228,071,464)	(180,642,597)	(1,386,055,168)	(172,813,814)
Risk-Based Capital Analysis					
30. Total adjusted capital.....	(915,731,212)	(466,814,972)	40,856,166	60,214,187	93,727,570
31. Authorized control level risk-based capital.....	59,722,365	51,352,310	28,828,614	36,717,738	58,321,985
Percentage Distribution of Cash, Cash Equivalents and Invested Assets (Page 2, Col. 3) (Line No. /Page 2, Line 12, Col. 3) x 100.0					
32. Bonds (Line 1).....	91.3	92.6	72.5	80.5	81.2
33. Stocks (Lines 2.1 and 2.2).....	4.8	5.1	2.9	5.2	3.3
34. Mortgage loans on real estate (Lines 3.1 and 3.2).....	0.7	0.8	1.2	1.8	2.1
35. Real estate (Line 4.1, 4.2 and 4.3).....					
36. Cash, cash equivalents and short-term investments (Line 5).....	2.5	1.0	19.1	6.6	3.1
37. Contract loans (Line 6).....					
38. Derivatives (Line 7).....					
39. Other invested assets (Line 8).....	0.8	0.5	4.2	5.7	10.4
40. Receivables for securities (Line 9).....	0.0		0.0	0.2	
41. Securities lending reinvested collateral assets (Line 10).....					
42. Aggregate write-ins for invested assets (Line 11).....					
43. Cash, cash equivalents and invested assets (Line 12).....	100.0	100.0	100.0	100.0	100.0

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Annual Statement for the year 2019 of the **Senior Health Insurance Company of Pennsylvania**
FIVE-YEAR HISTORICAL DATA

(continued)

	1 2019	2 2018	3 2017	4 2016	5 2015
Investments in Parent, Subsidiaries and Affiliates					
44. Affiliated bonds (Sch. D Summary, Line 12, Col. 1).....					
45. Affiliated preferred stocks (Sch. D Summary, Line 18, Col. 1).....					
46. Affiliated common stocks (Sch. D Summary, Line 24, Col. 1).....	2,975,269				
47. Affiliated short-term investments (subtotal included in Sch. DA, Verif., Col. 5, Line 10).....					
48. Affiliated mortgage loans on real estate					
49. All other affiliated.....					
50. Total of above Lines 44 to 49.....	2,975,269	0	0	0	
51. Total investment in parent included in Lines 44 to 49 above.....					
Total Nonadmitted and Admitted Assets					
52. Total nonadmitted assets (Page 2, Line 28, Col. 2).....	9,949,027	19,565,734	55,065	53,950	57,593
53. Total admitted assets (Page 2, Line 28, Col. 3).....	1,907,181,137	2,186,058,273	2,688,468,510	2,744,535,287	2,879,794,716
Investment Data					
54. Net investment income (Exhibit of Net Investment Income).....	69,898,628	81,934,413	100,395,540	148,680,691	159,278,389
55. Realized capital gains (losses) (Page 4, Line 34, Column 1).....	(44,066,405)	(175,822,458)	6,491,743	(23,658,295)	10,206,458
56. Unrealized capital gains (losses) (Page 4, Line 38, Column 1).....	842,233	131,852	3,163,766	6,180,235	(15,016,725)
57. Total of above Lines 54, 55 and 56.....	26,674,456	(93,756,193)	110,051,048	131,202,632	154,468,102
Benefits and Reserve Increase (Page 6)					
58. Total contract/certificate benefits - life (Lines 10, 11, 12, 13, 14 and 15, Col. 1 minus Lines 10, 11, 12, 13, 14 and 15, Cols. 6, 7 & 8).....					
59. Total contract/certificate benefits - A&H (Lines 13 & 14, Col. 6).....	371,758,091	390,323,186	199,171,910	308,511,558	413,521,598
60. Increase in life reserves - other than group and annuities (Line 19, Col. 2).....					
61. Increase in A&H reserves (Line 19, Col. 6).....	157,863,106	1,391,115,603	(78,887,076)	(1,339,128,038)	(100,507,596)
62. Dividends to policyholders and refunds to members (Line 30, Col 1).....					
Operating Percentages					
63. Insurance expense percent (Page 6, Col. 1, Lines 21, 22, & 23 less Line (6) / (Page 6, Col. 1, Line 1 plus Exhibit 7, Col. 2, Line 2) x 100.00.....	44.6	3.2	47.7	(2.7)	29.9
64. Lapse percent (ordinary only) [(Exhibit of Life Insurance, Col. 4, Lines 14 & 15) / 1/2 (Exhibit of Life Insurance, Col. 4, Lines 1 & 21)] x 100.00.....					
65. A&H loss percent (Schedule H, Part 1, Lines 5 & 6, Col. 2).....	659.3	51.5	259.1	89.2	263.9
66. A&H cost containment percent (Schedule H, Part 1, Line 4, Col. 2).....	0.2	0.0	1.2	(0.1)	0.3
67. A&H expense percent excluding cost containment expenses (Schedule H, Part 1, Line 10, Col. 2).....	48.1	3.4	49.7	(2.9)	30.7
A&H Claim Reserve Adequacy					
68. Incurred losses on prior years' claims - group health (Sch. H, Part 3, Line 3.1, Col. 2).....	21,441,957	23,710,984	12,030,545	16,093,686	26,958,966
69. Prior years' claim liability and reserve - group health (Sch. H, Part 3, Line 3.2, Col. 2).....	23,338,313	22,699,092	11,990,691	26,759,010	24,321,970
70. Incurred losses on prior years' claims - health other than group (Sch. H, Part 3, Line 3.1, Col. 1 less Col. 2).....	961,510,874	981,095,409	511,372,752	611,712,185	1,004,808,131
71. Prior years' claim liability and reserve - health other than group (Sch. H, Part 3, Line 3.2, Col. 1 less Col. 2).....	935,631,618	909,860,269	484,840,984	958,623,938	958,289,818
Net Gains From Operations After Dividends to Policyholders/Members' Refunds and Federal Income Taxes by Lines of Business (Page 6.x, Line 33)					
72. Industrial life (Page 6.1, Col. 2).....					
73. Ordinary - life (Page 6.1, Col. 1 less Cols. 2, 10 and 12).....					
74. Ordinary - individual annuities (Page 6, Col. 4).....					
75. Ordinary - supplementary contracts.....	XXX				
76. Credit life (Page 6.1, Col. 10 plus Page 6.2, Col. 7).....					
77. Group life (Page 6.2, Col. 1 less Col. 7 less Col. 9).....					
78. Group annuities (Page 6, Col. 5).....					
79. A&H - group (Page 6.5, Col. 3).....		(5,330,981)	(737,443)	1,168,637	(4,122,548)
80. A&H - credit (Page 6.5, Col. 10).....					
81. A&H - other (Page 6.5, Col. 1 less Cols. 3 and 10).....	(417,967,639)	(318,765,355)	(19,704,154)	(23,507,603)	(15,105,585)
82. Aggregate of all other lines of business (Page 6, Col. 8).....					
83. Fraternal (Page 6, Col. 7).....					
84. Total (Page 6, Col. 1).....	(417,967,639)	(324,096,336)	(20,441,597)	(22,338,965)	(19,228,134)

NOTE: If a party to a merger, have the two most recent years of this exhibit been restated due to a merger in compliance with the disclosure requirements of SSAP No. 3, Accounting Changes and Correction of Errors? Yes [] No []

If no, please explain:

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DIRECT BUSINESS IN GRAND TOTAL DURING THE YEAR

NAIC Company Code.....76325

LIFE INSURANCE

	1	2	3	4	5
	Ordinary	Credit Life (Group and Individual)	Group	Industrial	Total
DIRECT PREMIUMS AND ANNUITY CONSIDERATIONS					
1. Life insurance.....					
2. Annuity considerations.....					
3. Deposit-type contract funds.....		XXX		XXX	
4. Other considerations.....					
5. Totals (Sum of Lines 1 to 4).....	0	0	0	0	
DIRECT DIVIDENDS TO POLICYHOLDERS/REFUNDS TO MEMBERS					
Life insurance:					
6.1 Paid in cash or left on deposit.....					
6.2 Applied to pay renewal premiums.....					
6.3 Applied to provide paid-up additions or shorten the endowment or premium-paying period.....					
6.4 Other.....					
6.5 Totals (Sum of Lines 6.1 to 6.4).....	0	0	0	0	
Annuities:					
7.1 Paid in cash or left on deposit.....					
7.2 Applied to provide paid-up annuities.....					
7.3 Other.....					
7.4 Totals (Sum of Lines 7.1 to 7.3).....	0	0	0	0	
8. Grand Totals (Lines 6.5 + 7.4).....	0	0	0	0	
DIRECT CLAIMS AND BENEFITS PAID					
9. Death benefits.....					
10. Matured endowments.....					
11. Annuity benefits.....					
12. Surrender values and withdrawals for life contracts.....					
13. Aggregate write-ins for miscellaneous direct claims and benefits paid....	0	0	0	0	
14. All other benefits, except accident and health.....					
15. Totals.....	0	0	0	0	

DETAILS OF WRITE-INS

1301. ....	.....	.....	.....	.....	.....
1302. ....	.....	.....	.....	.....	.....
1303. ....	.....	.....	.....	.....	.....
1398. Summary of remaining write-ins for Line 13 from overflow page.....	0	0	0	0	0
1399. Total (Lines 1301 through 1303 plus 1398)(Line 13 above).....	0	0	0	0	0

	Ordinary		Credit Life (Group and Individual)		Group		Industrial		Total	
	1	2	3	4	5	6	7	8	9	10
	No. of Pols. & Certifs.	Amount	No. of Ind. Pols. & Gr. Certifs.	Amount	No. of Certifs.	Amount	No. of Pols. & Certifs.	Amount	No. of Pols. & Certifs.	Amount
DIRECT DEATH BENEFITS AND MATURED ENDOWMENTS INCURRED										
16. Unpaid December 31, prior year.....									0	0
17. Incurred during current year.....									0	0
Settled during current year:										
18.1 By payment in full.....									0	0
18.2 By payment on compromised claims.....									0	0
18.3 Totals paid.....	0	0			0	0	0	0	0	0
18.4 Reduction by compromise.....									0	0
18.5 Amount rejected.....									0	0
18.6 Total settlements.....	0	0	0	0	0	0	0	0	0	0
19. Unpaid Dec. 31, current year										
(Lines 16 + 17 - 18.6).....	0	0	0	0	0	0	0	0	0	0
POLICY EXHIBIT					No. of Pol.					
20. In force December 31, prior year.....				(a).....					0	0
21. Issued during year.....									0	0
22. Other changes to in force (Net).....									0	0
23. In force December 31 of current year.....	0	0	0	(a).....0	0	0	0	0	0	0

(a) Includes Individual Credit Life Insurance, prior year \$.....0 current year \$.....0.

Includes Group Credit Life Insurance Loans less than or equal to 60 months at issue, prior year \$.....0 current year \$.....0.

Loans greater than 60 months at issue BUT NOT GREATER THAN 120 MONTHS, prior year \$.....0 current year \$.....0.

ACCIDENT AND HEALTH INSURANCE

	1	2	3	4	5
	Direct Premiums	Direct Premiums Earned	Policyholder Dividends Paid, Refunds to Members or Credited on Direct Business	Direct Losses Paid	Direct Losses Incurred
24. Group policies (b).....	553,440	696,731		4,931,308	4,480,908
24.1 Federal Employee Health Benefits Plan premium (b).....					
24.2 Credit (group and individual).....					
24.3 Collectively renewable policies/certificates (b).....					
24.4 Medicare Title XVIII exempt from state taxes or fees.....					
Other Individual Policies:					
25.1 Non-cancelable (b).....					
25.2 Guaranteed renewable (b).....	58,544,203	75,086,483		338,322,153	314,349,936
25.3 Non-renewable for stated reasons only (b).....	22,491	23,526		40,565	(8,412)
25.4 Other accident only.....					
25.5 All other (b).....					
25.6 Totals (Sum of Lines 25.1 to 25.5).....	58,566,694	75,110,009	0	338,362,718	314,341,524
26. Totals (Lines 24 + 24.1 + 24.2 + 24.3 + 24.4 + 25.6).....	59,120,134	75,806,740	0	343,294,026	318,822,432

(b) For health business on indicated lines report: Number of persons insured under PPO managed products.....0 and number of persons insured under indemnity only products.....0.

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EXHIBIT OF NUMBER OF POLICIES, CONTRACTS, CERTIFICATES, INCOME PAYABLE
AND ACCOUNT VALUES IN FORCE FOR SUPPLEMENTARY CONTRACTS,
ANNUITIES, ACCIDENT & HEALTH AND OTHER POLICIES

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	Ordinary		Group	
	1 Involving Life Contingencies	2 Not Involving Life Contingencies	3 Involving Life Contingencies	4 Not Involving Life Contingencies
1. In force end of prior year.....	.....	.....	.....	.....
2. Issued during year.....	.....	.....	.....	.....
3. Reinsurance assumed.....	.....	.....	.....	.....
4. Increased during year (net).....	.....	.....	.....	.....
5. Total (Lines 1 to 4).....	0	0	0	0
Deductions during year:				
6. Decreased (net).....	.....	.....	.....	.....
7. Reinsurance ceded.....	.....	.....	.....	.....
8. Totals (Lines 6 and 7).....	0	0	0	0
9. In force end of year.....	0	0	0	0
10. Amount on deposit.....	(a).....	.....	.....	(a).....
11. Income now payable.....	.....	.....	.....	.....
12. Amount of income payable.....	(a).....	(a).....	(a).....	(a).....

	Ordinary		Group	
	1 Immediate	2 Deferred	3 Contracts	4 Certificates
1. In force end of prior year.....	.....	.....	.....	.....
2. Issued during year.....	.....	.....	.....	.....
3. Reinsurance assumed.....	.....	.....	.....	.....
4. Increased during year (net).....	.....	.....	.....	.....
5. Total (Lines 1 to 4).....	0	0	0	0
Deductions during year:				
6. Decreased (net).....	.....	.....	.....	.....
7. Reinsurance ceded.....	.....	.....	.....	.....
8. Totals (Lines 6 and 7).....	0	0	0	0
9. In force end of year.....	0	0	0	0
Income now payable:				
10. Amount of income payable.....	(a).....	XXX.....	XXX.....	(a).....
Deferred fully paid:				
11. Account balance.....	XXX.....	(a).....	XXX.....	(a).....
Deferred not fully paid:				
12. Account balance.....	XXX.....	(a).....	XXX.....	(a).....

	Group		Credit		Other	
	1 Certificates	2 Premiums in force	3 Policies	4 Premiums in force	5 Policies	6 Premiums in force
1. In force end of prior year.....	1,294	1,616,781	.....	.....	.....48,649	86,663,119
2. Issued during year.....	.....	.....	.....	.....	.....	.....
3. Reinsurance assumed.....	.....	.....	.....	.....	.....	.....
4. Increased during year (net).....	.....	.....XXX.....	.....	.....XXX.....	.....	.....XXX.....
5. Total (Lines 1 to 4).....	1,294	XXX.....	0	XXX.....	48,649	XXX.....
Deductions during year:						
6. Conversions.....	235	XXX.....	XXX.....	XXX.....	XXX.....	XXX.....
7. Decreased (net).....	.....	.....XXX.....	.....	.....XXX.....	5,520	XXX.....
8. Reinsurance ceded.....	.....	.....XXX.....	.....	.....XXX.....	.....	.....XXX.....
9. Totals (Lines 6 to 8).....	235	XXX.....	0	XXX.....	5,520	XXX.....
10. In force end of year.....	1,059	(a).....1,308,714	0	(a).....	43,129	(a).....74,333,137

DEPOSIT FUNDS AND DIVIDEND ACCUMULATIONS		
	1 Deposit Funds Contracts	2 Dividend Accumulations Contracts
1. In force end of prior year.....	.....	.....
2. Issued during year.....	.....	.....
3. Reinsurance assumed.....	.....	.....
4. Increased during year (net).....	.....	.....
5. Total (Lines 1 to 4).....	0	0
Deductions during year:		
6. Decreased (net).....	.....	.....
7. Reinsurance ceded.....	.....	.....
8. Totals (Lines 6 and 7).....	0	0
9. In force end of year.....	0	0
10. Amount of account balance.....	(a).....	(a).....

(a) See the Annual Audited Financial Reports section of the Annual Statement Instructions.

Annual Statement for the year 2019 of the

Senior Health Insurance Company of Pennsylvania

FORM FOR CALCULATING THE INTEREST MAINTENANCE RESERVE

Interest Maintenance Reserve

	1 Amount
1. Reserve as of December 31, prior year.....	1,564,865
2. Current year's realized pre-tax capital gains/(losses) of \$.....4,656,834 transferred into the reserve net of taxes of \$.....(977,935).....	3,678,897
3. Adjustment for current year's liability gains/(losses) released from the reserve.....	0
4. Balance before reduction for amount transferred to Summary of Operations (Line 1 + Line 2 + Line 3).....	5,243,762
5. Current year's amortization released to Summary of Operations (Amortization, Line 1, Column 4).....	497,421
6. Reserve as of December 31, current year (Line 4 minus Line 5).....	4,746,341

Amortization

Year of Amortization	1 Reserve as of December 31, Prior Year	2 Current Year's Realized Capital Gains/(Losses) Transferred into the Reserve Net of Taxes	3 Adjustment for Current Year's Liability Gains/(Losses) Released from the Reserve	4 Balance Before Reduction for the Current Year's Amortization (Cols. 1 + 2 + 3)
1. 2019.....	152,863	344,558	.....	.....497,421
2. 2020.....	102,734	644,106	.....	.....746,840
3. 2021.....	87,317	598,744	.....	.....686,061
4. 2022.....	70,864	504,117	.....	.....574,981
5. 2023.....	53,661	408,186	.....	.....461,847
6. 2024.....	48,782	309,763	.....	.....358,545
7. 2025.....	58,169	233,921	.....	.....292,090
8. 2026.....	66,394	190,939	.....	.....257,333
9. 2027.....	76,165	144,297	.....	.....220,462
10. 2028.....	85,726	95,701	.....	.....181,427
11. 2029.....	90,433	43,915	.....	.....134,348
12. 2030.....	85,715	17,795	.....	.....103,510
13. 2031.....	82,562	15,424	.....	.....97,986
14. 2032.....	77,862	13,102	.....	.....90,964
15. 2033.....	75,301	10,458	.....	.....85,759
16. 2034.....	67,396	7,987	.....	.....75,383
17. 2035.....	56,934	6,745	.....	.....63,679
18. 2036.....	45,989	6,745	.....	.....52,734
19. 2037.....	34,153	6,893	.....	.....41,046
20. 2038.....	22,854	7,029	.....	.....29,883
21. 2039.....	16,482	7,017	.....	.....23,499
22. 2040.....	16,523	7,240	.....	.....23,763
23. 2041.....	16,097	7,561	.....	.....23,658
24. 2042.....	16,326	7,722	.....	.....24,048
25. 2043.....	15,956	8,205	.....	.....24,161
26. 2044.....	14,667	8,366	.....	.....23,033
27. 2045.....	11,674	7,883	.....	.....19,557
28. 2046.....	8,381	6,274	.....	.....14,655
29. 2047.....	5,089	4,505	.....	.....9,594
30. 2048.....	1,796	2,734		4,530
31. 2049 and Later.....		965		965
32. Total (Lines 1 to 31).....	1,564,865	3,678,897	0	5,243,762

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ASSET VALUATION RESERVE

	Default Component			Equity Component			7 Total Amount (Cols. 3 + 6)
	1 Other Than Mortgage Loans	2 Mortgage Loans	3 Total (Cols. 1 + 2)	4 Common Stock	5 Real Estate and Other Invested Assets	6 Total (Cols. 4 + 5)	
1. Reserve as of December 31, prior year.....	0	58,003	58,003	0	0	0	58,004
2. Realized capital gains/(losses) net of taxes - General Account.....	(26,746,425)		(26,746,425)	167,638	(7,552,704)	(7,385,066)	(34,131,491)
3. Realized capital gains/(losses) net of taxes - Separate Accounts.....			0			0	0
4. Unrealized capital gains/(losses) - net of deferred taxes - General Account.....	301,032		301,032	84,644		84,644	385,676
5. Unrealized capital gains/(losses) - net of deferred taxes - Separate Accounts.....			0			0	0
6. Capital gains credited/(losses charged) to contract benefits, payments or reserves.....			0			0	0
7. Basic contribution.....	2,698,383	29,414	2,727,797		823	823	2,728,620
8. Accumulated balances (Lines 1 through 5, minus 6 plus 7).....	(23,747,010)	87,417	(23,659,593)	252,282	(7,551,881)	(7,299,599)	(30,959,192)
9. Maximum reserve.....	15,336,443	133,838	15,470,281	601,632	2,079,198	2,680,831	18,151,112
10. Reserve objective.....	10,013,298	102,680	10,115,978	599,784	2,076,400	2,676,185	12,792,163
11. 20% of (Line 10 minus Line 8).....	6,752,062	3,053	6,755,114	69,500	1,925,656	1,995,157	8,750,271
12. Balance before transfers (Lines 8 + 11).....	(16,994,948)	90,469	(16,904,479)	321,783	(5,626,225)	(5,304,442)	(22,208,921)
13. Transfers.....	45,235	(45,235)	(0)	(160,891)	160,891	(0)	(1)
14. Voluntary contribution.....			0			0	0
15. Adjustment down to maximum/up to zero.....	16,949,714		16,949,714		5,465,334	5,465,334	22,415,048
16. Reserve as of December 31, current year (Lines 12 + 13 + 14 + 15).....	0	45,234	45,235	160,891	0	160,892	206,126

ASSET VALUATION RESERVE

Basic Contribution, Reserve Objective and Maximum Reserve Calculations

Default Component

Line Number	NAIC Desig- nation	Description	1	2	3	4	Basic Contribution		Reserve Objective		Maximum Reserve		
			Book/Adjusted Carrying Value	Reclassify Related Party Encumbrances	Add Third Party Encumbrances	Balance for AVR Reserve Calculations (Cols. 1 + 2 + 3)	5	6	7	8	9	10	
							Factor	Amount (Cols. 4 x 5)	Factor	Amount (Cols. 4 x 7)	Factor	Amount (Cols. 4 x 9)	
LONG-TERM BONDS													
1		Exempt obligations.....	23,648,054	XXX	XXX	23,648,054	0.0000	0	0.0000	0	0.0000	0	
2	1	Highest quality.....	1,236,645,801	XXX	XXX	1,236,645,801	0.0005	618,323	0.0016	1,978,633	0.0033	4,080,931	
3	2	High quality.....	410,591,075	XXX	XXX	410,591,075	0.0021	862,241	0.0064	2,627,783	0.0106	4,352,265	
4	3	Medium quality.....	14,285,525	XXX	XXX	14,285,525	0.0099	141,427	0.0263	375,709	0.0376	537,136	
5	4	Low quality.....	19,255,293	XXX	XXX	19,255,293	0.0245	471,755	0.0572	1,101,403	0.0817	1,573,157	
6	5	Lower quality.....	6,462,482	XXX	XXX	6,462,482	0.0630	407,136	0.1128	728,968	0.1880	1,214,947	
7	6	In or near default.....	11,000,000	XXX	XXX	11,000,000	0.0000	0	0.2370	2,607,000	0.2370	2,607,000	
8		Total unrated multi-class securities acquired by conversion.....	XXX	XXX	XXX	0	XXX		XXX		XXX		
9		Total long-term bonds (sum of Lines 1 through 8).....	1,721,888,230	XXX	XXX	1,721,888,230	XXX	2,500,882	XXX	9,419,496	XXX	14,365,436	
PREFERRED STOCKS													
10	1	Highest quality.....		XXX	XXX	0	0.0005	0	0.0016	0	0.0033	0	
11	2	High quality.....	84,177,542	XXX	XXX	84,177,542	0.0021	176,773	0.0064	538,736	0.0106	892,282	
12	3	Medium quality.....	2,093,750	XXX	XXX	2,093,750	0.0099	20,728	0.0263	55,066	0.0376	78,725	
13	4	Low quality.....		XXX	XXX	0	0.0245	0	0.0572	0	0.0817	0	
14	5	Lower quality.....		XXX	XXX	0	0.0630	0	0.1128	0	0.1880	0	
15	6	In or near default.....		XXX	XXX	0	0.0000	0	0.2370	0	0.2370	0	
16		Affiliated life with AVR.....		XXX	XXX	0	0.0000	0	0.0000	0	0.0000	0	
17		Total preferred stocks (sum of Lines 10 through 16).....	86,271,292	XXX	XXX	86,271,292	XXX	197,501	XXX	593,802	XXX	971,007	
SHORT-TERM BONDS													
18		Exempt obligations.....		XXX	XXX	0	0.0000	0	0.0000	0	0.0000	0	
19	1	Highest quality.....		XXX	XXX	0	0.0005	0	0.0016	0	0.0033	0	
20	2	High quality.....		XXX	XXX	0	0.0021	0	0.0064	0	0.0106	0	
21	3	Medium quality.....		XXX	XXX	0	0.0099	0	0.0263	0	0.0376	0	
22	4	Low quality.....		XXX	XXX	0	0.0245	0	0.0572	0	0.0817	0	
23	5	Lower quality.....		XXX	XXX	0	0.0630	0	0.1128	0	0.1880	0	
24	6	In or near default.....		XXX	XXX	0	0.0000	0	0.2370	0	0.2370	0	
25		Total short-term bonds (sum of Lines 18 through 24).....	0	XXX	XXX	0	XXX	0	XXX	0	XXX	0	
DERIVATIVE INSTRUMENTS													
26		Exchange traded.....		XXX	XXX	0	0.0005	0	0.0016	0	0.0033	0	
27	1	Highest quality.....		XXX	XXX	0	0.0005	0	0.0016	0	0.0033	0	
28	2	High quality.....		XXX	XXX	0	0.0021	0	0.0064	0	0.0106	0	
29	3	Medium quality.....		XXX	XXX	0	0.0099	0	0.0263	0	0.0376	0	
30	4	Low quality.....		XXX	XXX	0	0.0245	0	0.0572	0	0.0817	0	
31	5	Lower quality.....		XXX	XXX	0	0.0630	0	0.1128	0	0.1880	0	
32	6	In or near default.....		XXX	XXX	0	0.0000	0	0.2370	0	0.2370	0	
33		Total derivative instruments.....	0	XXX	XXX	0	XXX	0	XXX	0	XXX	0	
34		Total (Lines 9 + 17 + 25 + 33).....	1,808,159,522	XXX	XXX	1,808,159,522	XXX	2,698,383	XXX	10,013,298	XXX	15,336,443	

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ASSET VALUATION RESERVE (continued)

Basic Contribution, Reserve Objective and Maximum Reserve Calculations

Default Component

Line Number	NAIC Desig- nation	Description	1	2	3	4	Basic Contribution		Reserve Objective		Maximum Reserve	
			Book/Adjusted Carrying Value	Reclassify Related Party Encumbrances	Add Third Party Encumbrances	Balance for AVR Reserve Calculations (Cols. 1 + 2 + 3)	5	6	7	8	9	10
							Factor	Amount (Cols. 4 x 5)	Factor	Amount (Cols. 4 x 7)	Factor	Amount (Cols. 4 x 9)
		MORTGAGE LOANS										
		In good standing:										
35		Farm mortgages - CM1 - highest quality.....			XXX.....	0	0.0011	0	0.0057	0	0.0074	0
36		Farm mortgages - CM2 - high quality.....			XXX.....	0	0.0040	0	0.0114	0	0.0149	0
37		Farm mortgages - CM3 - medium quality.....			XXX.....	0	0.0069	0	0.0200	0	0.0257	0
38		Farm mortgages - CM4 - low medium quality.....			XXX.....	0	0.0120	0	0.0343	0	0.0428	0
39		Farm mortgages - CM5 - low quality.....			XXX.....	0	0.0183	0	0.0486	0	0.0628	0
40		Residential mortgages-insured or guaranteed.....			XXX.....	0	0.0003	0	0.0007	0	0.0011	0
41		Residential mortgages-all other.....			XXX.....	0	0.0015	0	0.0034	0	0.0046	0
42		Commercial mortgages-insured or guaranteed.....			XXX.....	0	0.0003	0	0.0007	0	0.0011	0
43		Commercial mortgages-all other - CM1 - highest quality.....	7,349,411		XXX.....	7,349,411	0.0011	8,084	0.0057	41,892	0.0074	54,386
44		Commercial mortgages-all other - CM2 - high quality.....	5,332,340		XXX.....	5,332,340	0.0040	21,329	0.0114	60,789	0.0149	79,452
45		Commercial mortgages-all other - CM3 - medium quality.....			XXX.....	0	0.0069	0	0.0200	0	0.0257	0
46		Commercial mortgages-all other - CM4 - low medium quality.....			XXX.....	0	0.0120	0	0.0343	0	0.0428	0
47		Commercial mortgages-all other - CM5 - low quality.....			XXX.....	0	0.0183	0	0.0486	0	0.0628	0
		Overdue, not in process:										
48		Farm mortgages.....			XXX.....	0	0.0480	0	0.0868	0	0.1371	0
49		Residential mortgages-insured or guaranteed.....			XXX.....	0	0.0006	0	0.0014	0	0.0023	0
50		Residential mortgages-all other.....			XXX.....	0	0.0029	0	0.0066	0	0.0103	0
51		Commercial mortgages-insured or guaranteed.....			XXX.....	0	0.0006	0	0.0014	0	0.0023	0
52		Commercial mortgages-all other.....			XXX.....	0	0.0480	0	0.0868	0	0.1371	0
		In process of foreclosure:										
53		Farm mortgages.....			XXX.....	0	0.0000	0	0.1942	0	0.1942	0
54		Residential mortgages-insured or guaranteed.....			XXX.....	0	0.0000	0	0.0046	0	0.0046	0
55		Residential mortgages-all other.....			XXX.....	0	0.0000	0	0.0149	0	0.0149	0
56		Commercial mortgages-insured or guaranteed.....			XXX.....	0	0.0000	0	0.0046	0	0.0046	0
57		Commercial mortgages-all other.....			XXX.....	0	0.0000	0	0.1942	0	0.1942	0
58		Total Schedule B mortgages (sum of Lines 35 through 57).....	12,681,751	0	XXX.....	12,681,751	XXX.....	29,414	XXX.....	102,680	XXX.....	133,838
59		Schedule DA mortgages.....			XXX.....	0	0.0034	0	0.0114	0	0.0149	0
60		Total mortgage loans on real estate (Lines 58 + 59).....	12,681,751	0	XXX.....	12,681,751	XXX.....	29,414	XXX.....	102,680	XXX.....	133,838

ASSET VALUATION RESERVE

Basic Contribution, Reserve Objective and Maximum Reserve Calculations

Equity and Other Invested Asset Component

Line Number	NAIC Desig- nation	Description	1	2	3	4	Basic Contribution		Reserve Objective		Maximum Reserve	
			Book/Adjusted Carrying Value	Reclassify Related Party Encumbrances	Add Third Party Encumbrances	Balance for AVR Reserve Calculations (Cols. 1 + 2 + 3)	5	6	7	8	9	10
							Factor	Amount (Cols. 4 x 5)	Factor	Amount (Cols. 4 x 7)	Factor	Amount (Cols. 4 x 9)
COMMON STOCK												
1		Unaffiliated public.....	89,817	.XXX.	XXX.	89,817	0.0000	0	(a).....0.2000	17,963	(a).....0.2000	17,963
2		Unaffiliated private.....		.XXX.	XXX.	0	0.0000	0	0.1945	0	0.1945	0
3		Federal Home Loan Bank.....	513,300	.XXX.	XXX.	513,300	0.0000	0	0.0061	3,131	0.0097	4,979
4		Affiliated life with AVR.....		.XXX.	XXX.	0	0.0000	0	0.0000	0	0.0000	0
Affiliated Investment Subsidiary:												
5		Fixed income exempt obligations.....				0	XXX.		.XXX.		.XXX.	
6		Fixed income highest quality.....				0	XXX.		.XXX.		.XXX.	
7		Fixed income high quality.....				0	XXX.		.XXX.		.XXX.	
8		Fixed income medium quality.....				0	XXX.		.XXX.		.XXX.	
9		Fixed income low quality.....				0	XXX.		.XXX.		.XXX.	
10		Fixed income lower quality.....				0	XXX.		.XXX.		.XXX.	
11		Fixed income in or near default.....				0	XXX.		.XXX.		.XXX.	
12		Unaffiliated common stock public.....				0	0.0000	0	(a).....	0	(a).....	0
13		Unaffiliated common stock private.....				0	0.0000	0	0.1945	0	0.1945	0
14		Real estate.....				0	(b).....	0	(b).....	0	(b).....	0
15		Affiliated - certain other (see SVO Purposes and Procedures Manual).....		.XXX.	XXX.	0	0.0000	0	0.1580	0	0.1580	0
16		Affiliated - all other.....	2,975,269	.XXX.	XXX.	2,975,269	0.0000	0	0.1945	578,690	0.1945	578,690
17		Total common stock (sum of Lines 1 through 16).....	3,578,386	0	0	3,578,386	XXX.	0	.XXX.	599,784	.XXX.	601,632
REAL ESTATE												
18		Home office property (General Account only).....				0	0.0000	0	0.0912	0	0.0912	0
19		Investment properties.....				0	0.0000	0	0.0912	0	0.0912	0
20		Properties acquired in satisfaction of debt.....				0	0.0000	0	0.1337	0	0.1337	0
21		Total real estate (sum of Lines 18 through 20).....	0	0	0	0	XXX.	0	.XXX.	0	.XXX.	0
OTHER INVESTED ASSETS												
INVESTMENTS WITH THE UNDERLYING CHARACTERISTICS OF BONDS												
22		Exempt obligations.....		.XXX.	XXX.	0	0.0000	0	0.0000	0	0.0000	0
23	1	Highest quality.....		.XXX.	XXX.	0	0.0005	0	0.0016	0	0.0033	0
24	2	High quality.....		.XXX.	XXX.	0	0.0021	0	0.0064	0	0.0106	0
25	3	Medium quality.....		.XXX.	XXX.	0	0.0099	0	0.0263	0	0.0376	0
26	4	Low quality.....		.XXX.	XXX.	0	0.0245	0	0.0572	0	0.0817	0
27	5	Lower quality.....		.XXX.	XXX.	0	0.0630	0	0.1128	0	0.1880	0
28	6	In or near default.....		.XXX.	XXX.	0	0.0000	0	0.2370	0	0.2370	0
29		Total with bond characteristics (sum of Lines 22 through 28).....	0	.XXX.	XXX.	0	XXX.	0	.XXX.	0	.XXX.	0

ASSET VALUATION RESERVE (continued)
Basic Contribution, Reserve Objective and Maximum Reserve Calculations
Equity and Other Invested Asset Component

Line Number	NAIC Desig- nation	Description	1 Book/Adjusted Carrying Value	2 Reclassify Related Party Encumbrances	3 Add Third Party Encumbrances	4 Balance for AVR Reserve Calculations (Cols. 1 + 2 + 3)	Basic Contribution		Reserve Objective		Maximum Reserve	
							5 Factor	6 Amount (Cols. 4 x 5)	7 Factor	8 Amount (Cols. 4 x 7)	9 Factor	10 Amount (Cols. 4 x 9)
30	1	INVESTMENTS WITH THE UNDERLYING CHARACTERISTICS OF PREFERRED STOCKS Highest quality.....	1,645,981	XXX	XXX	1,645,981	0.0005	.823	0.0016	2,634	0.0033	5,432
31	2	High quality.....		XXX	XXX	0	0.0021	.0	0.0064	.0	0.0106	.0
32	3	Medium quality.....		XXX	XXX	0	0.0099	.0	0.0263	.0	0.0376	.0
33	4	Low quality.....		XXX	XXX	0	0.0245	.0	0.0572	.0	0.0817	.0
34	5	Lower quality.....		XXX	XXX	0	0.0630	.0	0.1128	.0	0.1880	.0
35	6	In or near default.....		XXX	XXX	0	0.0000	.0	0.2370	.0	0.2370	.0
36		Affiliated life with AVR.....		XXX	XXX	0	0.0000	.0	0.0000	.0	0.0000	.0
37		Total with preferred stock characteristics (sum of Lines 30 through 36).....	1,645,981	XXX	XXX	1,645,981	XXX	.823	XXX	2,634	XXX	5,432
38		INVESTMENTS WITH THE UNDERLYING CHARACTERISTICS OF MORTGAGE LOANS In Good Standing Affiliated: Mortgages - CM1 - highest quality.....			XXX	0	0.0011	.0	0.0057	.0	0.0074	.0
39		Mortgages - CM2 - high quality.....			XXX	0	0.0040	.0	0.0114	.0	0.0149	.0
40		Mortgages - CM3 - medium quality.....			XXX	0	0.0069	.0	0.0200	.0	0.0257	.0
41		Mortgages - CM4 - low medium quality.....			XXX	0	0.0120	.0	0.0343	.0	0.0428	.0
42		Mortgages - CM5 - low quality.....			XXX	0	0.0183	.0	0.0486	.0	0.0628	.0
43		Residential mortgages-insured or guaranteed.....			XXX	0	0.0003	.0	0.0007	.0	0.0011	.0
44		Residential mortgages-all other.....		XXX	XXX	0	0.0015	.0	0.0034	.0	0.0046	.0
45		Commercial mortgages-insured or guaranteed.....			XXX	0	0.0003	.0	0.0007	.0	0.0011	.0
46		Overdue, Not in Process Affiliated: Farm mortgages.....			XXX	0	0.0480	.0	0.0868	.0	0.1371	.0
47		Residential mortgages-insured or guaranteed.....			XXX	0	0.0006	.0	0.0014	.0	0.0023	.0
48		Residential mortgages-all other.....			XXX	0	0.0029	.0	0.0066	.0	0.0103	.0
49		Commercial mortgages-insured or guaranteed.....			XXX	0	0.0006	.0	0.0014	.0	0.0023	.0
50		Commercial mortgages-all other.....			XXX	0	0.0480	.0	0.0868	.0	0.1371	.0
51		In Process of foreclosure Affiliated: Farm mortgages.....			XXX	0	0.0000	.0	0.1942	.0	0.1942	.0
52		Residential mortgages-insured or guaranteed.....			XXX	0	0.0000	.0	0.0046	.0	0.0046	.0
53		Residential mortgages-all other.....			XXX	0	0.0000	.0	0.0149	.0	0.0149	.0
54		Commercial mortgages-insured or guaranteed.....			XXX	0	0.0000	.0	0.0046	.0	0.0046	.0
55		Commercial mortgages-all other.....			XXX	0	0.0000	.0	0.1942	.0	0.1942	.0
56		Total Affiliated (Sum of Lines 38 through 55).....	0	0	XXX	0	XXX	.0	XXX	.0	XXX	.0
57		Unaffiliated - In Good Standing with Covenants.....			XXX	0	(c)	.0	(c)	.0	(c)	.0
58		Unaffiliated - In Good Standing Deceased with Government Securities.....			XXX	0	0.0011	.0	0.0057	.0	0.0074	.0
59		Unaffiliated - In Good Standing Primarily Senior.....			XXX	0	0.0040	.0	0.0114	.0	0.0149	.0
60		Unaffiliated - In Good Standing All Other.....			XXX	0	0.0069	.0	0.0200	.0	0.0257	.0
61		Unaffiliated - Overdue, Not in Process.....			XXX	0	0.0480	.0	0.0868	.0	0.1371	.0
62		Unaffiliated - In Process of Foreclosure.....			XXX	0	0.0000	.0	0.1942	.0	0.1942	.0
63		Total Unaffiliated (Sum of Lines 57 through 62).....	0	0	XXX	0	XXX	.0	XXX	.0	XXX	.0
64		Total with Mortgage Loan Characteristics (Lines 56 + 63).....	0	0	XXX	0	XXX	.0	XXX	.0	XXX	.0

ASSET VALUATION RESERVE (continued)
Basic Contribution, Reserve Objective and Maximum Reserve Calculations
Equity and Other Invested Asset Component

Line Number	NAIC Designation	Description	1	2	3	4	Basic Contribution		Reserve Objective		Maximum Reserve	
			Book/Adjusted Carrying Value	Reclassify Related Party Encumbrances	Add Third Party Encumbrances	Balance for AVR Reserve Calculations (Cols. 1 + 2 + 3)	5	6	7	8	9	10
							Factor	Amount (Cols. 4 x 5)	Factor	Amount (Cols. 4 x 7)	Factor	Amount (Cols. 4 x 9)
65		INVESTMENTS WITH THE UNDERLYING CHARACTERISTICS OF COMMON STOCK										
		Unaffiliated public.....		XXX.....	XXX.....	0.....	0.0000.....	0.....	(a).....	0.....	(a).....	0.....
		Unaffiliated private.....		XXX.....	XXX.....	0.....	0.0000.....	0.....	0.1945.....	0.....	0.1945.....	0.....
		Affiliated life with AVR.....		XXX.....	XXX.....	0.....	0.0000.....	0.....	0.0000.....	0.....	0.0000.....	0.....
		Affiliated certain other (see SVO Purposes and Procedures Manual).....		XXX.....	XXX.....	0.....	0.0000.....	0.....	0.1580.....	0.....	0.1580.....	0.....
		Affiliated other - all other.....		XXX.....	XXX.....	0.....	0.0000.....	0.....	0.1945.....	0.....	0.1945.....	0.....
		Total with Common Stock Characteristics (Sum of Lines 65 through 69).....	0.....	XXX.....	XXX.....	0.....	XXX.....	0.....	XXX.....	0.....	XXX.....	0.....
71		INVESTMENTS WITH THE UNDERLYING CHARACTERISTICS OF REAL ESTATE										
		Home office property (general account only).....				0.....	0.0000.....	0.....	0.0912.....	0.....	0.0912.....	0.....
		Investment properties.....				0.....	0.0000.....	0.....	0.0912.....	0.....	0.0912.....	0.....
		Properties acquired in satisfaction of debt.....				0.....	0.0000.....	0.....	0.1337.....	0.....	0.1337.....	0.....
74		Total with Real Estate Characteristics (Sum of Lines 71 through 73).....	0.....	0.....	0.....	0.....	XXX.....	0.....	XXX.....	0.....	XXX.....	0.....
75		LOW INCOME HOUSING TAX CREDIT INVESTMENTS										
		Guaranteed federal low income housing tax credit.....				0.....	0.0003.....	0.....	0.0006.....	0.....	0.0010.....	0.....
		Non-guaranteed federal low income housing tax credit.....				0.....	0.0063.....	0.....	0.0120.....	0.....	0.0190.....	0.....
		Guaranteed state low income housing tax credit.....				0.....	0.0003.....	0.....	0.0006.....	0.....	0.0010.....	0.....
		Non-guaranteed state low income housing tax credit.....				0.....	0.0063.....	0.....	0.0120.....	0.....	0.0190.....	0.....
		All other low income housing tax credit.....				0.....	0.0273.....	0.....	0.0600.....	0.....	0.0975.....	0.....
		Total LIHTC (Sum of Lines 75 through 79).....	0.....	0.....	0.....	0.....	XXX.....	0.....	XXX.....	0.....	XXX.....	0.....
81		ALL OTHER INVESTMENTS										
		NAIC 1 working capital finance investments.....		XXX.....		0.....	0.0000.....	0.....	0.0042.....	0.....	0.0042.....	0.....
		NAIC 2 working capital finance investments.....		XXX.....		0.....	0.0000.....	0.....	0.0137.....	0.....	0.0137.....	0.....
		Other invested assets - Schedule BA.....	13,125,106.....	XXX.....		13,125,106.....	0.0000.....	0.....	0.1580.....	2,073,767.....	0.1580.....	2,073,767.....
		Other short-term invested assets - Schedule DA.....		XXX.....		0.....	0.0000.....	0.....	0.1580.....	0.....	0.1580.....	0.....
		Total All Other (sum of Lines 81, 82, 83 and 84).....	13,125,106.....	XXX.....	0.....	13,125,106.....	XXX.....	0.....	XXX.....	2,073,767.....	XXX.....	2,073,767.....
		Total Other Invested Assets - Schedule BA & DA (Sum of Lines 29, 37, 64, 70, 74, 80 and 85).....	14,771,087.....	0.....	0.....	14,771,087.....	XXX.....	823.....	XXX.....	2,076,400.....	XXX.....	2,079,198.....

(a) Times the company's weighted average portfolio beta (Minimum .1215, Maximum .2431).
(b) Determined using same factors and breakdowns used for directly owned real estate.
(c) This will be the factor associated with the risk category determined in the company generated worksheet.

SCHEDULE H - ACCIDENT AND HEALTH EXHIBIT

	Total		Group Accident and Health		Credit A&H (Group and Individual)		Collectively Renewable		Other Individual Contracts									
									Non-Cancelable		Guaranteed Renewable		Non-Renewable for Stated Reasons Only		Other Accident Only		All Other	
	1 Amount	2 %	3 Amount	4 %	5 Amount	6 %	7 Amount	8 %	9 Amount	10 %	11 Amount	12 %	13 Amount	14 %	15 Amount	16 %	17 Amount	18 %
PART 1 - ANALYSIS OF UNDERWRITING OPERATIONS																		
1. Premiums written.....	78,564,612	XXX...	1,422,165	XXX...	-	XXX...	-	XXX...	-	XXX...	77,119,635	XXX..	22,812	XXX...	-	XXX...	-	XXX...
2. Premiums earned.....	80,672,475	XXX...	1,471,834	XXX...	-	XXX...	-	XXX...	-	XXX...	79,177,115	XXX..	23,526	XXX...	-	XXX...	-	XXX...
3. Incurred claims.....	343,522,577	425.8	6,678,252	453.7	0	0.0	0	0.0	0	0.0	336,852,736	425.4	(8,411)	(35.8)	0	0.0	0	0.0
4. Cost containment expenses.....	146,777	0.2	2,542	0.2	-	0.0	-	0.0	-	0.0	144,231	0.2	4	0.0	-	0.0	-	0.0
5. Incurred claims and cost containment expenses (Lines 3 and 4).....	343,669,354	426.0	6,680,794	453.9	0	0.0	0	0.0	0	0.0	336,996,967	425.6	(8,407)	(35.7)	0	0.0	0	0.0
6. Increase in contract reserves.....	188,206,480	233.3	3,730,616	253.5	0	0.0	0	0.0	0	0.0	184,478,663	233.0	(2,800)	(11.9)	0	0.0	0	0.0
7. Commissions (a).....	5,654,040	7.0	165,888	11.3	-	0.0	-	0.0	-	0.0	5,486,929	6.9	1,223	5.2	-	0.0	-	0.0
8. Other general insurance expenses.....	29,248,903	36.3	506,549	34.4	-	0.0	-	0.0	-	0.0	28,741,522	36.3	832	3.5	-	0.0	-	0.0
9. Taxes, licenses and fees.....	3,889,990	4.8	67,369	4.6	-	0.0	-	0.0	-	0.0	3,822,510	4.8	111	0.5	-	0.0	-	0.0
10. Total other expenses incurred.....	38,792,933	48.1	739,806	50.3	0	0.0	0	0.0	0	0.0	38,050,961	48.1	2,166	9.2	0	0.0	0	0.0
11. Aggregate write-ins for deductions.....	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
12. Gain from underwriting before dividends or refunds.....	(489,996,292)	(607.4)	(9,679,382)	(657.6)	0	0.0	0	0.0	0	0.0	(480,349,476)	(606.7)	32,567	138.4	0	0.0	0	0.0
13. Dividends or refunds.....	0	0.0	-	0.0	-	0.0	-	0.0	-	0.0	-	0.0	-	0.0	-	0.0	-	0.0
14. Gain from underwriting after dividends or refunds.....	(489,996,292)	(607.4)	(9,679,382)	(657.6)	0	0.0	0	0.0	0	0.0	(480,349,476)	(606.7)	32,567	138.4	0	0.0	0	0.0
DETAILS OF WRITE-INS																		
1101.	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
1102.	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
1103.	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
1198. Summary of remaining write-ins for Line 11 from overflow page.....	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
1199. Total (Lines 1101 through 1103 plus 1198) (Line 11 above).	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0

(a) Includes \$......0 reported as 'Contract, membership and other fees retained by agents.'

SCHEDULE H - ACCIDENT AND HEALTH EXHIBIT (continued)

	1 Total	2 Group Accident and Health	3 Credit A&H (Group and Individual)	4 Collectively Renewable	Other Individual Contracts				
					5 Non-Cancelable	6 Guaranteed Renewable	7 Non-Renewable for Stated Reasons Only	8 Other Accident Only	9 All Other
PART 2 - RESERVES AND LIABILITIES									
A. Premium Reserves:									
1. Unearned premiums.....	12,001,851	218,552	-	-	-	11,778,391	4,908	-	-
2. Advance premiums.....	1,462,254	14,467	-	-	-	1,446,484	1,303	-	-
3. Reserve for rate credits.....	0	-	-	-	-	-	-	-	-
4. Total premium reserves, current year.....	13,464,105	233,019	0	0	0	13,224,875	6,211	0	0
5. Total premium reserves, prior year.....	15,765,356	284,928				15,473,085	7,343		
6. Increase in total premium reserves.....	(2,301,251)	(51,909)	0	0	0	(2,248,210)	(1,132)	0	0
B. Contract Reserves:									
1. Additional reserves (a).....	1,859,365,860	30,472,028	-	-	-	1,828,606,953	286,879		
2. Reserve for future contingent benefits.....	0	-	-	-	-	-	-		
3. Total contract reserves, current year.....	1,859,365,860	30,472,028	0	0	0	1,828,606,953	286,879	0	0
4. Total contract reserves, prior year.....	1,671,159,380	26,741,412				1,644,128,290	289,679		
5. Increase in contract reserves.....	188,206,480	3,730,616	0	0	0	184,478,663	(2,800)	0	0
C. Claim Reserves and Liabilities:									
1. Total current year.....	932,810,659	20,862,412	0	0	0	911,905,206	43,041	0	0
2. Total prior year.....	958,969,931	23,338,313				935,539,601	92,017		
3. Increase.....	(26,159,272)	(2,475,901)	0	0	0	(23,634,395)	(48,976)	0	0

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PART 3 - TEST OF PRIOR YEAR'S CLAIM RESERVES AND LIABILITIES

1. Claims Paid During the Year:									
1.1 On claims incurred prior to current year.....	327,667,476	8,048,297				319,584,725	34,454		
1.2 On claims incurred during current year.....	42,014,373	1,105,856				40,902,406	6,111		
2. Claim Reserves and Liabilities, December 31, current year:									
2.1 On claims incurred prior to current year.....	655,285,355	13,393,660				641,886,828	4,867		
2.2 On claims incurred during current year.....	277,525,304	7,468,752				270,018,378	38,174		
3. Test:									
3.1 Lines 1.1 and 2.1.....	982,952,831	21,441,957	0	0	0	961,471,553	39,321	0	0
3.2 Claim reserves and liabilities, December 31, prior year.....	958,969,931	23,338,313				935,539,601	92,017		
3.3 Line 3.1 minus Line 3.2.....	23,982,900	(1,896,356)	0	0	0	25,931,952	(52,696)	0	0

PART 4 - REINSURANCE

A. Reinsurance Assumed:									
1. Premiums written.....	4,762,558	752,793	-	-	-	4,009,765	-		
2. Premiums earned.....	4,876,022	775,103	-	-	-	4,100,919	-		
3. Incurred claims.....	24,996,645	2,197,343	-	-	-	22,799,302	-		
4. Commissions.....	482,173	79,268	-	-	-	402,905	-		
B. Reinsurance Ceded:									
1. Premiums written.....	10,295	-	-	-	-	10,295			
2. Premiums earned.....	10,288	-	-	-	-	10,288			
3. Incurred claims.....	296,501	-	-	-	-	296,501			
4. Commissions.....	244	-	-	-	-	244			

(a) Includes \$.....636,536,764 premium deficiency reserve.

	1	2	3	4
	Medical	Dental	Other	Total
A. Direct:				
1. Incurred claims.....			318,822,432	318,822,432
2. Beginning claim reserves and liabilities.....			885,942,063	885,942,063
3. Ending claim reserves and liabilities.....			861,420,525	861,420,525
4. Claims paid.....	0	0	343,343,970	343,343,970
B. Assumed Reinsurance:				
5. Incurred claims.....			24,996,645	24,996,645
6. Beginning claim reserves and liabilities.....			73,702,436	73,702,436
7. Ending claim reserves and liabilities.....			72,223,363	72,223,363
8. Claims paid.....	0	0	26,475,718	26,475,718
C. Ceded Reinsurance:				
9. Incurred claims.....			296,501	296,501
10. Beginning claim reserves and liabilities.....			687,988	687,988
11. Ending claim reserves and liabilities.....			855,232	855,232
12. Claims paid.....	0	0	129,257	129,257
D. Net:				
13. Incurred claims.....	0	0	343,522,576	343,522,576
14. Beginning claim reserves and liabilities.....	0	0	958,956,510	958,956,510
15. Ending claim reserves and liabilities.....	0	0	932,788,656	932,788,656
16. Claims paid.....	0	0	369,690,430	369,690,430
E. Net Incurred Claims and Cost Containment Expenses:				
17. Incurred claims and cost containment expenses.....			343,669,353	343,669,353
18. Beginning reserves and liabilities.....			959,031,665	959,031,665
19. Ending reserves and liabilities.....			932,918,182	932,918,182
20. Paid claims and cost containment expenses.....	0	0	369,782,836	369,782,836

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Annual Statement for the year 2019 of the

Senior Health Insurance Company of Pennsylvania

SCHEDULE T - PREMIUMS AND ANNUITY CONSIDERATIONS (b)

Allocated by States and Territories

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States, Etc.		1	Life Contracts		Direct Business Only		7		
			2	3	4	5		6	
									Life Insurance Premiums
		Active Status (a)							Deposit-Type Contracts
1.	Alabama.....AL	L			106,514		106,514		
2.	Alaska.....AK	L			33,188		33,188		
3.	Arizona.....AZ	L			1,421,606		1,421,606		
4.	Arkansas.....AR	L			294,050		294,050		
5.	California.....CA	L			5,183,274		5,183,274		
6.	Colorado.....CO	L			650,164		650,164		
7.	Connecticut.....CT	N			104,227		104,227		
8.	Delaware.....DE	L			158,088		158,088		
9.	District of Columbia.....DC	L			37,270		37,270		
10.	Florida.....FL	L			5,102,403		5,102,403		
11.	Georgia.....GA	L			972,991		972,991		
12.	Hawaii.....HI	L			144,435		144,435		
13.	Idaho.....ID	L			119,857		119,857		
14.	Illinois.....IL	L			3,374,402		3,374,402		
15.	Indiana.....IN	L			1,634,548		1,634,548		
16.	Iowa.....IA	L			1,397,413		1,397,413		
17.	Kansas.....KS	L			1,018,522		1,018,522		
18.	Kentucky.....KY	L			839,943		839,943		
19.	Louisiana.....LA	L			413,911		413,911		
20.	Maine.....ME	L			465,326		465,326		
21.	Maryland.....MD	L			1,807,150		1,807,150		
22.	Massachusetts.....MA	L			510,020		510,020		
23.	Michigan.....MI	L			1,467,232		1,467,232		
24.	Minnesota.....MN	L			853,598		853,598		
25.	Mississippi.....MS	L			338,643		338,643		
26.	Missouri.....MO	L			1,530,613		1,530,613		
27.	Montana.....MT	L			263,422		263,422		
28.	Nebraska.....NE	L			653,491		653,491		
29.	Nevada.....NV	L			148,496		148,496		
30.	New Hampshire.....NH	L			112,549		112,549		
31.	New Jersey.....NJ	L			1,210,622		1,210,622		
32.	New Mexico.....NM	L			262,823		262,823		
33.	New York.....NY	N			340,722		340,722		
34.	North Carolina.....NC	L			2,114,765		2,114,765		
35.	North Dakota.....ND	L			679,940		679,940		
36.	Ohio.....OH	L			2,692,556		2,692,556		
37.	Oklahoma.....OK	L			1,049,596		1,049,596		
38.	Oregon.....OR	L			270,698		270,698		
39.	Pennsylvania.....PA	L			7,288,325		7,288,325		
40.	Rhode Island.....RI	N			32,940		32,940		
41.	South Carolina.....SC	L			744,826		744,826		
42.	South Dakota.....SD	L			471,979		471,979		
43.	Tennessee.....TN	L			936,968		936,968		
44.	Texas.....TX	L			5,707,739		5,707,739		
45.	Utah.....UT	L			372,626		372,626		
46.	Vermont.....VT	N			34,790		34,790		
47.	Virginia.....VA	L			1,326,097		1,326,097		
48.	Washington.....WA	L			1,386,979		1,386,979		
49.	West Virginia.....WV	L			116,884		116,884		
50.	Wisconsin.....WI	L			827,992		827,992		
51.	Wyoming.....WY	L			72,529		72,529		
52.	American Samoa.....AS	N					0		
53.	Guam.....GU	N					0		
54.	Puerto Rico.....PR	N					0		
55.	US Virgin Islands.....VI	L					0		
56.	Northern Mariana Islands.....MP	N					0		
57.	Canada.....CAN	N			6,481		6,481		
58.	Aggregate Other Alien.....OT	XXX	0	0	13,907	0	13,907	0	
59.	Subtotal.....	XXX	0	0	59,120,134	0	59,120,134	0	
90.	Reporting entity contributions for employee benefit plans.....	XXX					0		
91.	Dividends or refunds applied to purchase paid-up additions and annuities.....	XXX					0		
92.	Dividends or refunds applied to shorten endowment or premium paying period.....	XXX					0		
93.	Premium or annuity considerations waived under disability or other contract provisions.....	XXX			14,626,335		14,626,335		
94.	Aggregate other amounts not allocable by State.....	XXX	0	0	0	0	0	0	
95.	Totals (Direct Business).....	XXX	0	0	73,746,469	0	73,746,469	0	
96.	Plus reinsurance assumed.....	XXX			4,795,804		4,795,804		
97.	Totals (All Business).....	XXX	0	0	78,542,273	0	78,542,273	0	
98.	Less reinsurance ceded.....	XXX			10,295		10,295		
99.	Totals (All Business) less reinsurance ceded.....	XXX	0	0	(c) 78,531,977	0	78,531,977	0	
DETAILS OF WRITE-INS									
58001.	Aggregate Other Alien.....	XXX			13,907		13,907		
58002.		XXX					0		
58003.		XXX					0		
58998.	Summ. of remaining write-ins for line 58 from overflow page.....	XXX	0	0	0	0	0	0	
58999.	Total (Lines 58001 thru 58003 plus 58998) (Line 58 above).....	XXX	0	0	13,907	0	13,907	0	
9401.		XXX					0		
9402.		XXX					0		
9403.		XXX					0		
9498.	Summ. of remaining write-ins for line 94 from overflow page.....	XXX	0	0	0	0	0	0	
9499.	Total (Lines 9401 thru 9403 plus 9498) (Line 94 above).....	XXX	0	0	0	0	0	0	
(a) Active Status Counts:									
L - Licensed or Chartered - Licensed insurance carrier or domiciled RRG.....			48	R - Registered - Non-domiciled RRGs.....			0		
E - Eligible - Reporting entities eligible or approved to write surplus lines in the state			0	Q - Qualified - Qualified or accredited reinsurer.....			0		
				N - None of the above - Not allowed to write business in the state.....			9		

SCHEDULE T - PART 2

INTERSTATE COMPACT - EXHIBIT OF PREMIUMS WRITTEN

Allocated by States and Territories

States, Etc.		Direct Business Only				
		1 Life (Group and Individual)	2 Annuities (Group and Individual)	3 Disability Income (Group and Individual)	4 Long-Term Care (Group and Individual)	5 Deposit-Type Contracts
		6 Totals				
1.	Alabama.....AL					
2.	Alaska.....AK					
3.	Arizona.....AZ					
4.	Arkansas.....AR					
5.	California.....CA					
6.	Colorado.....CO					
7.	Connecticut.....CT					
8.	Delaware.....DE					
9.	District of Columbia.....DC					
10.	Florida.....FL					
11.	Georgia.....GA					
12.	Hawaii.....HI					
13.	Idaho.....ID					
14.	Illinois.....IL					
15.	Indiana.....IN					
16.	Iowa.....IA					
17.	Kansas.....KS					
18.	Kentucky.....KY					
19.	Louisiana.....LA					
20.	Maine.....ME					
21.	Maryland.....MD					
22.	Massachusetts.....MA					
23.	Michigan.....MI					
24.	Minnesota.....MN					
25.	Mississippi.....MS					
26.	Missouri.....MO					
27.	Montana.....MT					
28.	Nebraska.....NE					
29.	Nevada.....NV					
30.	New Hampshire.....NH					
31.	New Jersey.....NJ					
32.	New Mexico.....NM					
33.	New York.....NY					
34.	North Carolina.....NC					
35.	North Dakota.....ND					
36.	Ohio.....OH					
37.	Oklahoma.....OK					
38.	Oregon.....OR					
39.	Pennsylvania.....PA					
40.	Rhode Island.....RI					
41.	South Carolina.....SC					
42.	South Dakota.....SD					
43.	Tennessee.....TN					
44.	Texas.....TX					
45.	Utah.....UT					
46.	Vermont.....VT					
47.	Virginia.....VA					
48.	Washington.....WA					
49.	West Virginia.....WV					
50.	Wisconsin.....WI					
51.	Wyoming.....WY					
52.	American Samoa.....AS					
53.	Guam.....GU					
54.	Puerto Rico.....PR					
55.	US Virgin Islands.....VI					
56.	Northern Mariana Islands.....MP					
57.	Canada.....CAN					
58.	Aggregate Other Alien.....OT					
59.	Totals.....	0	0	0	0	0

NONE

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SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 – ORGANIZATIONAL CHART



SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	Is an SCA Filing Required? (Y/N)	
Members															
.....			75-3269792..	.....	.....	.....	SENIOR HEALTH CARE OVERSIGHT TRUST	PA.....	UDP.....	.....	.....	.....	.....	.....N.....	.....
.....		76325...	23-0704970..	.....	.....	.....	SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA	PA.....	RE.....	SENIOR HEALTH CARE OVERSIGHT TRUST	OWNERSHIP....	100.000	SENIOR HEALTH CARE OVERSIGHT TRUST	N.....	.....
.....			45-4844825..				FUZION ANALYTICS, INC.....	DE.....	NIA.....	SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA	OWNERSHIP....	100.000	SENIOR HEALTH CARE OVERSIGHT TRUST	N.....	

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SCHEDULE Y

PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1	2	3	4	5	6	7	8	9	10	11	12	13
NAIC Company Code	ID Number	Names of Insurers and Parent, Subsidiaries or Affiliates	Shareholder Dividends	Capital Contributions	Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	Management Agreements and Service Contracts	Income/ (Disbursements) Incurred under Reinsurance Agreements	*	Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	Totals	Reinsurance Recoverable (Payable) on Losses and/or Reserve Credit Taken/ (Liability)
Affiliated Transactions												
.....	45-4844825.....	FUZION ANALYTICS, INC.....	.....	.....	.....	.....	.....12,778,644	.....	.....	.....	.....12,778,644	.....
76325.....	23-0704970.....	SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA.....	.....	.....	.....	.....	.....(12,778,644)	.....	.....	.....	.....(12,778,644)	.....
9999999.	Control Totals.....	.....	.....0	0	0	0	0	0	XXX	0	0	0

Senior Health Insurance Company in Rehabilitation**Balance Sheet**

(\$ in thousands)

	YTD 06/30/2020	Year Ended 12/31/2019
Assets		
Bonds	\$ 1,604,419	\$ 1,721,888
Preferred stock	79,903	86,271
Common stock	4,153	3,578
Mortgage loans	12,212	12,682
Cash and short term investments	30,918	46,682
Other invested assets	12,612	15,701
Receivable for securities	-	136
Total invested assets	<u>1,744,217</u>	<u>1,886,938</u>
Investment income due and accrued	11,720	12,082
Uncollected premiums	997	928
Federal income tax recoverable	2,364	2,364
Guaranty funds receivable	1,218	1,209
Reimbursement from insurance carrier	1,006	3,588
Other	184	72
Total Assets	<u><u>\$ 1,761,706</u></u>	<u><u>\$ 1,907,181</u></u>
Liabilities and Capital and Surplus		
Liabilities		
Active life reserves	\$ 1,177,017	\$ 1,234,831
Premium deficiency reserves	761,096	636,537
Claim reserves	896,046	932,811
Premiums paid in advance	1,365	1,462
Interest maintenance reserve	5,525	4,746
Accounts payable and other liabilities	<u>8,386</u>	<u>12,892</u>
Total Liabilities	<u>\$ 2,849,435</u>	<u>\$ 2,823,279</u>
Capital and Surplus		
Common stock	\$ 2,500	\$ 2,500
Preferred capital stock	5,000	5,000
Surplus notes	50,000	50,000
Unassigned surplus	<u>(1,145,229)</u>	<u>(973,598)</u>
Total Capital and Surplus	<u>\$ (1,087,729)</u>	<u>\$ (916,098)</u>
Total Liabilities and Capital and Surplus	<u><u>\$ 1,761,706</u></u>	<u><u>\$ 1,907,181</u></u>

Senior Health Insurance Company in Rehabilitation**Income Statement***(\$ in thousands)*

	YTD 06/30/2020	Year Ended 12/31/2019
Premiums	\$ 35,628	\$ 80,672
Investment Income	36,164	77,412
Investment Expense	<u>(525)</u>	<u>(10,695)</u>
Total Income	71,267	147,389
Benefits Paid	178,970	369,626
Change in Claim Reserves	(36,765)	(26,160)
Change in ALR	(57,366)	(74,651)
Change in PDR Reserves	<u>124,559</u>	<u>262,914</u>
Total Benefits	<u>209,398</u>	<u>531,729</u>
Commissions	2,568	5,654
General Insurance Expenses	16,464	29,396
Insurance Taxes, Licenses and Fees	<u>381</u>	<u>3,888</u>
Total Benefits and Expenses	228,811	570,667
Federal Income Taxes	<u>-</u>	<u>207</u>
Net Loss before Realized Losses	(157,544)	(423,485)
Realized Losses	<u>(13,110)</u>	<u>(38,549)</u>
Net Loss	<u>\$ (170,654)</u>	<u>\$ (462,034)</u>
Cash from Operations	<u>\$ (121,810)</u>	<u>\$ (251,711)</u>

Senior Health Insurance Company in Rehabilitation**Income Statement***(\$ in thousands)*

	Quarter Ended 09/30/2020	Year Ended 12/31/2019
Premiums	\$ 52,217	\$ 80,672
Investment Income	51,509	77,412
Investment Expense	<u>(794)</u>	<u>(10,695)</u>
Total Income	102,932	147,389
Benefits Paid	261,760	369,626
Change in Claim Reserves	(47,675)	(26,160)
Change in ALR	(91,744)	(74,651)
Change in PDR Reserves	<u>96,122</u>	<u>262,914</u>
Total Benefits	<u>218,463</u>	<u>531,729</u>
Commissions	3,651	5,654
General Insurance Expenses	24,153	29,396
Insurance Taxes, Licenses and Fees	<u>722</u>	<u>3,890</u>
Total Benefits and Expenses	246,989	570,669
Federal Income Taxes	<u>(217)</u>	<u>205</u>
Net Loss before Realized Losses	(143,840)	(423,485)
Realized Losses	<u>(6,281)</u>	<u>(38,549)</u>
Net Loss	<u>\$ (150,121)</u>	<u>\$ (462,034)</u>
Cash from Operations	<u>\$ (169,210)</u>	<u>\$ (251,711)</u>

Senior Health Insurance Company in Rehabilitation**Balance Sheet**

(\$ in thousands)

	Quarter Ended 09/30/2020	Year Ended 12/31/2019
Assets		
Bonds	\$ 1,548,916	\$ 1,721,888
Preferred stock	79,903	86,271
Common stock	4,264	3,578
Mortgage loans	11,967	12,682
Cash and short term investments	47,736	46,682
Other invested assets	9,263	15,701
Receivable for securities	-	136
Total invested assets	1,702,049	1,886,938
Investment income due and accrued	10,852	12,082
Uncollected premiums	879	928
Federal income tax recoverable	2,581	2,364
Guaranty funds receivable	1,220	1,209
Reimbursement from insurance carrier	1,497	3,588
Other	127	72
Total Assets	<u>\$ 1,719,205</u>	<u>\$ 1,907,181</u>
Liabilities and Capital and Surplus		
Liabilities		
Active life reserves	\$ 1,141,574	\$ 1,234,831
Premium deficiency reserves	732,659	636,537
Claim reserves	885,098	932,811
Premiums paid in advance	1,214	1,462
Interest maintenance reserve	5,849	4,746
Accounts payable and other liabilities	23,188	12,892
Total Liabilities	<u>\$ 2,789,582</u>	<u>\$ 2,823,279</u>
Capital and Surplus		
Common stock	\$ 2,500	\$ 2,500
Preferred capital stock	5,000	5,000
Surplus notes	50,000	50,000
Unassigned surplus	(1,127,877)	(973,598)
Total Capital and Surplus	<u>\$ (1,070,377)</u>	<u>\$ (916,098)</u>
Total Liabilities and Capital and Surplus	<u>\$ 1,719,205</u>	<u>\$ 1,907,181</u>

Senior Health Insurance Company in Rehabilitation Investment Summary

Core Portfolio

	<u>9/30/2020</u>	<u>12/31/2019</u>	<u>Incr(Decr)</u>
Bonds and Short Term Investments	\$ 1,585,652,266	\$ 1,757,570,714	\$ (171,918,448)
Sutton Capital Trust	72,143,500	72,143,500	-
Preferred and Common Stock Unaffiliated	7,759,540	14,641,092	(6,881,552)
Common Stock - Fuzion Analytics	4,263,838	2,975,269	1,288,569
Mortgage Loans	11,966,574	12,681,751	(715,177)
Other Invested Assets	1,612,467	1,645,981	(33,514)
	<u>\$ 1,683,398,184</u>	<u>\$ 1,861,658,307</u>	<u>\$ (178,260,123)</u>

Non-Core Portfolio

	<u>9/30/2020</u>	<u>12/31/2019</u>	<u>Incr(Decr)</u>
AB Private Credit	\$ 16,373,979	\$ 19,435,088	\$ (3,061,109)
Phonex	-	89,817	(89,817)
Sun Trust COOF	262,862	271,266	(8,404)
Equipment Finance V	11,000,000	11,000,000	-
PPCO	-	3,335,380	(3,335,380)
Kingdom	930,000	930,000	-
Rent Path	-	-	-
PPCA	-	-	-
	<u>\$ 28,566,841</u>	<u>\$ 35,061,551</u>	<u>\$ (6,494,710)</u>

Senior Health Insurance Company in Rehabilitation**Income Statement***(\$ in thousands)*

	Year Ended 12/31/2020	Year Ended 12/31/2019
Premiums	\$ 66,982	\$ 80,672
Investment Income	70,421	77,412
Investment Expense	(1,053)	(10,695)
Gain/Loss Transferred to IMR	(16,210)	(3,679)
Transamerica Service Fees	144	-
Total Income	120,284	143,710
Benefits Paid	333,201	369,626
Change in Claim Reserves	(143,406)	(26,160)
Change in ALR	(128,983)	(74,651)
Change in PDR Reserves	170,775	262,914
Loss from Transamerica Recapture	168,507	-
Total Benefits	400,094	531,729
Commissions	4,622	5,654
General Insurance Expenses	31,306	29,396
Insurance Taxes, Licenses and Fees	1,132	3,890
Total Benefits and Expenses	437,154	570,669
Federal and State Income Taxes	(505)	205
Net Loss before Realized Gains/ Losses	(316,365)	(427,164)
Realized Gains/Losses	10,518	(34,870)
Net Loss	<u>\$ (305,847)</u>	<u>\$ (462,034)</u>
Cash from Operations	<u>\$ (208,461)</u>	<u>\$ (251,711)</u>

Senior Health Insurance Company in Rehabilitation**Balance Sheet**

(\$ in thousands)

	Year Ended 12/31/2020	Year Ended 12/31/2019
Assets		
Bonds	\$ 1,201,083	\$ 1,721,888
Preferred stock	77,608	86,271
Common stock	4,735	3,578
Mortgage loans	11,717	12,682
Cash and short term investments	46,100	46,682
Other invested assets	9,862	15,701
Receivable for securities	-	136
Total invested assets	1,351,105	1,886,938
Investment income due and accrued	9,362	12,082
Uncollected premiums	961	928
Federal income tax recoverable	1,380	2,364
Guaranty funds receivable	1,135	1,209
Reimbursement from insurance carrier	421	3,588
Transamerica receivable	5,408	-
Other	136	72
Total Assets	<u>\$ 1,369,908</u>	<u>\$ 1,907,181</u>
Liabilities and Capital and Surplus		
Liabilities		
Active life reserves	\$ 1,047,771	\$ 1,234,831
Premium deficiency reserves	762,600	636,537
Claim reserves	732,814	932,811
Premiums paid in advance	972	1,462
Interest maintenance reserve	18,457	4,746
Transamerica liability	21,073	-
Accounts payable and other liabilities	8,728	12,892
Total Liabilities	<u>\$ 2,592,415</u>	<u>\$ 2,823,279</u>
Capital and Surplus		
Common stock	\$ 2,500	\$ 2,500
Preferred capital stock	5,000	5,000
Surplus notes	50,000	50,000
Unassigned surplus	(1,280,007)	(973,598)
Total Capital and Surplus	<u>\$ (1,222,507)</u>	<u>\$ (916,098)</u>
Total Liabilities and Capital and Surplus	<u>\$ 1,369,908</u>	<u>\$ 1,907,181</u>

EXHIBIT C

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

IN RE: Senior Health Insurance :
 Company of Pennsylvania :
 In Rehabilitation : No. 1 SHP 2020

ORDER OF REHABILITATION

AND NOW, this 29th day of January, 2020, upon consideration of the Application for Order Placing Senior Health Insurance Company of Pennsylvania in Rehabilitation (Petition for Rehabilitation) filed by Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, it is hereby ORDERED as follows:

1. The Petition for Rehabilitation is GRANTED, and effective January 29, 2020, Senior Health Insurance Company of Pennsylvania (SHIP) is placed into rehabilitation in accordance with the provisions of Article V of The Insurance Department Act of 1921, Act of May 17, 1921, P.L. 789, *as amended*, 40 P.S. §§221.1-221.63, on the ground that rehabilitation has been requested by and consented to by SHIP's board of directors and the trustees of the Senior Health Care Oversight Trust.

2. Insurance Commissioner Jessica K. Altman and her successors in office are hereby appointed Rehabilitator of SHIP and invested with the full powers and authority of a rehabilitator as set forth in Section 516 of The Insurance Department Act of 1921, 40 P.S. §221.16.

3. The Rehabilitator is hereby directed to rehabilitate the business of SHIP; to take possession of the assets of SHIP; and to administer the SHIP assets in accordance with the orders of this Court. Specifically, the Rehabilitator is directed to:

- (a) Inform all banks, investment banks, and other financial institutions or persons with custody of SHIP assets to identify and report these assets to the Rehabilitator and advise these institutions not to disburse, transfer, hypothecate or encumber such assets without the prior written consent of the Rehabilitator.
- (b) Inform all banks and other financial institutions with SHIP accounts that checks or other payments that have been processed and transmitted may be honored without prejudice to the ability of the Rehabilitator to recover said amounts from the recipient or payee in accordance with applicable law.
- (c) Inform all insurance producers, agents, managing general agents, brokers or other persons who have collected premiums on behalf of SHIP to account for all earned and unearned premiums and commissions to the Rehabilitator at the offices of SHIP within thirty (30) days of the date of this Order and that premium monies owed to SHIP must be remitted to the Rehabilitator.
- (d) Inform all attorneys employed or retained by SHIP that within thirty (30) days of this Order they must report to the Rehabilitator the name of the case or claim they are handling; the claim or docket number, if one is assigned; the status of each such case; and, further, that the Rehabilitator will not make payment for any unsolicited reports.

- (e) Inform all vendors providing claims or data processing services to SHIP that they shall continue such services unless and until instructed to the contrary by the Rehabilitator.
- (f) Inform all vendors with custody or control of any data processing information and electronic records belonging to SHIP to preserve these electronic files and information and to transfer the data to the control of the Rehabilitator upon request.

4. The filing or recording of this Order with the Prothonotary of the Commonwealth Court shall impart the same notice as is imparted by any deed, bill of sale or other evidence of title duly filed or recorded.

5. The Rehabilitator shall take such actions as are necessary to correct the condition that prompted SHIP's board of directors and the Senior Health Care Oversight Trust to request and consent to the rehabilitation of SHIP.

6. The Rehabilitator shall authorize, where appropriate and necessary, the payment of expenses, including employee compensation, incurred in the ordinary course of SHIP's business, as well as the actual, reasonable, and necessary costs of preserving or recovering the assets of SHIP.

7. The Rehabilitator shall prepare a plan of rehabilitation, which may include a consolidation, merger or other transformation of SHIP and to that end may retain accountants, actuaries, attorneys and other consultants at the expense of SHIP.

8. In the event this Court should determine that a rehabilitation of SHIP is not feasible and a liquidation of SHIP is ordered, the actual, reasonable and necessary costs of goods or services provided to and approved by the Rehabilitator during the period of rehabilitation will be treated as costs and

expenses of administration for purposes of Section 544 of The Insurance Department Act of 1921, 40 P.S. §221.44.

9. The Rehabilitator may, in her discretion, pay claims, in whole or in part, arising under SHIP's contracts of insurance; provided, however, that the Rehabilitator may not pay bad faith claims or claims for extra-contractual charges or damages.

10. The Rehabilitator may, in her discretion, write new and renewal policies or may cancel or refuse to renew existing policies, as she deems appropriate.

11. In accordance with Section 515 of The Insurance Department Act of 1921, 40 P.S. §221.15(c), the Rehabilitator is authorized to take possession of the statutory deposits held by any state or territory and to do all things necessary to manage and apply the deposits in accordance with the application agreements; provided, however, the Rehabilitator shall not post additional statutory security deposits in any state or territory on behalf of SHIP.

12. All court actions, arbitrations and mediations currently or hereafter pending against SHIP in the Commonwealth of Pennsylvania are stayed for ninety (90) days from the effective date of this Order and such additional time as the Rehabilitator may request, to allow the Rehabilitator an opportunity to review litigation and where appropriate retain new counsel.

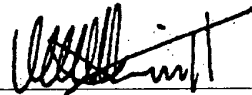
13. The Rehabilitator is directed to review all litigation pending outside the courts of the Commonwealth of Pennsylvania and petition these other courts or tribunals for a ninety (90) day stay of litigation where necessary to protect the estate of SHIP.

14. The Rehabilitator may appoint a Special Deputy Rehabilitator to be compensated from SHIP's assets, and such Special Deputy Rehabilitator shall have all the same rights and authority under this Order and applicable law as the Rehabilitator, subject to oversight and supervision by the Rehabilitator and this Court.

15. This Order is not, and shall not be considered, a finding or declaration of insolvency that can activate the provisions of the Pennsylvania Life and Health Insurance Guaranty Act, *as added by* the Act of Dec. 18, 1992, P.L. 1519, 40 P.S. §§991.1701-991.1718, or the provisions of similar acts of any other state or territory.

16. On or before April 22, 2020, the Rehabilitator shall file a preliminary plan of rehabilitation with the Court, which shall include a timeline for the preparation of a final plan of rehabilitation.

17. This Court shall retain jurisdiction of this proceeding to the full extent necessary to enforce the terms of this Order and to issue such other orders that may be required in the course of the rehabilitation.



MARY HANNAH LEAVITT, Judge

Certified from the Record

JAN 29 2020

And Order Exit

EXHIBIT D

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

In Re: Senior Health Insurance :
 Company of Pennsylvania in :
 Rehabilitation : No. 1 SHP 2020

**CASE MANAGEMENT ORDER FOR COMMENTS AND
 HEARING ON THE PROPOSED PLAN OF REHABILITATION**

AND NOW, this 12th day of June, 2020, upon consideration of the Application of Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as Statutory Rehabilitator of Senior Health Insurance Company of Pennsylvania (In Rehabilitation) (SHIP), for approval of Form and Distribution of Notice of Application for Approval of Plan of Rehabilitation for SHIP (Application), and any objections filed thereto, it is hereby **ORDERED** as follows:

1. The Court directs the Statutory Rehabilitator to use the Notice attached to this Order as Exhibit A to advise the Interested Parties (as defined below) of the filing in this Court by the Rehabilitator of the Application for Approval of the Plan of Rehabilitation for SHIP (Plan Application) and the procedures for offering comments on the proposed Plan of Rehabilitation and participating in the hearing thereon, which will be scheduled by the Court by separate order.

2. As soon as reasonably practical, the Rehabilitator shall send by U.S. mail a copy of the attached Notice to all Interested Parties, defined as: all persons identified on the Master Service List; all known policyholders and certificate holders having policies or other coverage in force with SHIP on the date of the mailing; all known SHIP insurance agents and all known creditors of SHIP (in each

case, addressed to their last known address as shown on the electronic books and records of SHIP); the insurance regulatory authorities in each jurisdiction in which SHIP issued policies that remain in effect; the state life and health insurance guaranty associations; the taxing authorities of the various states where SHIP has policies or other coverage in force at the time of mailing the notice; the National Association of Insurance Commissioners; the National Organization of Life and Health Insurance Guaranty Associations; and the Senior Health Care Oversight Trust and its Trustees.

3. Notice is not required to be mailed to persons who have changed their addresses without notifying SHIP and for whom the Rehabilitator, after good effort, has been unable to establish a current address.

4. The Rehabilitator shall continue to maintain the website addressed at <https://www.shipltc.com/court-documents> (Site) and post thereon the Application for Approval of the Plan of Rehabilitation for SHIP, a copy of this Order and such other documents that are from time to time required by Pa. R.A.P. 3779 or provide a link thereon to such documents. Absent further order by this Court, updates to the Site shall serve as official notice of filings, orders, deadlines and hearings.

5. As soon as reasonably practical, the Rehabilitator shall cause a copy of the attached Notice, in substantially the same form, to be published in The Wall Street Journal, USA Today, The Indianapolis Star, The Philadelphia Inquirer, and The Harrisburg Patriot-News, twice a week in each publication for two weeks.

6. The Rehabilitator shall maintain a “hard copy” service list for those Interested Parties requesting hard copies of relevant documentation. Interested Parties who affirm that they either do not have regular access to a computer or are unable to view, download or print the applicable documents may be placed on the “hard copy” list and receive copies of all Court orders and filings by the Rehabilitator

in this matter by making a request for placement on the “hard copy” service list. Requests for placement on the “hard copy” service list shall be made by sending a written request by mail to Senior Health Insurance Company of Pennsylvania (In Rehabilitation), Attention: Rehabilitation Administrator, 550 Congressional Boulevard, Suite 200, Carmel, IN 46032; or by facsimile to the attention of Senior Health Insurance Company of Pennsylvania (In Rehabilitation), Attention: Rehabilitation Administrator, at the following number: (317) 566-7588; or by email to rehabilitation@shipltc.com. The request should be signed and contain the following statement:

In making this request, I hereby affirm to the Commonwealth Court of Pennsylvania that I do not have regular access to a computer or other device providing me internet access to the Site or I am otherwise unable to view, download or print documents from the Site related to this matter.

7. Informal Comments in support of or in objection to the proposed Plan of Rehabilitation may be sent to Patrick H. Cantilo, Special Deputy Rehabilitator at the following address: Senior Health Insurance Company of Pennsylvania (In Rehabilitation), 550 Congressional Blvd., Suite 200, Carmel, IN 46032; or by email to: plan.comments@shipltc.com.

8. Formal Comments in support of or in objection to the proposed Plan of Rehabilitation shall be filed with the Court on or before September 15, 2020. Formal Comments shall be identified at the top of the document as being filed in “In re: Senior Health Insurance Company of Pennsylvania (In Rehabilitation), No. 1 SHP 2020.” Formal Comments shall state with specificity the Commenter’s identity and interest in the proceeding, the facts on which the comments are based, and any suggested modifications to the proposed Plan of Rehabilitation. A person may

submit Formal Comments without participating in the hearing on the proposed Plan of Rehabilitation. A Commenter who intends to participate in the hearing must notify the Court of that intention in his Formal Comments.

9. Any Commenter who intends to call or examine witnesses or introduce exhibits at the hearing on the proposed Plan of Rehabilitation or participate in any discovery that this Court may permit must file an application with the Court to intervene in the proceeding under the Pennsylvania Rules of Appellate Procedure on or before July 31, 2020, and must also file their Formal Comments in accordance with this Order. Any response to an application to intervene shall be filed and served on or before August 21, 2020. Any Commenter who is permitted to intervene shall file with the Court and serve on the Rehabilitator on or before September 30, 2020, (i) a narrative or other description consisting substantially of the direct testimony of each witness the Commenter intends to call at the hearing and (ii) the exhibits the Commenter intends to introduce at the hearing.

10. Formal Comments to the proposed Plan of Rehabilitation shall be filed with the Court at the following address:

Office of Prothonotary of the Commonwealth Court of Pennsylvania
ATTN: 1 SHP 2020
Pennsylvania Judicial Center
601 Commonwealth Avenue, Suite 2100
Harrisburg, PA 17106.

11. Service by Commenters on the Rehabilitator shall be made by electronic delivery to the Rehabilitator's counsel and the Special Deputy Rehabilitator at the following addresses:

Counsel

Cozen O'Connor
shipcomments@cozen.com

SDR

Patrick Cantilo
service@cb-firm.com

12. A Commenter who is unable to make service on the Rehabilitator by electronic delivery may serve the Rehabilitator by first-class mail or overnight delivery service to the Rehabilitator's counsel and the Special Deputy Rehabilitator at the following physical addresses:

James R. Potts	Patrick Cantilo
Cozen O'Connor	Cantilo & Bennett, L.L.P.
One Liberty Place	11401 Century Oaks Terrace
1650 Market Street, Suite 2800	Suite 300
Philadelphia, PA 19103	Austin, Texas 78758

Any materials served by this method must contain an affirmation to the Court that the Commenter is unable to serve the Rehabilitator by electronic delivery.

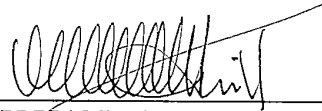
13. A Commenter who has complied with the procedures set forth in this Order and been granted intervenor status by this Court shall have the right to participate in the hearing, including the examination of witnesses proffered in support of or opposition to the proposed Plan of Rehabilitation. Evidence presented by the Commenter may be subject to cross-examination by the Rehabilitator and any other party to the proceeding. The Court may limit such participation to ensure an orderly proceeding.

14. The Rehabilitator shall not be required to respond to Formal or Informal Comments or other filings by Commenters pursuant to this Order and any failure to respond shall not constitute an admission or waiver by the Rehabilitator.

15. All other dates and requirements established by the Court relevant to the proceedings concerning the proposed Plan of Rehabilitation,

including any changes to the dates and procedures set forth in this Order, will be posted to the Site and will not be delivered by mail or other means except as otherwise provided herein.

16. This Case Management Order governs the procedures for the presentation of comments to, and the hearing on, the proposed Plan of Rehabilitation. All other orders, injunctions, and stays issued by this Court in this matter shall continue in full force and effect except as modified by this Order.



MARY HANNAH LEAVITT, President Judge

06/12/2020

EXHIBIT E

**Senior Health Insurance Company of
Pennsylvania Docket Sheet**

Commonwealth Court of Pennsylvania

Docket Number: 1 SHP 2020

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August 22, 2021



CAPTION

In Re: Senior Health Insurance
Company of Pennsylvania,
(In Rehabilitation)

CASE INFORMATION

Initiating Document: Complaint

Case Status: Active

Case Processing Status: October 7, 2020 Awaiting Decision

Journal Number:

Case Category: Miscellaneous Case Type(s): Insurance
Rehabilitation

CONSOLIDATED CASES

RELATED CASES

COUNSEL INFORMATION

Plaintiff Insurance Commissioner of the Commonwealth of Pennsylvania

Pro Se: No

IFP Status:

Attorney: Daubert, Amy Griffith
Address: PA Dept Of Insurance
1341 Strawberry Sq
Harrisburg, PA 17120-0046
Phone No: (717) 787-2567 Fax No:

Attorney: Hamilton, Dexter Ryan
Law Firm: Cozen O'Connor
Address: 1650 Market St Ste 2800
Philadelphia, PA 19103
Phone No: (215) 665-2000 Fax No:

Attorney: Buckman, Preston M.
Law Firm: Pennsylvania Insurance Department
Address: Pa Dept Of Insurance
901 N 7TH St Ste 200
Harrisburg, PA 17102
Phone No: (717) 886-2080 Fax No:

Attorney: Greenspan, Leslie Miller
Law Firm: Tucker Law Group, LLC
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1801 Market St Ste 2500
Philadelphia, PA 19103
Phone No: (215) 875-0609 Fax No:

**Senior Health Insurance Company of
Pennsylvania Docket Sheet**

Commonwealth Court of Pennsylvania

Docket Number: 1 SHP 2020

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August 22, 2021



COUNSEL INFORMATION

Plaintiff Insurance Commissioner of the Commonwealth of Pennsylvania

Pro Se: No

IFP Status:

Attorney: Frantz, Jodi A.
Law Firm: Pennsylvania Insurance Department
Address: 1341 Strawberry Square
Harrisburg, PA 17120
Phone No: (717) 787-2567 Fax No: (717) 772-1969

Attorney: Broadbent, Michael John
Law Firm: Cozen O'Connor
Address: 1650 Market St Ste 2800
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Phone No: (215) 665-4732 Fax No:

Attorney: McDermott Speaks, Kathryn
Law Firm: Pennsylvania Department of Insurance
Address: Pa Dept Of Insurance
1341 Strawberry Sq
Harrisburg, PA 17120
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Attorney: Kaldis, Haryle
Law Firm: Cozen O'Connor
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Suite 2800
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Attorney: Cantilo, Patrick Herrera
Law Firm: Cantilo & Bennett, L.L.P.
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11401 Century Oaks Ter Ste 300
Austin, TX 78758
Phone No: (512) 478-6000 Fax No:

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**Senior Health Insurance Company of
Pennsylvania Docket Sheet**

Commonwealth Court of Pennsylvania

Docket Number: 1 SHP 2020

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August 22, 2021



COUNSEL INFORMATION

Plaintiff Altman, Jessica K.

Pro Se: No

IFP Status:

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Attorney: Hamilton, Dexter Ryan
Law Firm: Cozen O'Connor
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Phone No: (215) 665-2000 Fax No:

Attorney: Buckman, Preston M.
Law Firm: Pennsylvania Insurance Department
Address: Pa Dept Of Insurance
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Phone No: (717) 886-2080 Fax No:

Attorney: Greenspan, Leslie Miller
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Attorney: Frantz, Jodi A.
Law Firm: Pennsylvania Insurance Department
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Phone No: (717) 787-2567 Fax No: (717) 772-1969

Attorney: Broadbent, Michael John
Law Firm: Cozen O'Connor
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Phone No: (215) 665-4732 Fax No:

Attorney: McDermott Speaks, Kathryn
Law Firm: Pennsylvania Department of Insurance
Address: Pa Dept Of Insurance
1341 Strawberry Sq
Harrisburg, PA 17120
Phone No: (717) 787-2567 Fax No:

**Senior Health Insurance Company of
Pennsylvania Docket Sheet**

Commonwealth Court of Pennsylvania

Docket Number: 1 SHP 2020

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August 22, 2021



COUNSEL INFORMATION

Commenter **Wisconsin Office of the Commissioner of Insurance**
Pro Se: Yes
IFP Status:
Pro Se: Wisconsin Office of the Commissioner of Insurance
Address: Office of the Commissioner of Insurance
 125 South Webster Street
 PO Box 7873
 Madison, WI 53707-7873

Commenter
Pro Se:
IFP Status:
Pro Se:
Address:

Commenter
Pro Se:
IFP Status:
Pro Se:
Address:

Commenter
Pro Se:
IFP Status:
Pro Se:
Address:

Commenter **Senior Health Care Oversight Trust**
Pro Se: No
IFP Status:
Attorney: Coble, Matthew David
Law Firm: Mette Evans & Woodside, PC
Address: Mette Evans & Woodside Pc
 3401 N Front St
 Harrisburg, PA 17110
Phone No: (717) 232-5000 Fax No:

Commenter
Pro Se:
IFP Status:
Pro Se:
Address:

**Senior Health Insurance Company of
Pennsylvania Docket Sheet**

Commonwealth Court of Pennsylvania

Docket Number: 1 SHP 2020**Page 5 of 55****August 22, 2021****COUNSEL INFORMATION****Commenter**

Pro Se:

IFP Status:

Attorney:

Address:

Phone No:

Fax No:

Commenter

Pro Se:

IFP Status:

Pro Se:

Address:

Commenter

Pro Se:

IFP Status:

Pro Se:

Address:

Commenter

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IFP Status:

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IFP Status:

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Address:

**Senior Health Insurance Company of
Pennsylvania Docket Sheet**

Commonwealth Court of Pennsylvania

Docket Number: 1 SHP 2020**Page 6 of 55****August 22, 2021****COUNSEL INFORMATION****Commenter**

Pro Se:

IFP Status:

Pro Se:

Address:

Commenter

Pro Se:

IFP Status:

Pro Se:

Address:

Commenter

Pro Se:

IFP Status:

Pro Se:

Address:

Commenter

Pro Se:

IFP Status:

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Pro Se:

Address:

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**Senior Health Insurance Company of
Pennsylvania Docket Sheet**

Commonwealth Court of Pennsylvania

Docket Number: 1 SHP 2020

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COUNSEL INFORMATION

Commenter

Pro Se:

IFP Status:

Pro Se:

Address:

Phone No:

Commenter

Pro Se:

IFP Status:

Pro Se:

Address:

Defendant

Senoir Health Insurance Company of Pennsylvania

Pro Se:

No

IFP Status:

Attorney: Broadbent, Michael John

Law Firm: Cozen O'Connor

Address: 1650 Market St Ste 2800
Philadelphia, PA 19103

Phone No: (215) 665-4732

Fax No:

Attorney: Hamilton, Dexter Ryan

Law Firm: Cozen O'Connor

Address: 1650 Market St Ste 2800
Philadelphia, PA 19103

Phone No: (215) 665-2000

Fax No:

Intervenor

Washington Insurance Commissioner

Pro Se:

No

IFP Status:

Attorney: Harvey, Stephen G.

Law Firm: Steve Harvey Law LLC

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Philadelphia, PA 19103

Phone No: (215) 438-6600

Fax No:

**Senior Health Insurance Company of
Pennsylvania Docket Sheet**

Commonwealth Court of Pennsylvania

Docket Number: 1 SHP 2020

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August 22, 2021



COUNSEL INFORMATION

Intervenor UnitedHealthcare Insurance Company

Pro Se: No

IFP Status:

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Law Firm: Morgan, Lewis & Bockius LLP
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1701 Market St
Philadelphia, PA 19103
Phone No: (215) 963-5000 Fax No:

Attorney: Horwich, Harold S.
Address: Bingham McCutchen, LLP
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Hartford, CT 06103-3178
Phone No: (860) 240-2700 Fax No: (860) 240-2800

Attorney: Cordiano, Benjamin J.
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Address: One State Street
Hartford, CT 06103

Intervenor United Insurance Group Agency, Inc.

Pro Se: No

IFP Status:

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Law Firm: Clark Hill, PLC
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2001 Market St Ste 2620
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Phone No: (215) 640-8525 Fax No:

Attorney: Galla, Scott Brandon
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**Senior Health Insurance Company of
Pennsylvania Docket Sheet**

Commonwealth Court of Pennsylvania

Docket Number: 1 SHP 2020

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August 22, 2021



COUNSEL INFORMATION

Intervenor Senior Health Care Insurance Services, Ltd., LLP

Pro Se: No

IFP Status:

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Philadelphia, PA 19103
Phone No: (215) 640-8500 Fax No:

Intervenor Senior Commission Funding LLC

Pro Se: No

IFP Status:

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Attorney: Galla, Scott Brandon
Law Firm: Clark Hill, PLC
Address: 2 Commerce Sq
2001 Market St Ste 2620
Philadelphia, PA 19103
Phone No: (215) 640-8500 Fax No:

Intervenor Primerica Life Insurance Company

Pro Se: No

IFP Status:

Attorney: Gkonos, James Steven
Law Firm: Saul Ewing Arnstein & Lehr LLP
Address: 1500 Market St Fl 38
Philadelphia, PA 19102-2184
Phone No: (215) 972-8667 Fax No:

Intervenor Parisi, Georgianna

Pro Se: Yes

IFP Status:

Pro Se: Georgianna Parisi

Address:

Phone No:

**Senior Health Insurance Company of
Pennsylvania Docket Sheet**

Commonwealth Court of Pennsylvania

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August 22, 2021



COUNSEL INFORMATION

Intervenor National Organization of Life and Health Insurance Guaranty Associations

Pro Se: No

IFP Status:

Attorney: Hickok, Dorothy Alicia
Law Firm: Faegre Drinker Biddle & Reath LLP
Address: 1 Logan Sq Ste 2000
Philadelphia, PA 19103
Phone No: (215) 988-2700 Fax No: (215) 988-2757

Attorney: Glawe, Caryn M.
Law Firm: Faegre Baker Daniels, LLP
Address: 300 N. Meridian Street, Suite 2500
Indianapolis, IN 46143

Attorney: Wilson, Jane Dall
Address: Faegre Baker Daniels LLP
300 N. Meridian Street
Suite 2500
Indianapolis, IN 46204

Intervenor Massachusetts Commissioner of Insurance

Pro Se: No

IFP Status:

Attorney: Harvey, Stephen G.
Law Firm: Steve Harvey Law LLC
Address: 1880 Jfk Blvd Ste 1715
Philadelphia, PA 19103
Phone No: (215) 438-6600 Fax No:

Attorney: Smith, Eric A.
Address: 160 Federal Street
Boston, MA 02110

Attorney: Leslie, J. David
Address: Sawyer & Brewster, P.C.
160 Federal Street
Boston, MA 02110

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COUNSEL INFORMATION

Intervenor Maine Superintendent of Insurance

Pro Se: No

IFP Status:

Attorney: Harvey, Stephen G.
Law Firm: Steve Harvey Law LLC
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Philadelphia, PA 19103
Phone No: (215) 438-6600 Fax No:

Attorney: Smith, Eric A.
Address: 160 Federal Street
Boston, MA 02110

Attorney: Leslie, J. David
Address: Sawyer & Brewster, P.C.
160 Federal Street
Boston, MA 02110

Intervenor LifeCare Health Insurance Plans, Inc.

Pro Se: No

IFP Status:

Attorney: Donley, Joseph M.
Law Firm: Clark Hill, PLC
Address: Clark Hill Plc
2001 Market St Ste 2620
Philadelphia, PA 19103-7081
Phone No: (215) 640-8525 Fax No:

Attorney: Galla, Scott Brandon
Law Firm: Clark Hill, PLC
Address: 2 Commerce Sq
2001 Market St Ste 2620
Philadelphia, PA 19103
Phone No: (215) 640-8500 Fax No:

Intervenor Lapinski, James F.

Pro Se: Yes

IFP Status:

Pro Se: James F. Lapinski
Address: [REDACTED]

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COUNSEL INFORMATION

Intervenor Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey

Pro Se: No

IFP Status:

Attorney: Lavelle, John P., Jr.
Law Firm: Morgan, Lewis & Bockius LLP
Address: Morgan Lewis & Bockius Llp
1701 Market St
Philadelphia, PA 19103
Phone No: (215) 963-5000

Fax No:

Attorney: Horwich, Harold S.
Address: Bingham McCutchen, LLP
One State Street
Hartford, CT 06103-3178
Phone No: (860) 240-2700

Fax No: (860) 240-2800

Attorney: Cordiano, Benjamin J.
Law Firm: Morgan Lewis & Bockius, L.L.P.
Address: One State Street
Hartford, CT 06103

Intervenor Health Care Service Corporation

Pro Se: No

IFP Status:

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Law Firm: Morgan, Lewis & Bockius LLP
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COUNSEL INFORMATION

Intervenor Global Commission Funding LLC

Pro Se: No

IFP Status:

Attorney: Donley, Joseph M.
Law Firm: Clark Hill, PLC
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2001 Market St Ste 2620
Philadelphia, PA 19103-7081
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Attorney: Galla, Scott Brandon
Law Firm: Clark Hill, PLC
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2001 Market St Ste 2620
Philadelphia, PA 19103
Phone No: (215) 640-8500 Fax No:

Intervenor Anthem, Inc.

Pro Se: No

IFP Status:

Attorney: Lavelle, John P., Jr.
Law Firm: Morgan, Lewis & Bockius LLP
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1701 Market St
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COUNSEL INFORMATION

Intervenor ACSIA Long Term Care, Inc.

Pro Se: No

IFP Status:

Attorney: Donley, Joseph M.
Law Firm: Clark Hill, PLC
Address: Clark Hill Plc
2001 Market St Ste 2620
Philadelphia, PA 19103-7081
Phone No: (215) 640-8525 Fax No:

Attorney: Galla, Scott Brandon
Law Firm: Clark Hill, PLC
Address: 2 Commerce Sq
2001 Market St Ste 2620
Philadelphia, PA 19103
Phone No: (215) 640-8500 Fax No:

FEE INFORMATION

Fee Dt	Fee Name	Fee Amt	Receipt Dt	Receipt No	Receipt Amt
01/24/2020	Copy Work by Clerk (Per Page)	274.00	01/24/2020	2020-CMW-H-000213	274.00
01/29/2020	Copy Work by Clerk (Per Page)	27.00	01/29/2020	2020-CMW-H-000231	27.00
01/31/2020	Copy Work by Clerk (Per Page)	265.00	01/31/2020	2020-CMW-H-000244	265.00

AGENCY/TRIAL COURT INFORMATION

Order Appealed From: Notice of Appeal Filed:

Order Type:

Documents Received: January 23, 2020

Court Below:

County:

Judge:

Docket Number:

NAIC Company Code 76325

Division:

OTN:

Judicial District:

ORIGINAL RECORD CONTENT

Original Record Item	Filed Date	Content Description

Date of Remand of Record:

BRIEFING SCHEDULE

None

None

DOCKET ENTRY

Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date

January 23, 2020	Complaint			
	Altman, Jessica K.		Plaintiff	
	Insurance Commissioner of the Commonwealth of Pennsylvania		Plaintiff	
Document Name: Application for Order Placing Senior Health Insurance Company of Pennsylvania in Rehabilitation				

3:24 P.M.

Sealed Documents

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DOCKET ENTRY

Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
	Comment: Treated as a Petition for Order of Rehabilitation			

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DOCKET ENTRY

Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
January 29, 2020	Order Granting Application for Rehabilitation Leavitt, Mary Hannah			01/29/2020
Document Name: AND NOW, this 29th day of January, 2020, upon consideration of the Application for Order Placing Sen				

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Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
	Comment: Senior Health Insurance Company of Pennsylvania in Rehabilitation (Petition for Rehabilitation) filed by Jessica K. Alhnan, Insurance Commissioner of the Commonwealth of Pennsylvania, it is hereby ORDERED as follows: 1. The Petition for Rehabilitation is GRANTED, and effective January 29, 2020, Senior Health Insurance Company of Pennsylvania (SHIP) is placed into rehabilitation in accordance with the provisions of Article V of The Insurance Department Act of 1921, Act of May 17, 1921, P.L. 789, as amended, 40 P.S. §§221.1-221.63, on the ground that rehabilitation has been requested by and consented to by SHIP's board of directors and the trustees of the Senior Health Care Oversight Trust. 2. Insurance Commissioner Jessica K. Altman and her successors in office are hereby appointed Rehabilitator of SHIP and invested with the full powers and authority of a rehabilitator as set forth in Section 516 of The Insurance Department Act of 1921, 40 P.S. §221.16. 3. The Rehabilitator is hereby directed to rehabilitate the business of SHIP; to take possession of the assets of SHIP; and to administer the SHIP assets in accordance with the orders of this Court. Specifically, the Rehabilitator is directed to: (a) Inform all banks, investment banks, and other financial institutions or persons with custody of SHIP assets to identify and report these assets to the Rehabilitator and advise these institutions not to disburse, transfer, hypothecate or encumber such assets without the prior written consent of the Rehabilitator. (b) Inform all banks and other financial institutions with SHIP accounts that checks or other payments that have been processed and transmitted may be honored without prejudice to the ability of the Rehabilitator to recover said amounts from the recipient or payee in accordance with applicable law. (c) Inform all insurance producers, agents, managing general agents, brokers or other persons who have collected premiums on behalf of SHIP to account for all earned and unearned premiums and commissions to the Rehabilitator at the offices of SHIP within thirty (30) days of the date of this Order and that premium monies owed to SHIP must be remitted to the Rehabilitator. (d) Inform all attorneys employed or retained by SHIP that within thirty (30) days of this Order they must report to the Rehabilitator the name of the case or claim they are handling; the claim or docket number, if one is assigned; the status of each such case; and, further, that the Rehabilitator will not make payment for any unsolicited reports. (e) Inform all vendors providing claims or data processing services to SHIP that they shall continue such services unless and until			

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	instructed to the contrary by the Rehabilitator. (f) Inform all vendors with custody or control of any data processing information and electronic records belonging to SHIP to preserve these electronic files and information and to transfer the data to the control of the Rehabilitator upon request. 4. The filing or recording of this Order with the Prothonotary of the Commonwealth Court shall impart the same notice as is imparted by any deed, bill of sale or other evidence of title duly filed or recorded. 5. The Rehabilitator shall take such actions as are necessary to correct the condition that prompted SHIP's board of directors and the Senior Health Care Oversight Trust to request and consent to the rehabilitation of SHIP . 6. The Rehabilitator shall authorize, where appropriate and necessary, the payment of expenses, including employee compensation, incurred in the ordinary course of SHIP's business, as well as the actual, reasonable, and necessary costs of preserving or recovering the assets of SHIP. 7. The Rehabilitator shall prepare a plan of rehabilitation, which may include a consolidation, merger or other transformation of SHIP and to that end may retain accountants, actuaries, attorneys and other consultants at the expense of SHIP. 8. In the event this Court should determine that a rehabilitation of SHIP is not feasible and a liquidation of SHIP is ordered, the actual, reasonable and necessary costs of goods or services provided to and approved by the Rehabilitator during the period of rehabilitation will be treated as costs and expenses of administration for purposes of Section 544 of The Insurance Depaiiment Act of 1921, 40 P.S. §221.44. 9. The Rehabilitator may, in her discretion, pay claims, in whole or in part, arising under SHIP's contracts of insurance; provided, however, that the Rehabilitator may not pay bad faith claims or claims for extra-contractual charges or damages. 10. The Rehabilitator may, in her discretion, write new and renewal policies or may cancel or refuse to renew existing policies, as she deems appropriate. 11. In accordance with Section 515 of The Insurance Department Act of 1921, 40 P.S. §221.15(c), the Rehabilitator is authorized to take possession of the statutory deposits held by any state or territory and to do all things necessary to manage and apply the deposits in accordance with the application agreements; provided, however, the Rehabilitator shall not post additional statutory security deposits in any state or territory on behalf of SHIP. 12. All court actions, arbitrations and mediations currently or hereafter pending against SHIP in the Commonwealth of Pennsylvania are stayed			

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	for ninety (90) days from the effective date of this Order and such additional time as the Rehabilitator may request, to allow the Rehabilitator an opportunity to review litigation and where appropriate retain new counsel. 13. The Rehabilitator is directed to review all litigation pending outside the courts of the Commonwealth of Pennsylvania and petition these other courts or tribunals for a ninety (90) day stay of litigation where necessary to protect the estate of SHIP. 14. The Rehabilitator may appoint a Special Deputy Rehabilitator to be compensated from SHIP's assets, and such Special Deputy Rehabilitator shall have all the same rights and authority under this Order and applicable law as the Rehabilitator, subject to oversight and supervision by the Rehabilitator and this Court. 15. This Order is not, and shall not be considered, a finding or declaration of insolvency that can activate the provisions of the Pennsylvania Life and Health Insurance Guaranty Act, as added by the Act of Dec. 18, 1992, P.L. 1519, 40 P.S. §§991.1701-991.1718, or the provisions of similar acts of any other state or territory. 16. On or before April 22, 2020, the Rehabilitator shall file a preliminary plan of rehabilitation with the Court, which shall include a timeline for the preparation of a final plan of rehabilitation. 17. This Court shall retain jurisdiction of this proceeding to the full extent necessary to enforce the terms of this Order and to issue such other orders that may be required in the course of the rehabilitation .			
January 30, 2020	Entry of Appearance Buckman, Preston M. Buckman, Preston M.	Insurance Commissioner of the Com Altman, Jessica K.	Plaintiff Plaintiff	
January 31, 2020	Entry of Appearance Darney, Page Darney, Page	Insurance Commissioner of the Com Altman, Jessica K.	Plaintiff Plaintiff	
April 22, 2020	Entry of Appearance Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John Hamilton, Dexter Ryan Potts, James Reeves Hamilton, Dexter Ryan Potts, James Reeves Hamilton, Dexter Ryan Potts, James Reeves	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o Insurance Commissioner of the Com Insurance Commissioner of the Com Altman, Jessica K. Altman, Jessica K. Senoir Health Insurance Company o Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant Plaintiff Plaintiff Plaintiff Plaintiff Defendant Defendant	

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Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
April 22, 2020	Application for Approval Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
	Document Name: OF THE PLAN OF REHABILITATION FOR SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA Comment: OF THE PLAN OF REHABILITATION FOR SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA			
April 22, 2020	Application for Approval Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
	Document Name: OF FORM AND DISTRIBUTION OF NOTICE OF APPLICATION FOR APPROVAL OF Comment: PLAN OF REHABILITATION FOR SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA			
April 23, 2020	Praeipce Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
	Document Name: TO SUBSTITUTE			
April 23, 2020	Praeipce Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
	Document Name: to Substitute			
April 24, 2020	Entry of Appearance Greenspan, Leslie Miller Greenspan, Leslie Miller Dugue, Dorothy M. Dugue, Dorothy M.	Insurance Commissioner of the Com Altman, Jessica K. Insurance Commissioner of the Com Altman, Jessica K.	Plaintiff Plaintiff Plaintiff Plaintiff	
May 7, 2020	Praeipce for Withdrawal of Appearance Darney, Page Darney, Page	Insurance Commissioner of the Com Altman, Jessica K.	Plaintiff Plaintiff	

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Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
June 12, 2020	Order Granting Application for Approval Leavitt, Mary Hannah			06/12/2020
Document Name: CASE MANAGEMENT ORDER FOR COMMENTS AND HEARING ON THE PROPOSED PLAN OF REHABILITATION				

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Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
	Comment: AND NOW, this 12th day of June, 2020, upon consideration of the Application of Jessica K. Altran, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as Statutory Rehabilitator of Senior Health Insurance Company of Pennsylvania (In Rehabilitation) (SHIP), for approval of Form and Distribution of Notice of Application for Approval of Plan of Rehabilitation for SHIP (Application), and any objections filed thereto, it is hereby ORDERED as follows: 1. The Court directs the Statutory Rehabilitator to use the Notice attached to this Order as Exhibit A to advise the Interested Parties (as defined below) of the filing in this Court by the Rehabilitator of the Application for Approval of the Plan of Rehabilitation for SHIP (Plan Application) and the procedures for offering comments on the proposed Plan of Rehabilitation and participating in the hearing thereon, which will be scheduled by the Court by separate order. 2. As soon as reasonably practical, the Rehabilitator shall send by U.S. mail a copy of the attached Notice to all Interested Parties, defined as: all persons identified on the Master Service List; all known policyholders and certificate holders having policies or other coverage in force with SHIP on the date of the mailing; all known SHIP insurance agents and all known creditors of SHIP (in each case, addressed to their last known address as shown on the electronic books and records of SHIP); the insurance regulatory authorities in each jurisdiction in which SHIP issued policies that remain in effect; the state life and health insurance guaranty associations; the taxing authorities of the various states where SHIP has policies or other coverage in force at the time of mailing the notice; the National Association of Insurance Commissioners; the National Organization of Life and Health Insurance Guaranty Associations; and the Senior Health Care Oversight Trust and its Trustees. 3. Notice is not required to be mailed to persons who have changed their addresses without notifying SHIP and for whom the Rehabilitator, after good effort, has been unable to establish a current address. 4. The Rehabilitator shall continue to maintain the website addressed at https://www.shipltc.com/court-documents (Site) and post thereon the Application for Approval of the Plan of Rehabilitation for SHIP, a copy of this Order and such other documents that are from time to time required by Pa. R.A.P. 3779 or provide a link thereon to such documents. Absent further order by this Court, updates to the Site shall serve as official notice of filings, orders, deadlines and hearings. 5. As soon as reasonably practical, the Rehabilitator shall cause a copy of the attached Notice, in substantially the same form, to be published in The Wall Street Journal, USA Today, The Indianapolis Star, The Philadelphia Inquirer, and The Harrisburg Patriot-News, twice a week in each publication for two weeks. 6. The Rehabilitator shall maintain a "hard copy" service list for those Interested Parties requesting hard copies of relevant documentation. Interested Parties who affirm that they either do not have regular access to a computer or are unable to view, download or print the applicable documents may be placed on the "hard copy" list and receive copies of all Court orders and filings by the Rehabilitator in this matter by making a request for placement on the "hard copy" service list. Requests for placement on the "hard copy" service list shall be made by sending a written request by mail to Senior Health Insurance Company of Pennsylvania (In Rehabilitation), Attention: Rehabilitation Administrator, 550 Congressional Boulevard, Suite 200, Carmel, IN 46032; or by facsimile to the attention of Senior Health Insurance Company of Pennsylvania (In Rehabilitation), Attention: Rehabilitation Administrator, at the following number: (317) 566-7588; or by email to rehabilitation@shipltc.com. The request should be signed and contain the following statement: In making this request, I hereby affirm to the Commonwealth Court of Pennsylvania that I do not have regular access to a computer or other device providing me internet access to the Site or I am otherwise unable to view, download or print documents from the Site related to this matter. 7. Informal Comments in support of or in objection to the proposed Plan of Rehabilitation may be sent to Patrick H. Cantilo, Special Deputy Rehabilitator at the following address: Senior Health Insurance Company of Pennsylvania (In			

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	Rehabilitation), 550 Congressional Blvd., Suite 200, Carmel, IN 46032; or by email to: plan.comments@shipltc.com. 8. Formal Comments in support of or in objection to the proposed Plan of Rehabilitation shall be filed with the Court on or before September 15, 2020. Formal Comments shall be identified at the top of the document as being filed in "In re: Senior Health Insurance Company of Pennsylvania (In Rehabilitation), No. 1 SHP 2020." Formal Comments shall state with specificity the Commenter's identity and interest in the proceeding, the facts on which the comments are based, and any suggested modifications to the proposed Plan of Rehabilitation. A person may submit Formal Comments without participating in the hearing on the proposed Plan of Rehabilitation. A Commenter who intends to participate in the hearing must notify the Court of that intention in his Formal Comments. 9. Any Commenter who intends to call or examine witnesses or introduce exhibits at the hearing on the proposed Plan of Rehabilitation or participate in any discovery that this Court may permit must file an application with the Court to intervene in the proceeding under the Pennsylvania Rules of Appellate Procedure on or before July 31, 2020, and must also file their Formal Comments in accordance with this Order. Any response to an application to intervene shall be filed and served on or before August 21, 2020. Any Commenter who is permitted to intervene shall file with the Court and serve on the Rehabilitator on or before September 30, 2020, (i) a narrative or other description consisting substantially of the direct testimony of each witness the Commenter intends to call at the hearing and (ii) the exhibits the Commenter intends to introduce at the hearing. 10. Formal Comments to the proposed Plan of Rehabilitation shall be filed with the Court at the following address: Office of Prothonotary of the Commonwealth Court of Pennsylvania ATTN: 1 SHP 2020 Pennsylvania Judicial Center 601 Commonwealth Avenue, Suite 2100 Harrisburg, PA 17106. I I . Service by Commenters on the Rehabilitator shall be made by electronic delivery to the Rehabilitator's counsel and the Special Deputy Rehabilitator at the following addresses: Counsel SDR Cozen O'Connor Patrick Cantilo shipcomments@cozen.com service@cb-firm.com 12. A Commenter who is unable to make service on the Rehabilitator by electronic delivery may serve the Rehabilitator by first-class mail or overnight delivery service to the Rehabilitator's counsel and the Special Deputy Rehabilitator at the following physical addresses: James R. Potts Patrick Cantilo Cozen O'Connor Cantilo & Bennett, L.L.P. One Liberty Place 1 1401 Century Oaks Terrace 1650 Market Street, Suite 2800 Suite 300 Philadelphia, PA 19103 Austin, Texas 78758 Any materials served by this method must contain an affirmation to the Court that the Commenter is unable to serve the Rehabilitator by electronic delivery. 13. A Commenter who has complied with the procedures set forth in this Order and been granted intervenor status by this Court shall have the right to participate in the hearing, including the examination of witnesses proffered in support of or opposition to the proposed Plan of Rehabilitation. Evidence presented by the Commenter may be subject to cross-examination by the Rehabilitator and any other party to the proceeding. The Court may limit such participation to ensure an orderly proceeding. 14. The Rehabilitator shall not be required to respond to Formal or			

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	Informal Comments or other filings by Commenters pursuant to this Order and any failure to respond shall not constitute an admission or waiver by the Rehabilitator. 15. All other dates and requirements established by the Court relevant to the proceedings concerning the proposed Plan of Rehabilitation, including any changes to the dates and procedures set forth in this Order, will be posted to the Site and will not be delivered by mail or other means except as otherwise provided herein. 16. This Case Management Order governs the procedures for the presentation of comments to, and the hearing on, the proposed Plan of Rehabilitation. All other orders, injunctions, and stays issued by this Court in this matter shall continue in full force and effect except as modified by this Order.			
July 22, 2020	Sealed Formal Comment [REDACTED]		Commenter	
July 30, 2020	Application for Intervention (Pa.R.A.P. 3775) Parisi, Georgianna Document Name: Georgianna Parisi		Intervenor	
July 30, 2020	Application for Intervention (Pa.R.A.P. 3775) Kline, Amy Stovall Kline, Amy Stovall Document Name: Unopposed Application to Intervene of Transamerica Life Insurance Company	Transamerica Life Insurance Compa Possible Intervenor	Intervenor	
July 30, 2020	Application for Intervention (Pa.R.A.P. 3775) Hickok, Dorothy Alicia Document Name: Unopposed Application of National Organization of Life and Health Insurance Guaranty Associations Comment: Requesting Leave to Intervene for a Limited Purpose	National Organization of Life and He	Intervenor	
July 30, 2020	Sealed Formal Comment [REDACTED] Document Name: [REDACTED]		Commenter	
July 30, 2020	Sealed Formal Comment [REDACTED] Document Name: [REDACTED]		Commenter	
July 31, 2020	Entry of Appearance Kline, Amy Stovall Hummer, Paul M.	Transamerica Life Insurance Compa Transamerica Life Insurance Compa	Intervenor Intervenor	
July 31, 2020	Memorandum of Law Filed Kline, Amy Stovall Kline, Amy Stovall Document Name: Brief in Support of Unopposed Application to Intervene of TransAmerica Life Insurance Company	Transamerica Life Insurance Compa Possible Intervenor	Intervenor	
July 31, 2020	Entry of Appearance Hummer, Paul M.	Transamerica Life Insurance Compa	Intervenor	
July 31, 2020	Application for Intervention (Pa.R.A.P. 3775) Gkonos, James Steven Document Name: Unopposed Application to Intervene of Primerica Life Insurance Company	Primerica Life Insurance Company	Intervenor	

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Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
July 31, 2020	Memorandum of Law Filed Gkonos, James Steven	Primerica Life Insurance Company	Intervenor	
	Document Name: Brief in Support of Unopposed Application to Intervene of Primerica Life Insurance Company			
July 31, 2020	Application for Intervention (Pa.R.A.P. 3775) Harvey, Stephen G.	Maine Superintendent of Insurance	Intervenor	
	Harvey, Stephen G.	Massachusetts Commissioner of Ins	Intervenor	
	Document Name: Joint Application for Intervention of the Maine Superintendent of Insurance and the Comment: Massachusetts Commissioner of Insurance and Request to Grant Leave to Extend the time to Intervene			
July 31, 2020	Application for Intervention (Pa.R.A.P. 3775) Donley, Joseph M.	ACSIA Long Term Care, Inc.	Intervenor	
	Donley, Joseph M.	Global Commission Funding LLC	Intervenor	
	Donley, Joseph M.	LifeCare Health Insurance Plans, Inc.	Intervenor	
	Donley, Joseph M.	Senior Commission Funding LLC	Intervenor	
	Donley, Joseph M.	Senior Health Care Insurance Servic	Intervenor	
	Donley, Joseph M.	United Insurance Group Agency, Inc	Intervenor	
July 31, 2020	Application for Intervention (Pa.R.A.P. 3775) Lavelle, John P., Jr.	Aetna Life Insurance Company	Intervenor	
	Lavelle, John P., Jr.	Anthem, Inc.	Intervenor	
	Lavelle, John P., Jr.	Health Care Service Corporation	Intervenor	
	Lavelle, John P., Jr.	Horizon Healthcare Services, Inc. d/I	Intervenor	
	Lavelle, John P., Jr.	UnitedHealthcare Insurance Compar	Intervenor	
	Document Name: of the Health Insurers...for a Limited Purpose			
August 3, 2020	Certificate of Service Filed Gkonos, James Steven	Primerica Life Insurance Company	Intervenor	
August 3, 2020	Application for Intervention (Pa.R.A.P. 3775) Lapinski, James F.		Intervenor	
	Document Name: James F. Lipinski			
August 5, 2020	Entry of Appearance Galla, Scott Brandon	ACSIA Long Term Care, Inc.	Intervenor	
	Galla, Scott Brandon	Global Commission Funding LLC	Intervenor	
	Galla, Scott Brandon	LifeCare Health Insurance Plans, Inc.	Intervenor	
	Galla, Scott Brandon	Senior Commission Funding LLC	Intervenor	
	Galla, Scott Brandon	Senior Health Care Insurance Servic	Intervenor	
	Galla, Scott Brandon	United Insurance Group Agency, Inc	Intervenor	
August 5, 2020	Sealed Formal Comment [REDACTED]		Commenter	
			Commenter	
	Document Nam [REDACTED]			

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Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
August 10, 2020	Praeipce Galla, Scott Brandon Galla, Scott Brandon Galla, Scott Brandon Galla, Scott Brandon Galla, Scott Brandon Galla, Scott Brandon	ACSIA Long Term Care, Inc. Global Commission Funding LLC Senior Commission Funding LLC United Insurance Group Agency, Inc LifeCare Health Insurance Plans, Inc. Senior Health Care Insurance Serviv	Intervenor Intervenor Intervenor Intervenor Intervenor Intervenor	
	Document Name: Praeipce to Conform Application for Relief Seeking Leave to Intervene Pursuant to Comment: Appellate Rule 3775			
August 10, 2020	Sealed Formal Comment [REDACTED]		Commenter	
	Document Name: [REDACTED]			
August 11, 2020	Sealed Formal Comment [REDACTED]		Commenter	
	Document Name: [REDACTED]			
August 11, 2020	Entry of Appearance Cantilo, Patrick Herrera	Insurance Commissioner of the Com	Plaintiff	
August 14, 2020	Application for Approval Greenspan, Leslie Miller Greenspan, Leslie Miller	Insurance Commissioner of the Com Altman, Jessica K.	Plaintiff Plaintiff	
	Document Name: of Senior Health Insurance Company of Pennsylvania's Purchase of Bankers Condeco Life Insurance Comment: Company and Washington National Insurance Company's Interests in a Loan			
August 21, 2020	Answer Filed Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
	Document Name: Response of the Rehabilitator to the Unopposed Application to Intervene of the National Comment: Organization of Life and Health Insurance Guaranty Associations			
August 21, 2020	Answer Filed Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
	Document Name: Response of the Rehabilitator to the Application to Intervene Filed by ACSIA Long Term Care, Inc., Comment: Global Commission Funding LLC, LifeCare Health Insurance Plans, Inc., Senior Commission Funding LLC, Senior Health Care Insurance Services, Ltd., LLP, and United Insurance Group Agency, Inc			
August 21, 2020	Answer Filed Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
	Document Name: Response of the Rehabilitator to the Unopposed Application to Intervene of Primerica Life Insurance Comment: Company			

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Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
August 21, 2020	Answer Filed Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
	Document Name: Response of the Rehabilitator to the Unopposed Application to Interene of Transamerica Life Comment: Insurance Company			
August 21, 2020	Answer Filed Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
	Document Name: Answer of the Rehabilitator to the Joint Application to Intervene and Request to Grant Leave Comment: to Extend the Time to Intervene Filed by the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance			
August 21, 2020	Answer Filed Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
	Document Name: Answer of Rehabilitator to Motion of Georgianna Parisi to Intervene			
August 21, 2020	Answer Filed Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
	Document Name: Answer of Rehabilitator to Application of James Lapinski to Intervene and Motion for Class Action by Comment: Policyholders			
August 21, 2020	Answer Filed Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
	Document Name: Response of the Rehabilitator to the Application to Intervene of Aetna Life Insurance Company, Comment: Anthem, Inc., Health Care Service Corporation, Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey, and UnitedHealthcare Insurance Company			
August 26, 2020	Answer Filed Harvey, Stephen G. Harvey, Stephen G.	Maine Superintendent of Insurance Massachusetts Commissioner of Ins	Intervenor Intervenor	
	Document Name: of the Main Superintendent of Insurance and the Massachusetts Commissioner of Insurance Comment: to Rehabilitor's Answer to Their Joint Application for Intervention and Request to Grant Leave to Extend Time to Intervene			
August 27, 2020	Sealed Formal Comment [REDACTED]		Commenter	
August 31, 2020	Sealed Formal Comment [REDACTED]		Commenter	

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Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
September 1, 2020	Answer Filed Harvey, Stephen G. Harvey, Stephen G. Document Name: Further Answer of the Main Superintensent of Insurance and the Massachusetts Commissioner Comment: of Insurance to Rehabilitator's Answer to their Joint Application for Intervention and Request to Grant Leave to Extend Time to Intervene	Maine Superintendent of Insurance Massachusetts Commissioner of Ins	Intervenor Intervenor	
September 3, 2020	Sealed Formal Comment [REDACTED]		Commenter	
September 4, 2020	Application for Relief Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John Document Name: Application for Leave to File a Response to the Answer and Further Answer of the Maine Superintendent Comment: of Insurance and the Massachusetts Commissioner of Insurance	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
September 8, 2020	Sealed Formal Comment [REDACTED]		Commenter	
September 10, 2020	Order Filed Per Curiam Document Name: it is ORDERED that all formal comments filed by individual policyholders Comment: shall be maintained by the Prothonotary under seal and be made available to the public only upon application to the Court.			09/10/2020
September 10, 2020	Formal Comment Wisconsin Office of the Commissioner of Insurance Document Name: and Limited Objections to the Plan of Rehabilitation by the Wisconsin Office of the Commissioner of Comment: Insurance		Commenter	
September 14, 2020	Formal Comment Hickok, Dorothy Alicia Document Name: Formal Comments of the National Organization of Life and Health Insurance Guranty Associations	National Organization of Life and He	Intervenor	
September 14, 2020	Answer Filed Kline, Amy Stovall Kline, Amy Stovall Document Name: Response of Transamerica Life Insurance Company to Proposed Plan of Rehabilitation	Transamerica Life Insurance Compa	Intervenor Possible Intervenor	
September 14, 2020	Sealed Formal Comment [REDACTED]		Commenter	
September 14, 2020	Sealed Formal Comment [REDACTED]		Commenter	
September 15, 2020	Formal Comment Gkonos, James Steven Document Name: Primerica Life Insurance Company	Primerica Life Insurance Company	Intervenor	

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Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
September 15, 2020	Order Filed Leavitt, Mary Hannah			09/15/2020
	Document Name: upon consideration of the Joint Application for Intervention of the Maine Superintendent Comment: of Insurance and the Massachusetts Commissioner of Insurance and Request to Grant Leave to Extend the Time to Intervene (Joint Application), and the Rehabilitator's response thereto, it is hereby ORDERED that the Joint Application is GRANTED IN PART and DENIED IN PART. The request of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance to intervene in the abovecaptioned proceeding is GRANTED. The request to extend the time for other state insurance regulators to join as intervenors is DENIED. The Rehabilitator's Application for Leave to File a Response to the Answer and Further Answer of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance is DENIED.			
September 15, 2020	Order Granting Application for Intervention Leavitt, Mary Hannah			09/15/2020
	Document Name: upon consideration of the Application of Georgianna Parisi to Intervene in the Comment: above-captioned proceeding for the limited purpose of participating in discovery, and the Rehabilitator's response thereto, it is hereby ORDERED that the Application is GRANTED.			
September 15, 2020	Order Granting Application for Intervention Leavitt, Mary Hannah			09/15/2020
	Document Name: upon consideration of the Application of James Lapinski to Intervene in the Comment: above-captioned proceeding and the Motion of James Lapinski for Class Action by Policyholders , and the Rehabilitator's response thereto, it is hereby ORDERED that the Application to Intervene is GRANTED and the Motion for Class Action is DENIED with prejudice.			
September 15, 2020	Order Granting Application for Intervention Leavitt, Mary Hannah			09/15/2020
	Document Name: upon consideration of the Unopposed Application to Intervene of Primerica Life Comment: Insurance Company (Primerica), and the Rehabilitator's response thereto, it is hereby ORDERED that the Application is GRANTED and Primerica is permitted to intervene in the above-captioned matter.			
September 15, 2020	Order Granting Application for Intervention Leavitt, Mary Hannah			09/15/2020
	Document Name: upon consideration of the Unopposed Application to Intervene of Transamerica Life Comment: Insurance Company (Transamerica), and the Rehabilitator's response thereto, it is hereby ORDERED that the Application is GRANTED and Transamerica is permitted to intervene in the above-captioned matter.			

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Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
September 15, 2020	Order Granting Application for Intervention Leavitt, Mary Hannah			09/15/2020
	Document Name: upon consideration of the Unopposed Application of the National Organization of Life Comment: and Health Insurance Guaranty Associations (NOLHGA) Requesting Leave to Intervene for a Limited Purpose, and the Rehabilitator's response thereto, it is hereby ORDERED that the Application is GRANTED and NOLHGA is permitted to intervene in the above-captioned proceeding.			
September 15, 2020	Order Granting Application for Intervention Leavitt, Mary Hannah			09/15/2020
	Document Name: upon consideration of the Application for Relief Seeking Leave to Intervene filed by ACSIA Comment: Long Term Care, Inc., Global Commission Funding LLC, LifeCare Health Insurance Plans, Inc., Senior Commission Funding LLC, Senior Health Care Insurance Services, Ltd., LLP, and United Insurance Group Agency, Inc., and the Rehabilitator's response thereto, it is hereby ORDERED that the Application is GRANTED and the above-listed entities are permitted to intervene in the above-captioned proceeding.			
September 15, 2020	Application for Intervention (Pa.R.A.P. 3775) Harvey, Stephen G. Harvey, Stephen G.	Maine Superintendent of Insurance Massachusetts Commissioner of Ins	Intervenor Intervenor	
	Document Name: Joinder of the Washington Insurance Commissioner in the Joint Application for Intervention of the Comment: Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance and Application to Intervene			
September 15, 2020	Entry of Appearance Coble, Matthew David	Senior Health Care Oversight Trust	Commenter	
September 15, 2020	Formal Comment Coble, Matthew David	Senior Health Care Oversight Trust	Commenter	
	Document Name: The Senior Health Care Oversight Trust			
September 15, 2020	Formal Comment Harvey, Stephen G. Harvey, Stephen G.	Maine Superintendent of Insurance Massachusetts Commissioner of Ins	Intervenor Intervenor	
	Document Name: of the Maine Superintendent of Insurance, The Massachusetts Commissioner of Insurance and Comment: the Washington Insurance Commissioner			
September 15, 2020	Formal Comment Insurance Commissioner for the State of Maryland		Commenter	
	Document Name: of Kathleen A. Birrane, Insurance Commissioner for the State of Maryland in Opposition to the Comment: Proposed Plan of Rehabilitation			
September 15, 2020	Sealed Formal Comment [REDACTED]		Commenter	
	Document Name: [REDACTED]			
September 15, 2020	Sealed Formal Comment [REDACTED]	[REDACTED]	Commenter	
	Document Name: [REDACTED]			

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September 15, 2020	Formal Comment			
	Donley, Joseph M.	ACSIA Long Term Care, Inc.	Intervenor	
	Donley, Joseph M.	Global Commission Funding LLC	Intervenor	
	Donley, Joseph M.	LifeCare Health Insurance Plans, Inc.	Intervenor	
	Donley, Joseph M.	Senior Commission Funding LLC	Intervenor	
	Donley, Joseph M.	Senior Health Care Insurance Service	Intervenor	
	Donley, Joseph M.	United Insurance Group Agency, Inc	Intervenor	
	Document Name: Formal Comments in Objection to the Proposed Plan of Rehabilitation			
September 15, 2020	Formal Comment			
	Lavelle, John P., Jr.	Aetna Life Insurance Company	Intervenor	
	Lavelle, John P., Jr.	Anthem, Inc.	Intervenor	
	Lavelle, John P., Jr.	Health Care Service Corporation	Intervenor	
	Lavelle, John P., Jr.	Horizon Healthcare Services, Inc. d/b	Intervenor	
	Lavelle, John P., Jr.	UnitedHealthcare Insurance Company	Intervenor	
	Document Name: Formal Comment of the Health Insurers on the Proposed Plan of Rehabilitation for Comment: Senior Health Insurance Company of Pennsylvania			
September 16, 2020	Entry of Appearance			
	Broadbent, Michael John	Insurance Commissioner of the Commonwealth	Plaintiff	
	Kaldis, Haryle	Insurance Commissioner of the Commonwealth	Plaintiff	
September 16, 2020	Sealed Formal Comment			
	[REDACTED]		Commenter	
September 16, 2020	Sealed Formal Comment			
	[REDACTED]		Commenter	
September 16, 2020	Sealed Formal Comment			
	[REDACTED]		Commenter	
September 17, 2020	Praecipe for Withdrawal of Appearance			
	Potts, James Reeves	Altman, Jessica K.	Plaintiff	
	Potts, James Reeves	Insurance Commissioner of the Commonwealth	Plaintiff	
	Potts, James Reeves	Senior Health Insurance Company of Pennsylvania	Defendant	
September 17, 2020	Sealed Formal Comment			
	[REDACTED]		Commenter	
September 18, 2020	Order Filed			09/18/2020
	Leavitt, Mary Hannah			
	Document Name: upon consideration of the Joinder of the Washington Insurance Commissioner in the Comment: Joint Application for Intervention of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance and Application to Intervene, which the Rehabilitator does not oppose, it is ORDERED that the Washington Insurance Commissioner is permitted to join with the intervention of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance in the above-captioned proceeding.			

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September 22, 2020	Application for Relief Harvey, Stephen G. Harvey, Stephen G. Harvey, Stephen G.	Maine Superintendent of Insurance Massachusetts Commissioner of Ins Washington Insurance Commissione	Intervenor Intervenor Intervenor	
	Document Name: Application of Intervenor State Insurance Regulators to Suspend September 30, 2020 Deadline Comment: for Filing of Witness Testimony Narratives and Exhibits			
September 22, 2020	Application to be Admitted Pro Hac Vice Filed Hickok, Dorothy Alicia	National Organization of Life and He	Intervenor	
	Document Name: Glawe			
September 22, 2020	Application to be Admitted Pro Hac Vice Filed Hickok, Dorothy Alicia	National Organization of Life and He	Intervenor	
	Document Name: Wilson			
September 25, 2020	Order Granting Application to be Admitted Pro Hac Vice Leavitt, Mary Hannah			09/25/2020
	Document Name: AND NOW this 25th day of September, 2020, upon consideration of the application of D. Alicia Hickok, Comment: Esquire, for admission pro hac vice of Caryn Glawe, Esquire, on behalf of intervenor National Organization of Life and Health Insurance Guaranty Associations (NOLHGA), it is hereby ORDERED: (1) Ms. Glawe is admitted pro hac vice to the bar of the Commonwealth of Pennsylvania under Pennsylvania Bar Admission Rule 301, as co-counsel on behalf of NOLHGA in this matter; (2) Ms. Glawe shall abide by the rules of this Court including all disciplinary rules; (3) Ms. Glawe shall immediately notify this Court of any matter affecting her standing at the bar of any other court where she may be admitted to practice; and (4) Ms. Hickok, as the moving attorney herein, shall continue to be responsible as counsel of record for the conduct of this matter on behalf of NOLHGA.			
September 25, 2020	Order Granting Application to be Admitted Pro Hac Vice Leavitt, Mary Hannah			09/25/2020
	Document Name: AND NOW this 25th day of September, 2020, upon consideration of the application of D. Alicia Hickok, Comment: Esquire, for admission pro hac vice of Jane Dall Wilson, Esquire, on behalf of intervenor National Organization of Life and Health Insurance Guaranty Associations (NOLHGA), it is hereby ORDERED: (1) Ms. Wilson is admitted pro hac vice to the bar of the Commonwealth of Pennsylvania under Pennsylvania Bar Admission Rule 301, as co-counsel on behalf of NOLHGA in this matter; (2) Ms. Wilson shall abide by the rules of this Court including all disciplinary rules; (3) Ms. Wilson shall immediately notify this Court of any matter affecting her standing at the bar of any other court where she may be admitted to practice; and (4) Ms. Hickok, as the moving attorney herein, shall continue to be responsible as counsel of record for the conduct of this matter on behalf of NOLHGA.			

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September 25, 2020	Order Granting Application for Approval Leavitt, Mary Hannah			09/25/2020
	Document Name: AND NOW, this 25th day of September, 2020, upon consideration of the Application for Approval of Comment: Senior Health Insurance Company of Pennsylvania's (SHIP) Purchase of Bankers Conesco Life Insurance Company's and Washington National Insurance Company's (together, Assignors) Interests In a Loan, Filed by Jessica K. Altman, Insurance Commissioner of Pennsylvania in her capacity as Statutory Rehabilitator of SHIP, it is ORDERED that the Rehabilitator's Application is GRANTED and SHIP is hereby authorized to purchase Assignors' interests in the eleven million eight hundred thousand dollar (\$11,800,000.00) and six million dollar (\$6,000,000.00) loans to Energy Resources, LLC; DDB Energy Resources, LLC; Montana Bakken, LLC; Little Creek Coal Co., Inc.; Green Equity Partners, LLC; and KEP-RMA, LLC for the sum of four million dollars (\$4,000,000.00).			
September 25, 2020	Order Granting Application for Relief Leavitt, Mary Hannah			09/25/2020
	Document Name: AND NOW, this 25th day of September, 2020, upon consideration of the Application of Intervenor Comment: State Insurance Regulators to Suspend September 30, 2020 Deadline for Filing of Witness Testimony Narratives and Exhibits, it is ORDERED that the deadline set forth in paragraph 9 of the Case Management Order for intervenors to file and serve narratives or descriptions of direct witness testimony and exhibits is extended to October 30, 2020.			
October 1, 2020	Answer to Application to be Admitted Pro Hac Vice Lapinski, James F.		Intervenor	
	Document Name: Lapinski's Objection to Admission fo Jane Dali Wilson and Caryn Glawe as Additional Counsel for Comment: NOLHGA			
October 2, 2020	Filed - Other Lapinski, James F.		Intervenor	
	Document Name: Description of Substance of Testamony of Patricia Sue Lapinski			
October 7, 2020	Hearing Cancelled Leavitt, Mary Hannah			10/07/2020
	Document Name: the pre-hearing conference scheduled for October 20, 2020, at 10:00 a.m. is CANCELLED. Comment: The Court will reschedule the conference by future order.			
October 9, 2020	Application to be Admitted Pro Hac Vice Filed Harvey, Stephen G. Harvey, Stephen G. Harvey, Stephen G.	Maine Superintendent of Insurance Massachusetts Commissioner of Ins Washington Insurance Commissione	Intervenor Intervenor Intervenor	
October 9, 2020	Answer Filed Hickok, Dorothy Alicia	National Organization of Life and He	Intervenor	
	Document Name: NOLHGA's Answer to Objections of James F. Lapinski to Pro Hac Applications of Jane Dall Wilson and Comment: Caryin Glawe			

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Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
October 13, 2020	Order Filed Leavitt, Mary Hannah			10/13/2020
	Document Name: upon consideration of Intervenor James F. Lapinski's Objections to Admission of Comment: Jane Dall Wilson and Caryn Glawe as Additional Counsel for Intervenor National Organization of Life and Health Insurance Guaranty Associations (NOLHGA), and NOLHGA's answer thereto, it is ORDERED that Mr. Lapinski's objections are OVERRULED as moot1 and his request for a hearing on his objections is DENIED.			
October 13, 2020	Order Granting Application to be Admitted Pro Hac Vice Leavitt, Mary Hannah			10/13/2020
	Document Name: upon consideration of the motion of Stephen G. Harvey, Esquire, for admission Comment: pro hac vice of J. David Leslie, Esquire, on behalf of Intervenor Maine Superintendent of Insurance, Massachusetts Commissioner of Insurance and Washington Insurance Commissioner (collectively, Intervenor), it is hereby ORDERED: (1) Mr. Leslie is admitted pro hac vice to the bar of the Commonwealth of Pennsylvania under Pennsylvania Bar Admission Rule 301, as co-counsel on behalf of Intervenor in this matter; (2) Mr. Leslie shall abide by the rules of this Court including all disciplinary rules; (3) Mr. Leslie shall immediately notify this Court of any matter affecting his standing at the bar of any other court where he may be admitted to practice; and (4) Mr. Harvey, the moving attorney herein, shall continue to be responsible as counsel of record for the conduct of this matter on behalf of Intervenor.			
October 13, 2020	Order Granting Application to be Admitted Pro Hac Vice Leavitt, Mary Hannah			10/13/2020
	Document Name: upon consideration of the motion of Stephen G. Harvey, Esquire, for admission Comment: pro hac vice of Eric A. Smith, Esquire, on behalf of Intervenor Maine Superintendent of Insurance, Massachusetts Commissioner of Insurance and Washington Insurance Commissioner (collectively, Intervenor), it is hereby ORDERED: (1) Mr. Smith is admitted pro hac vice to the bar of the Commonwealth of Pennsylvania under Pennsylvania Bar Admission Rule 301, as co-counsel on behalf of Intervenor in this matter; (2) Mr. Smith shall abide by the rules of this Court including all disciplinary rules; (3) Mr. Smith shall immediately notify this Court of any matter affecting his standing at the bar of any other court where he may be admitted to practice; and (4) Mr. Harvey, the moving attorney herein, shall continue to be responsible as counsel of record for the conduct of this matter on behalf of Intervenor.			

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Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
October 13, 2020	Application for Relief Harvey, Stephen G. Harvey, Stephen G. Harvey, Stephen G.	Maine Superintendent of Insurance Massachusetts Commissioner of Ins Washington Insurance Commissione	Intervenor Intervenor Intervenor	
	Document Name: Intervenor State Insurance Regulators' Application for Order Directing the Rehabilitator to Provide Comment: Information Regarding the Proposed Plan and Extending the Deadline for Submission of Witness Narratives and Exhibits			
October 16, 2020	Answer Filed Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
	Document Name: Rehabilitator's Response to Intervenor State Insurance Regulator's Applicatio for Order Directing Comment: the Rehavitator to Porvide Information Regarding the Proposed Plan and Extending the Deadline for Submission of Witness Narratives and Exhibits			
October 20, 2020	Filed - Other Lapinski, James F.		Intervenor	
	Document Name: Description of Substance of Testimony of J.F. Lapinski Witness...and Exhibits to be Introduced			
October 21, 2020	Notice Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
	Document Name: Notice of Filing of Amended Rehabilitation Plan			
October 21, 2020	Amended Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
	Document Name: Amended Rehabilitation Plan			
October 22, 2020	Application for Relief Lapinski, James F.		Intervenor	
	Document Name: Motion to Strike and Objections to Erroneous Court Order of Hon. Judge M.H. Leavitt			
October 27, 2020	Order Filed Leavitt, Mary Hannah			10/27/2020
	Document Name: the Court ORDERS as follows: Comment: (1) Any party that filed a formal comment in support of or in objection to the proposed Plan of Rehabilitation in accordance with paragraph 8 of the Case Management Order of June 12, 2020, may amend its comment no later than November 30, 2020, to address material issues first raised in the Amended Rehabilitation Plan filed by the Rehabilitator on October 21, 2020. (2) The deadline set forth in paragraph 9 of the Case Management Order for intervenors to file and serve narratives or descriptions of direct witness testimony and exhibits is extended to November 30, 2020.			

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October 27, 2020	Order Denying Application for Relief Leavitt, Mary Hannah			10/27/2020
	Document Name: upon consideration of Intervenor State Insurance Regulators' Application for Order Directing Comment: the Rehabilitator to Provide Information Regarding the Proposed Plan and Extending the Deadline for Submission of Witness Narratives and Exhibits, and in consideration of the Rehabilitator's filing of an Amended Rehabilitation Plan and provision of actuarial data to all interested parties, it is ORDERED that the Application is DENIED. If, after review of the new information provided by the Rehabilitator, Intervenor State Insurance Regulators still require additional information, they may file an appropriate application no later than November 10, 2020.			
November 4, 2020	Application to Strike Lapinski, James F.		Intervenor	
	Document Name: and Objections to Erroneous Court Order of Hon. Judge M.H. Leavitt			
November 4, 2020	Application to Strike Lapinski, James F.		Intervenor	
	Document Name: Motion to Strike Judge M.H. Leavitt's Order of October 13, 2020 and Motions for Discovery and Comment: Motion to Strike SHIP Rehabilitation Plan			
November 9, 2020	Application for Approval Greenspan, Leslie Miller Greenspan, Leslie Miller	Insurance Commissioner of the Com Plaintiff Altman, Jessica K. Plaintiff		
	Document Name: of Senior Health Insurance Company fo Pennsylvania's Recapture Agreement with Transamerica Comment: Life Insurance Company			
November 10, 2020	Application for Relief Harvey, Stephen G. Harvey, Stephen G. Harvey, Stephen G.	Maine Superintendent of Insurance Intervenor Washington Insurance Commissione Intervenor Massachusetts Commissioner of Ins Intervenor		
	Document Name: Intervenor State Insurance Regulators' Renewed Application for Order Directing the Rehabilitator Comment: to Provide Reprots adn Analyses and Extending Time to Address Recently Provided Spreadsheet and Additional Analyses			
November 17, 2020	Order Filed Leavitt, Mary Hannah			11/18/2020
	Document Name: Intervenor James F. Lapinski's Motions to Strike the Court's order of October 13, 2020, Comment: which he filed on October 22, 2020, and November 4, 2020, are Denied			
November 19, 2020	Application for Extension of Time to File Boyd, Richard Blair, IV		Commenter	

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November 24, 2020	Answer Filed Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
	Document Name: Rehabilitator's Response to Intervenor State Insurance Regulators' Renewed Application for an Order			
	Comment: Directing the Rehabilitator to Provide Reports and Analyses and Extending Time to Address Recently Provided Spreadsheet and Additional Analyses			
November 25, 2020	Order Granting Application for Extension of Time to File Leavitt, Mary Hannah			11/25/2020
	Document Name: upon consideration of the application of Richard Blair Boyd IV for an extension of time to			
	Comment: file amended formal comments to address material issues first raised in the Amended Rehabilitation Plan filed by the Rehabilitator on October 21, 2020, it is ORDERED that Mr. Boyd may file his amended comments no later than December 30, 2020.			
November 30, 2020	Filed - Other Hickok, Dorothy Alicia	National Organization of Life and He	Intervenor	
	Document Name: Witness and Exhibit List of Intervenor The National Organization of Life and Health Insurance			
	Comment: Guaranty Associations			
November 30, 2020	Formal Comment Gkonos, James Steven	Primerica Life Insurance Company	Intervenor	
	Document Name: Amended Formal Comment of Primerica Life Insurance Company			
November 30, 2020	Filed - Other Gkonos, James Steven	Primerica Life Insurance Company	Intervenor	
	Document Name: Statement of Primerica Life Insurance Company Regarding Witnesses and Exhibits			
November 30, 2020	Filed - Other Donley, Joseph M. Donley, Joseph M. Donley, Joseph M. Donley, Joseph M. Donley, Joseph M. Donley, Joseph M.	ACSIA Long Term Care, Inc. Global Commission Funding LLC LifeCare Health Insurance Plans, Inc. Senior Commission Funding LLC Senior Health Care Insurance Serv United Insurance Group Agency, Inc	Intervenor Intervenor Intervenor Intervenor Intervenor Intervenor	
	Document Name: Description of Testimony of Witnesses Agent Commenters Intend to Call and Exhibits They Intend			
	Comment: to Introduce at Hearing			
November 30, 2020	Amended Harvey, Stephen G. Harvey, Stephen G. Harvey, Stephen G.	Maine Superintendent of Insurance Massachusetts Commissioner of Ins Washington Insurance Commissione	Intervenor Intervenor Intervenor	
	Document Name: Amendment to the Formal Comments of the Maine Superintendent of Insurance, The Massachusetts			
	Comment: Commissioner of Insurance and the Washington Insurance Commissioner			
November 30, 2020	Amended Hickok, Dorothy Alicia	National Organization of Life and He	Intervenor	
	Document Name: Amended Formal Comments of the National Organization of Life and Health Insurance			
	Comment: Guaranty Association on the Proposed Amended Plan of Rehabilitation			

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Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
November 30, 2020	Filed - Other Harvey, Stephen G. Harvey, Stephen G. Harvey, Stephen G.	Maine Superintendent of Insurance Massachusetts Commissioner of Ins Washington Insurance Commissione	Intervenor Intervenor Intervenor	
	Document Name: Intervenor State Insurance Regulators' Filin Regarding Witnesses and Exhibits			
November 30, 2020	Amended Lavelle, John P., Jr. Lavelle, John P., Jr. Lavelle, John P., Jr. Lavelle, John P., Jr. Lavelle, John P., Jr.	Aetna Life Insurance Company Anthem, Inc. Health Care Service Corporation Horizon Healthcare Services, Inc. d/l UnitedHealthcare Insurance Compar	Intervenor Intervenor Intervenor Intervenor Intervenor	
	Document Name: Amendment to Formal Comment of the Healt Insurers of the Proposed Plan of Rehabilitation for Comment: Senior Health Insurance Company of Pennsylvania			
November 30, 2020	Filed - Other Lavelle, John P., Jr. Lavelle, John P., Jr. Lavelle, John P., Jr. Lavelle, John P., Jr. Lavelle, John P., Jr.	Aetna Life Insurance Company Anthem, Inc. Health Care Service Corporation Horizon Healthcare Services, Inc. d/l UnitedHealthcare Insurance Compar	Intervenor Intervenor Intervenor Intervenor Intervenor	
	Document Name: The Health Insurers Statement Regarding Witness Testimony and Exhibits			
November 30, 2020	Formal Comment Kline, Amy Stovall	Transamerica Life Insurance Compa	Intervenor	
	Document Name: Response of Transamerica Life Insurance Company to Proposed Amended Plan of Rehabilitation and Comment: Notice of Intent Regarding Participation in Hearing.			
November 30, 2020	Amended Insurance Commissioner for the State of Maryland		Commenter	
	Document Name: Amendment to Formal Comments of Kathleen A. Birrane, Insurance Commissioner for the State of Comment: Maryland, In Opposition to the Proposed Amended Plan of Rehabilitation			
December 2, 2020	Order Denying Application for Relief Leavitt, Mary Hannah			12/02/2020
	Document Name: upon consideration of Intervenor State Insurance Regulators' Renewed Application for an order Comment: (1) directing the Rehabilitator to provide, inter alia, all analyses or reports prepared by or for the Rehabilitator or Senior Health Insurance Company of Pennsylvania on benefit reductions or premium increases contemplated by the Rehabilitation Plan, and (2) extending the time to address recently provided actuarial data, it is ORDERED that the Renewed Application is DENIED as overbroad, without prejudice to Intervenor State Insurance Regulators' right to make a more targeted document request.			

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Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
December 3, 2020	Order Granting Application for Intervention Leavitt, Mary Hannah			12/03/2020
	Document Name: upon consideration of the Application for Limited Intervention of Aetna Life Insurance Company, Comment: Anthem, Inc., Health Care Service Corporation, Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey, and United Healthcare Insurance Company (collectively, Health Insurers), and the Statutory Rehabilitator's response thereto, it is hereby ORDERED as follows: 1. The Application is GRANTED. 2. Pursuant to Pennsylvania Rule of Appellate Procedure 3775, Health Insurers are granted limited intervention to participate in (a) the proceedings related to the proposed amended plan of rehabilitation (Plan) of Senior Health Insurance Company of Pennsylvania (in Rehabilitation), including calling or examining witnesses, introducing exhibits at the hearing on the Plan and participating in any discovery permitted by the Court and (b) any subsequent liquidation proceeding on issues of claim priority and asset distribution.			
December 9, 2020	Answer Filed Hickok, Dorothy Alicia	National Organization of Life and He Intervenor		
	Document Name: Response to the Rehabilitator's Application for Approval of Senior Health Insurance Company of Comment: Pennsylvania's Recapture Agreement with Transamerica Life Insurance Company			
December 14, 2020	Praecipe for Withdrawal of Appearance Dugue, Dorothy M. Dugue, Dorothy M.	Altman, Jessica K. Insurance Commissioner of the Com Plaintiff	Plaintiff	
	Document Name: Duge			
December 16, 2020	Praecipe to Withdraw Lavelle, John P., Jr. Lavelle, John P., Jr. Lavelle, John P., Jr. Lavelle, John P., Jr. Lavelle, John P., Jr.	Anthem, Inc. Aetna Life Insurance Company Health Care Service Corporation Horizon Healthcare Services, Inc. d/l UnitedHealthcare Insurance Compar	Intervenor Intervenor Intervenor Intervenor Intervenor	
	Document Name: of Aetna Life Insurance Company as Intervenor			
December 16, 2020	Answer Filed Greenspan, Leslie Miller Greenspan, Leslie Miller	Insurance Commissioner of the Com Plaintiff Altman, Jessica K.	Plaintiff	
	Document Name: Reply in Support of Application for Approval of Senior Health Insurance Company of PA's Recapture Comment: Agreement with Transamerica Life Insurance Company			
December 29, 2020	Order Granting Application for Approval Leavitt, Mary Hannah			12/29/2020
	Document Name: upon consideration of the Application for Approval of Senior Health Insurance Company Comment: of Pennsylvania's (SHIP) Recapture Agreement with Transamerica Life Insurance Company (Transamerica) filed by Jessica K. Altman, as Statutory Rehabilitator of SHIP, and the response thereto filed by the National Organization of Life and Health Insurance Guaranty Associations, it is hereby ORDERED that the Rehabilitator's Application is GRANTED and SHIP is authorized to execute the Recapture Agreement with Transamerica, attached as Exhibit 5 to the Application.			

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Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
December 30, 2020	Sealed Answer Filed Boyd, Richard Blair, IV		Commenter	
	Document Name: Sealed Revised Formal Comments and Concerns			
January 20, 2021	Application for Relief Harvey, Stephen G. Harvey, Stephen G. Harvey, Stephen G.	Maine Superintendent of Insurance Massachusetts Commissioner of Ins Washington Insurance Commissione	Intervenor Intervenor Intervenor	
	Document Name: Intervenor State Insurance Regulators' Application for Order Regarding Rehabilitator's Exhibits and Comment: Witness Testimony			
January 25, 2021	Praeipce Kline, Amy Stovall	Transamerica Life Insurance Compa	Intervenor	
	Document Name: Praeipce for Withdrawl of Transamerica Life Insurance Company as Intervenor			
January 26, 2021	Order Filed Leavitt, Mary Hannah			01/26/2021
	Document Name: in accordance with the Praeipce for Withdrawal of Transamerica Life Insurance Company Comment: as Intervenor, the Prothonotary is directed to mark Transamerica Life Insurance Company as withdrawn from the above-captioned matter.			
January 29, 2021	Application for Approval Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
	Document Name: Application for Approval of a Second Case Management Order			
January 29, 2021	Answer Filed Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
	Document Name: Rehabilitator's Response to Intervenor State Insurance Regulators' Application for Order Regarding Comment: Rehabilitator's Exhibits and Witness Testimony			
February 11, 2021	Order Denying Application for Relief Leavitt, Mary Hannah			02/11/2021
	Document Name: Re: Application for Order Regarding Rehabilitator's Exhibits and Witness Testimony filed 1/20/2021 Comment: AND NOW, this 1 lth day ofFebruary, 2021, Intervenor State Insurance Regulators' Application for Order Regarding Rehabilitator's Exhibits and Witness Testimony is DENIED as premature			

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Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
February 11, 2021	Order Filed Leavitt, Mary Hannah			02/11/2021
	Document Name: Order Denying Application for Approval filed 1/29/2021 Comment: AND NOW, this 11 th day of February, 2021, upon consideration of the Application for Approval of a Second Case Management Order filed by Jessica K. Altman, Rehabilitator of Senior Health Insurance Company of Pennsylvania (SHIP), it is ORDERED that the Application is DENIED as premature. It is further ORDERED that the Court will conduct a pre-hearing conference via WebEx videoconferencing on Wednesday, February 24, 2021, at 10:00 a.m., to discuss the schedule for a hearing on the Amended Rehabilitation Plan, unresolved information requests and all other matters relevant to the hearing. The Rehabilitator shall secure the services of a court reporter. Counsel of record and pro se parties who wish to participate shall provide the Court with their email addresses and telephone numbers immediately upon receipt of this order, unless they have already done so. The contact email address for the Court is: CommCourtRemote@pacourts.us. The Court will provide counsel with the information for connecting to the argument. The parties are directed to connect to the conference 10 minutes before the starting time. Please see the Protocol for WebEx Video Proceedings attached to this order			
February 18, 2021	Application to be Admitted Pro Hac Vice Filed			
	Lavelle, John P., Jr.	Anthem, Inc.	Intervenor	
	Lavelle, John P., Jr.	Health Care Service Corporation	Intervenor	
	Lavelle, John P., Jr.	Horizon Healthcare Services, Inc. d/I	Intervenor	
	Lavelle, John P., Jr.	UnitedHealthcare Insurance Compar	Intervenor	
	Document Name: Harold S. Horwich			
February 18, 2021	Application to be Admitted Pro Hac Vice Filed			
	Lavelle, John P., Jr.	Anthem, Inc.	Intervenor	
	Lavelle, John P., Jr.	Health Care Service Corporation	Intervenor	
	Lavelle, John P., Jr.	Horizon Healthcare Services, Inc. d/I	Intervenor	
	Lavelle, John P., Jr.	UnitedHealthcare Insurance Compar	Intervenor	
	Document Name: Benjamin J. Cordiano			
February 19, 2021	Order Granting Application to be Admitted Pro Hac Vice			02/19/2021
	Leavitt, Mary Hannah			
	Document Name: Benjamin J. Cordiano Comment: AND NOW this 19th day of February, 2021, upon consideration of the motion of John P. Lavelle, Jr., Esq., for admission pro hac vice of Benjamin J. Cordiano, Esq., on behalf of Intervenor Anthem, Inc.; Health Care Service Corporation; Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey; and UnitedHealthcare Insurance Company (collectively, Health Insurers), it is hereby ORDERED: (1) Mr. Cordiano is admitted pro hac vice to the bar of the Commonwealth of Pennsylvania under Pennsylvania Bar Admission Rule 301, as co-counsel on behalf of Health Insurers in this matter; (2) Mr. Cordiano shall abide by the rules of this Court including all disciplinary rules; (3) Mr. Cordiano shall immediately notify this Court of any matter affecting his standing at the bar of any other court where he may be admitted to practice; and (4) Mr. Lavelle, the moving attorney herein, shall continue to be responsible as counsel of record for the conduct of this matter on behalf of Health Insurers.			

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February 19, 2021	Order Granting Application to be Admitted Pro Hac Vice Leavitt, Mary Hannah			02/19/2021
	Document Name: Horwich			
	Comment: AND NOW this 19th day of February, 2021, upon consideration of the motion of John P. Lavelle, Jr., Esq., for admission pro hac vice of Harold S. Horwich, Esq., on behalf of Intervenor Anthem, Inc.; Health Care Service Corporation; Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey; and UnitedHealthcare Insurance Company (collectively, Health Insurers), it is hereby ORDERED: (1) Mr. Horwich is admitted pro hac vice to the bar of the Commonwealth of Pennsylvania under Pennsylvania Bar Admission Rule 301, as co-counsel on behalf of Health Insurers in this matter; (2) Mr. Horwich shall abide by the rules of this Court including all disciplinary rules; (3) Mr. Horwich shall immediately notify this Court of any matter affecting his standing at the bar of any other court where he may be admitted to practice; and (4) Mr. Lavelle, the moving attorney herein, shall continue to be responsible as counsel of record for the conduct of this matter on behalf of Health Insurers.			
February 25, 2021	Order Filed Leavitt, Mary Hannah			02/26/2021
	Document Name: Case Management Order for Hearing on the Amended Rehabilitation Plan			
	Comment: AND NOW, this 25th day of February, 2021, following a pre-hearing conference on the scheduling of the hearing on the Amended Rehabilitation Plan for Senior Health Insurance Company of Pennsylvania (In Rehabilitation), it is ORDERED as follows: (1) All parties shall file pre-hearing memoranda with witness narratives, exhibit lists and copies of exhibits by April 5, 2021. (2) Rebuttal pre-hearing memoranda, including rebuttal witness narratives, exhibit lists and copies of exhibits, shall be filed by April 19, 2021. (3) The Rehabilitator shall file a supplemental pre-hearing memorandum, including any new or responsive witness narratives and a description of new or responsive exhibits by May 3, 2021. (4) The Rehabilitator shall file any proposed amendments to the Amended Rehabilitation Plan, which will include any new data or information not contained in the Rehabilitator's April 15, 2021, pre-hearing recommendation by May 3, 2021. (5) The Court will conduct a final pre-hearing conference via WebEx videoconferencing on May 10, 2021, at 10:00 a.m. The Rehabilitator shall secure the services of a court reporter. Counsel of record and pro se parties who wish to participate shall provide the Court with their email addresses and telephone numbers by May 3, 2021. The contact email address for the Court is: CommCourtRemote@pacourts.us. The Court will provide counsel with the information for connecting to the argument. The parties are directed to connect to the conference 10 minutes before the starting time. Please see the Protocol for WebEx Video Proceedings attached to this order. (6) The hearing on the Amended Rehabilitation Plan will commence on Monday, May 17, 2021, at 10:00 a.m. in Courtroom No. 3002 in the Pennsylvania Judicial Center, 601 Commonwealth Avenue, Harrisburg, Pennsylvania.			

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March 4, 2021	Amended Leavitt, Mary Hannah Document Name: Amendment Order Comment: AND NOW, this 4th day of March, 2021, the Court's scheduling order filed February 25, 2021, is amended as follows: Paragraph 4 should state: The Rehabilitator shall file any proposed amendments to the Amended Rehabilitation Plan by May 3, 2021. In all other respects the order remains the same.			03/04/2021
March 9, 2021	Application for Relief Lapinski, James F. Document Name: Motion for May 18, 19, 2021 Hearing Evidence Before April 6, 2021 to James Lapinsky		Intervenor	
March 24, 2021	Formal Comment Coble, Matthew David Document Name: Supplement to Formal Comments of the Senior Health Care Oversight Trust	Senior Health Care Oversight Trust	Commenter	
March 25, 2021	Filed - Other Lapinski, James F. Document Name: First Supplemental Prehearing Memo and Propsed Amendments to Rehabilitation Plan		Intervenor	
March 31, 2021	Quarterly Report of the Liquidator Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John Document Name: Notice of Filing Quarterly Report	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
March 31, 2021	Quarterly Report of the Liquidator Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
April 2, 2021	Memorandum of Law Filed Hickok, Dorothy Alicia Document Name: Pre Hearing memorandum of Intervenor the National Organization fo Life and Health Ins. Guarnty Assoc	National Organization of Life and He	Intervenor	
April 5, 2021	Notice Gkonos, James Steven Document Name: Notice of Primerica Life Insurance Company Pursuant toe the Court's Order of February 25,2021	Primerica Life Insurance Company	Intervenor	
April 5, 2021	Filed - Other Lapinski, James F. Document Name: Second Supplemental List of Witnesses in Addition to Lapinskis		Intervenor	
April 5, 2021	Memorandum of Law Filed Harvey, Stephen G. Harvey, Stephen G. Harvey, Stephen G. Document Name: State Insurance Regulators' Pre Hearing Memorandum	Maine Superintendent of Insurance Massachusetts Commissioner of Ins Washington Insurance Commissione	Intervenor Intervenor Intervenor	

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April 5, 2021	Filed - Other			
	Harvey, Stephen G.	Maine Superintendent of Insurance	Intervenor	
	Harvey, Stephen G.	Massachusetts Commissioner of Ins	Intervenor	
	Harvey, Stephen G.	Washington Insurance Commissione	Intervenor	
	Document Name: State Insurance Regulators' Witness Narrative			
April 5, 2021	Exhibit			
	Harvey, Stephen G.	Maine Superintendent of Insurance	Intervenor	
	Harvey, Stephen G.	Massachusetts Commissioner of Ins	Intervenor	
	Harvey, Stephen G.	Washington Insurance Commissione	Intervenor	
	Document Name: State Insurance Regulators' Exhibit List and Exhibits			
April 5, 2021	Memorandum of Law Filed			
	Donley, Joseph M.	ACSIA Long Term Care, Inc.	Intervenor	
	Donley, Joseph M.	Global Commission Funding LLC	Intervenor	
	Donley, Joseph M.	LifeCare Health Insurance Plans, Inc.	Intervenor	
	Donley, Joseph M.	Senior Commission Funding LLC	Intervenor	
	Donley, Joseph M.	Senior Health Care Insurance Servic	Intervenor	
	Donley, Joseph M.	United Insurance Group Agency, Inc	Intervenor	
	Document Name: Intervening Agents' and Brokers's Pre Hearing Memorandum on the Amended Rehabilitation Plan...			
April 5, 2021	Exhibit			
	Donley, Joseph M.	ACSIA Long Term Care, Inc.	Intervenor	
	Donley, Joseph M.	Global Commission Funding LLC	Intervenor	
	Donley, Joseph M.	LifeCare Health Insurance Plans, Inc.	Intervenor	
	Donley, Joseph M.	Senior Commission Funding LLC	Intervenor	
	Donley, Joseph M.	Senior Health Care Insurance Servic	Intervenor	
	Donley, Joseph M.	United Insurance Group Agency, Inc	Intervenor	
	Document Name: A to Intervening Agents' and Brokers's Pre Hearing Memorandum			
April 5, 2021	Exhibit			
	Donley, Joseph M.	ACSIA Long Term Care, Inc.	Intervenor	
	Donley, Joseph M.	Global Commission Funding LLC	Intervenor	
	Donley, Joseph M.	LifeCare Health Insurance Plans, Inc.	Intervenor	
	Donley, Joseph M.	Senior Commission Funding LLC	Intervenor	
	Donley, Joseph M.	Senior Health Care Insurance Servic	Intervenor	
	Donley, Joseph M.	United Insurance Group Agency, Inc	Intervenor	
	Document Name: B to Intervening Agents' and Brokers's Pre Hearing Memorandum			
April 5, 2021	Exhibit			
	Donley, Joseph M.	ACSIA Long Term Care, Inc.	Intervenor	
	Donley, Joseph M.	Global Commission Funding LLC	Intervenor	
	Donley, Joseph M.	LifeCare Health Insurance Plans, Inc.	Intervenor	
	Donley, Joseph M.	Senior Commission Funding LLC	Intervenor	
	Donley, Joseph M.	Senior Health Care Insurance Servic	Intervenor	
	Donley, Joseph M.	United Insurance Group Agency, Inc	Intervenor	
	Document Name: C to Intervening Agents' and Brokers's Pre Hearing Memorandum			

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April 5, 2021	Exhibit			
	Donley, Joseph M.	ACSIA Long Term Care, Inc.	Intervenor	
	Donley, Joseph M.	Global Commission Funding LLC	Intervenor	
	Donley, Joseph M.	LifeCare Health Insurance Plans, Inc.	Intervenor	
	Donley, Joseph M.	Senior Commission Funding LLC	Intervenor	
	Donley, Joseph M.	Senior Health Care Insurance Service	Intervenor	
	Donley, Joseph M.	United Insurance Group Agency, Inc	Intervenor	
	Document Name: D to Intervening Agents' and Brokers's Pre Hearing Memorandum			
April 5, 2021	Exhibit			
	Donley, Joseph M.	ACSIA Long Term Care, Inc.	Intervenor	
	Donley, Joseph M.	Global Commission Funding LLC	Intervenor	
	Donley, Joseph M.	LifeCare Health Insurance Plans, Inc.	Intervenor	
	Donley, Joseph M.	Senior Commission Funding LLC	Intervenor	
	Donley, Joseph M.	Senior Health Care Insurance Service	Intervenor	
	Donley, Joseph M.	United Insurance Group Agency, Inc	Intervenor	
	Document Name: E to Intervening Agents' and Brokers's Pre Hearing Memorandum			
April 5, 2021	Memorandum of Law Filed			
	Lavelle, John P., Jr.	Anthem, Inc.	Intervenor	
	Lavelle, John P., Jr.	Health Care Service Corporation	Intervenor	
	Lavelle, John P., Jr.	Horizon Healthcare Services, Inc. d/l	Intervenor	
	Lavelle, John P., Jr.	UnitedHealthcare Insurance Compar	Intervenor	
	Document Name: Pre Hearing Memorandum of the Health Insurers Regarding the Proposed Plan of Rehabilitation...			
April 5, 2021	Memorandum of Law Filed			
	Broadbent, Michael John	Insurance Commissioner of the Com	Plaintiff	
	Broadbent, Michael John	Altman, Jessica K.	Plaintiff	
	Broadbent, Michael John	Senior Health Insurance Company o	Defendant	
	Document Name: Rehabilitator's Pre Hearing Memorandum			
April 6, 2021	Filed - Other			
	Lapinski, James F.		Intervenor	
	Document Name: Second Supplemental Documents for May 10, 17 18 Hearings from Intervenor James Lapinski and			
	Comment: Motion to Deny SHIP Rehabilitation			
April 6, 2021	Memorandum of Law Filed			
	Lapinski, James F.		Intervenor	
	Document Name: Pre Hearing Memorandum: Witnesses; Exhibits; Motions for Facts; Recovery of Assets; Illegal Policy			
	Comment: Restructuring; ect.			
April 6, 2021	Amended			
	Lapinski, James F.		Intervenor	
	Document Name: Second Supplemental List of Witnesses in Addition to Lapinskis			

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April 8, 2021	Hearing Rescheduled Leavitt, Mary Hannah			04/09/2021
	Document Name: Pre Hearing is Rescheduled to May 13, 2021, at 10:00 am Comment: AND NOW this 8th day of April, 2021, the final pre-hearing conference scheduled for May 10, 2021 at 10:00 a.m. is rescheduled to May 13, 2021, at 10:00 a.m., and will be conducted via WebEx videoconferencing. The Rehabilitator shall secure the services of a court reporter. Counsel of record and pro se parties who wish to participate shall provide the Court with their email addresses and telephone numbers by May 6, 2021. The contact email address for the Court is: CommCourtRemote@pacourts.us. The Court will provide counsel with the information for connecting to the argument. The parties are directed to connect to the conference 10 minutes before the starting time. Please see the Protocol for WebEx Video Proceedings attached to this order. s/Mary Hannah Leavitt			
April 19, 2021	Memorandum of Law Filed Harvey, Stephen G. Harvey, Stephen G. Harvey, Stephen G.	Maine Superintendent of Insurance Massachusetts Commissioner of Ins Washington Insurance Commissione	Intervenor Intervenor Intervenor	
	Document Name: State Insurance Rebutal Pre Hearing Memorandum			
April 19, 2021	Praeipue Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
	Document Name: to Substitute Annual Report			
April 19, 2021	Memorandum of Law Filed Donley, Joseph M. Donley, Joseph M. Donley, Joseph M. Donley, Joseph M. Donley, Joseph M. Donley, Joseph M.	ACSIA Long Term Care, Inc. Global Commission Funding LLC LifeCare Health Insurance Plans, Inc. Senior Commission Funding LLC Senior Health Care Insurance Servic United Insurance Group Agency, Inc	Intervenor Intervenor Intervenor Intervenor Intervenor Intervenor	
	Document Name: Intervening Agents' and Brokers' Rebuttal Pre Hearing Memorandum on the Amended Rehabilitation Plan...			
April 19, 2021	Memorandum of Law Filed Lavelle, John P., Jr. Lavelle, John P., Jr. Lavelle, John P., Jr. Lavelle, John P., Jr.	Anthem, Inc. Health Care Service Corporation Horizon Healthcare Services, Inc. d/l UnitedHealthcare Insurance Compar	Intervenor Intervenor Intervenor Intervenor	
	Document Name: Rebuttal Pre Hearing Memorandum of the Health Insurers			
April 19, 2021	Memorandum of Law Filed Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
	Document Name: Rehabilitator's Pre Hearing Rebuttal Memorandum			

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April 20, 2021	Memorandum of Law Filed Lapinski, James F.		Intervenor	
	Document Name: Rebuttal Memoranda for Pre-Hearing by Policy Holders & Intervenor Lapinskis			
April 28, 2021	Application for Relief Broadbent, Michael John	Insurance Commissioner of the Com Plaintiff		
	Broadbent, Michael John	Altman, Jessica K.	Plaintiff	
	Broadbent, Michael John	Senior Health Insurance Company of Defendant		
	Document Name: Application for Injunction and Stay Order			
April 30, 2021	Order Granting Application for Relief Leavitt, Mary Hannah			04/30/2021
	Document Name: Stay of court actions, arbitrations and mediations Granted to October 27, 2021			
	Comment: AND NOW, this 30th day of April, 2021, upon consideration of the Application for Injunction and Stay Order (Application) filed by the Statutory Rehabilitator of Senior Health Insurance Company of Pennsylvania (In Rehabilitation) (SHIP), it is hereby ORDERED as follows:			
	1. The Application is GRANTED.			
	2. The stay set forth in paragraph 12 of this Court's rehabilitation order dated January 29, 2021, is hereby extended for 180 days from the effective date of this Order. Except for the matter of Anthony v. Senior Health Insurance Company of Pennsylvania identified in paragraph 8a of the Application, all court actions, arbitrations and mediations currently or hereafter pending against SHIP in the Commonwealth of Pennsylvania are stayed until October 27, 2021.			
	3. The Rehabilitator is directed to review all litigation pending outside the courts of the Commonwealth of Pennsylvania and petition these courts or tribunals for an additional 180-day stay of litigation or until October 27, 2021, where necessary to protect the estate of SHIP.			
May 3, 2021	Notice Broadbent, Michael John	Insurance Commissioner of the Com Plaintiff		
	Broadbent, Michael John	Altman, Jessica K.	Plaintiff	
	Broadbent, Michael John	Senior Health Insurance Company of Defendant		
	Document Name: Notice of Filing of Second Rehabilitation Plan / Second Rehabilitation Plan			
May 3, 2021	Filed - Other Broadbent, Michael John	Insurance Commissioner of the Com Plaintiff		
	Broadbent, Michael John	Altman, Jessica K.	Plaintiff	
	Broadbent, Michael John	Senior Health Insurance Company of Defendant		
	Document Name: Rehabilitator's Pre Hearing Supplemental Filing			
May 10, 2021	Answer Filed Boyd, Richard Blair, IV		Commenter	
	Document Name: Response to Revised Rehabilitation Plan			

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May 11, 2021	Application for Relief Lavelle, John P., Jr. Lavelle, John P., Jr. Lavelle, John P., Jr. Lavelle, John P., Jr.	Anthem, Inc. Health Care Service Corporation Horizon Healthcare Services, Inc. d/l UnitedHealthcare Insurance Compar	Intervenor Intervenor Intervenor Intervenor	
	Document Name: The Health Insurers' Application for Relief from Scheduling Order			
May 12, 2021	Order Granting Application for Relief Leavitt, Mary Hannah			05/12/2021
	Document Name: Permission to use the Policy Documents attached to Application at Hearing			
	Comment: AND NOW, this 12th day of May, 2021, upon consideration of the Application for Relief from Scheduling Order (Application) filed by intervenors Anthem, Inc., Health Care Service Corporation, Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey, and UnitedHealthcare Insurance Company (collectively, Health Insurers), which the Statutory Rehabilitator does not oppose, it is hereby ORDERED as follows: 1. The Application is GRANTED. 2. The Health Insurers are permitted to use the Policy Documents attached to the Application at the hearing on the Second Amended Rehabilitation Plan.			
May 12, 2021	Application for Relief Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John	Insurance Commissioner of the Com Altman, Jessica K. Senior Health Insurance Company o	Plaintiff Plaintiff Defendant	
	Document Name: Rehabilitator's Application for Order Establishing Supplemental Remote Access to the Hearing on the			
	Comment: Second Amended Rehabilitation Plan for SHIP			

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Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
May 13, 2021	Order Filed Per Curiam			05/14/2021
	Document Name: Decorum Order			
	Comment: NOW, this 13th day of May, 2021, after consultation with the Capitol Police and the Administrative Office of Pennsylvania Courts (AOPC) regarding the hearing that is scheduled for May 17, 2021, at 10:00 a.m., in Courtroom 3002 (the courtroom) of the Pennsylvania Judicial Center (PJC), and to reduce the risk of transmission of the COVID-19 virus, the Court ORDERS as follows: 1. Access to the courtroom will be limited to counsel of record; their clients, witnesses and observers registered with the Court; and Court personnel. The seating capacity of the courtroom is limited to 26 persons and will comport with relevant guidelines on social distancing. 2. The hearing will be broadcast in real time to Courtroom 5001 on the Fifth Floor of the PJC (observation room). Seating in the observation room will be on a "first come, first seated" basis, and will comport with relevant guidelines on social distancing. 3. Decorum will be maintained at all times by all persons present in the courtroom and in the observation room. Signs are not permitted inside the PJC. 4. No electronic devices may be used in the courtroom except by the Court and by counsel of record. Except for those electronic devices used by the Court and counsel of record, no electronic devices will be allowed in the courtroom or the observation room, with the exception of cellular or smart phones and watches. Cellular or smart phones and watches may be taken into the courtroom and observation rooms, but they must be turned off at all times. 5. All persons participating in or observing the hearing in the PJC shall adhere to the posted COVID-19 precautions and procedures, including, but not limited to, the wearing of face masks and social distancing. 6. No person who (i) has returned from international travel or travel to a state listed on the Department of Health's travel guidance list in the last 14 days, (ii) demonstrates symptoms of respiratory illness or fever, or (iii) has had contact with a person who has been diagnosed with, or is under investigation for, COVID-19 may attend as counsel, a party, witness, credentialed member of the media, or public observer. 7. Courtroom Protocols a. The courtroom will be unlocked and available for counsel of record and other authorized persons approximately 30 minutes before the opening of court. Counsel who require earlier access to set up electronic equipment must make prior arrangements with the Court. b. Counsel of record must wear a face mask at all times except when directly addressing the Court. c. Counsel of record shall address the Court and examine witnesses from their places at the counsel tables. 8. All participants and observers must exit the PJC promptly and in a manner that provides for social distancing following the conclusion of the proceedings. 9. Persons who fail to comply with this Order or maintain proper decorum will be removed by Court personnel or the Capitol Police.			
May 17, 2021	Sealed Formal Comment [REDACTED]		Commenter	

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Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
May 19, 2021	Filed - Other Lapinski, James F.		Intervenor	
	Document Name: Hearing Documents & Testimony & Formal Connemts Objecting to the Proposed Plan of Rehabilitation Comment: And Motion for Classaction by Policyholders			
May 19, 2021	Application for Relief Lapinski, James F.		Intervenor	
	Document Name: Updated Discovery Motion by Lapinskis for May 17, 18, 2021 SHP Rehab Hearing			
May 21, 2021	Filed - Other Lapinski, James F.		Intervenor	
	Document Name: Opening Argument / Application for Relief			
May 24, 2021	Order Filed Leavitt, Mary Hannah			05/24/2021
	Document Name: Post-Hearing Memoranda Schedule Comment: AND NOW this 24th day of May, 2021, the Court ORDERS as follows: 1. Post-hearing memoranda, with proposed findings of fact, conclusions of law, and a recommendation to approve, disapprove or modify the Second Amended Rehabilitation Plan, shall be filed on or before June 14, 2021. 2. Post-hearing memoranda shall include a proposed order on the Second Amended Rehabilitation Plan. Proposed modifications, if any, shall be presented in precise terms, i.e., with reference to the relevant page, paragraph and line of the Second Amended Rehabilitation Plan. 3. Responsive memoranda shall be filed on or before June 28, 2021.			
June 1, 2021	Application for Reconsideration/Reargument Harvey, Stephen G. Harvey, Stephen G. Harvey, Stephen G.	Maine Superintendent of Insurance Massachusetts Commissioner of Ins Washington Insurance Commissione	Intervenor Intervenor Intervenor	
	Document Name: Intervenor State Insurance Regulators' Application to Reconsider Order Granting Rehabilitator's Oral Comment: Motion Regarding Issue State Rate Approval Option			
June 2, 2021	Application for Relief Lapinski, James F.		Intervenor	
	Document Name: Motions to Order Legal Discovery From SHIP Rehabilitator, Special Deputy Rehabilitator Comment: Patrick Cantillo, Magma Legal Services, Veritext			

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Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
June 4, 2021	Order Denying Application for Relief Leavitt, Mary Hannah			06/04/2021
	Document Name: Re: Motion to Order Legal Discovery Comment: AND NOW this 4th day of June, 2021, upon consideration of Intervenor James Lapinski's Motion to Order Legal Discovery from the Statutory Rehabilitator and the Special Deputy Rehabilitator, it is ORDERED that the Motion is DENIED. Any party seeking a copy of the transcript of the hearing on the Second Amended Plan of Rehabilitation conducted by the Court from May 17 to May 21, 2021, must contact the court reporting services, Magna Legal Services and Veritext. The Second Amended Plan of Rehabilitation and other important documents are publicly available in the Liquidation and Rehab section of the Pennsylvania Insurance Department's website, www.insurance.pa.gov. Any questions regarding the 2020 balance sheet of Senior Health Insurance Company of Pennsylvania (In Rehabilitation) should be directed to the Statutory Rehabilitator.			
June 4, 2021	Order Filed Leavitt, Mary Hannah			06/04/2021
	Document Name: Re: Responding to Application for Reconsideration Comment: AND NOW this 4th day of June, 2021, upon consideration of the Intervenor State Insurance Regulators' Application to Reconsider Order Granting Rehabilitator's Oral Motion Regarding Issue State Rate Approval Option, it is ORDERED that any party may respond to the Application separately or in a post-hearing memoranda submitted pursuant to the Court's order entered May 24, 2021.			
June 10, 2021	Sealed Formal Comment [REDACTED]		Commenter	
June 11, 2021	Application for Relief Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
	Document Name: Joint Application for Relief From Scheduling Order			

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Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
June 11, 2021	Order Filed Leavitt, Mary Hannah			06/11/2021
	Document Name: Deadlines for Post Hearing Memoranda and Responsive Memoranda Continued until future Order of Court			
	Comment: AND NOW, this 11 th day of June, 2021, upon consideration of the Joint Application for Relief from Scheduling Order filed by Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as the Statutory Rehabilitator of Senior Health Insurance Company of Pennsylvania (SHIP), and Intervenor ACSIA Long Term Care, Inc.; Global Commission Funding LLC; LifeCare Health Insurance Plans, Inc.; Senior Commission Funding LLC; Senior Health Care Insurance Services, Ltd., LLP; and United Insurance Group Agency, Inc. (collectively, Intervening Agents and Brokers), the Court ORDERS as follows:			
	1. The deadline for post-hearing memoranda set forth in the Court's May 24, 2021, Scheduling Order is hereby CONTINUED with respect to Section VI.N of the Second Amended Rehabilitation Plan until such time as the Court shall order.			
	2. The deadline for responsive memoranda is hereby CONTINUED with respect to Section VI.N of the Second Amended Rehabilitation Plan until such time as the Court shall order.			
	3. All other deadlines in the Court's May 24, 2021, Scheduling Order shall remain in place.			
June 14, 2021	Memorandum of Law Filed Lapinski, James F.		Intervenor	
	Document Name: Post-Hearing Memoranda from Lapinskis			
June 14, 2021	Memorandum of Law Filed Lapinski, James F.		Intervenor	
	Document Name: Amended Post-Hearing Memoranda from Lapinskis			
June 14, 2021	Memorandum of Law Filed Harvey, Stephen G. Harvey, Stephen G. Harvey, Stephen G. Leslie, J. David Leslie, J. David Smith, Eric A. Smith, Eric A.	Maine Superintendent of Insurance Massachusetts Commissioner of Ins Washington Insurance Commissione Maine Superintendent of Insurance Massachusetts Commissioner of Ins Maine Superintendent of Insurance Massachusetts Commissioner of Ins	Intervenor Intervenor Intervenor Intervenor Intervenor Intervenor Intervenor	
	Document Name: State Insurance Regulators' Post-Hearing Memorandum			
June 14, 2021	Memorandum of Law Filed Hickok, Dorothy Alicia Glawe, Caryn M. Wilson, Jane Dall	National Organization of Life and He National Organization of Life and He National Organization of Life and He	Intervenor Intervenor Intervenor	
	Document Name: Post-Hearing Memorandum of Intervenor The National Organization of Life and Health Insurance			
	Comment: Guaranty Associations (Including Proposed Findings of Fact and Conclusions of Law)			

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Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
June 14, 2021	Memorandum of Law Filed			
	Broadbent, Michael John	Insurance Commissioner of the Com	Plaintiff	
	Broadbent, Michael John	Altman, Jessica K.	Plaintiff	
	Broadbent, Michael John	Senoir Health Insurance Company o	Defendant	
	Greenspan, Leslie Miller	Altman, Jessica K.	Plaintiff	
	Hamilton, Dexter Ryan	Altman, Jessica K.	Plaintiff	
	Greenspan, Leslie Miller	Insurance Commissioner of the Com	Plaintiff	
	Hamilton, Dexter Ryan	Insurance Commissioner of the Com	Plaintiff	
	Kaldis, Haryle	Insurance Commissioner of the Com	Plaintiff	
	Document Name: Rehabilitator's Opposition to the Intervenor State Insurance Regulators' Application to Reconsider			
	Comment: Order Granting Rehabilitator's Oral Motion Regarding the Issue State Rate Approval Option			
June 14, 2021	Memorandum of Law Filed			
	Lavelle, John P., Jr.	Anthem, Inc.	Intervenor	
	Lavelle, John P., Jr.	Health Care Service Corporation	Intervenor	
	Lavelle, John P., Jr.	Horizon Healthcare Services, Inc. d/I	Intervenor	
	Lavelle, John P., Jr.	UnitedHealthcare Insurance Compar	Intervenor	
	Cordiano, Benjamin J.	Anthem, Inc.	Intervenor	
	Cordiano, Benjamin J.	Health Care Service Corporation	Intervenor	
	Cordiano, Benjamin J.	UnitedHealthcare Insurance Compar	Intervenor	
	Cordiano, Benjamin J.	Horizon Healthcare Services, Inc. d/I	Intervenor	
	Horwich, Harold S.	Anthem, Inc.	Intervenor	
	Horwich, Harold S.	Health Care Service Corporation	Intervenor	
	Horwich, Harold S.	UnitedHealthcare Insurance Compar	Intervenor	
	Horwich, Harold S.	Horizon Healthcare Services, Inc. d/I	Intervenor	
	Document Name: Post-Hearing Memorandum of the Health Insurers Regarding the Second Amended Plan of			
	Comment: Rehabilitation of Senior Health Insurance Company of Pennsylvania			
June 14, 2021	Memorandum of Law Filed			
	Broadbent, Michael John	Insurance Commissioner of the Com	Plaintiff	
	Broadbent, Michael John	Altman, Jessica K.	Plaintiff	
	Broadbent, Michael John	Senoir Health Insurance Company o	Defendant	
	Hamilton, Dexter Ryan	Insurance Commissioner of the Com	Plaintiff	
	Kaldis, Haryle	Insurance Commissioner of the Com	Plaintiff	
	Hamilton, Dexter Ryan	Senoir Health Insurance Company o	Defendant	
	Greenspan, Leslie Miller	Altman, Jessica K.	Plaintiff	
	Greenspan, Leslie Miller	Insurance Commissioner of the Com	Plaintiff	
	Document Name: Rehabilitator's Post-Hearing Submission Seeking Approval of the Second Amended Plan of			
	Comment: Rehabilitation			
June 24, 2021	Answer Filed			
	Lapinski, James F.		Intervenor	
	Document Name: Rebuttal Testimony of Lapinskis to Post Hearing SHIP Memoranda of Intervenor			

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DOCKET ENTRY

Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
June 28, 2021	Memorandum of Law Filed Harvey, Stephen G. Harvey, Stephen G. Harvey, Stephen G.	Maine Superintendent of Insurance Massachusetts Commissioner of Ins Washington Insurance Commissione	Intervenor Intervenor Intervenor	
	Document Name: Rebuttal Post-Hearing Memorandum			
June 28, 2021	Memorandum of Law Filed Hickok, Dorothy Alicia	National Organization of Life and He	Intervenor	
	Document Name: Response to Post-Hearing Filings of All Parties			
June 28, 2021	Memorandum of Law Filed Lavelle, John P., Jr. Lavelle, John P., Jr. Lavelle, John P., Jr. Lavelle, John P., Jr.	Anthem, Inc. Health Care Service Corporation Horizon Healthcare Services, Inc. d/l UnitedHealthcare Insurance Compar	Intervenor Intervenor Intervenor Intervenor	
	Document Name: Post-Hearing Response Regarding the Second Amended Plan of Rehabilitation of Senior Health Ins. Co.			
June 29, 2021	Memorandum of Law Filed Broadbent, Michael John Broadbent, Michael John Broadbent, Michael John	Insurance Commissioner of the Com Altman, Jessica K. Senoir Health Insurance Company o	Plaintiff Plaintiff Defendant	
	Document Name: BRIEF: In Response to the Post-Hearing Submissions of Certain Intervenors			
June 29, 2021	Transcript Filed Court Reporter			
	Document Name: May 21, 2021, Day Five/ Afternoon Session pgs 976-1003			
June 30, 2021	Amended Lapinski, James F.		Intervenor	
	Document Name: Amended Second Rebuttal Testimony of Lapinskis to Post Hearing Memoranda of Intervenors			
July 6, 2021	Amended Lapinski, James F.		Intervenor	
	Document Name: Amended Second Rebuttle of Testimony of Lapinskis			
July 6, 2021	Transcript Filed Court Reporter			
	Document Name: Pre Hearing Conference February 24, 2021			
July 6, 2021	Transcript Filed Court Reporter			
	Document Name: Pre Hearing Conference May 13, 2021			
July 6, 2021	Transcript Filed Court Reporter			
	Document Name: Proceedings held May 13, 17-21 2021			

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Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
July 21, 2021	Application for Approval of Settlement Agreement			
	Broadbent, Michael John	Insurance Commissioner of the Com	Plaintiff	
	Broadbent, Michael John	Altman, Jessica K.	Plaintiff	
	Broadbent, Michael John	Senoir Health Insurance Company o	Defendant	
	Document Name: Joint Application for Approval of Settlement Agreement			
July 26, 2021	Sealed Formal Comment			
	[REDACTED]		Commenter	
	Document Name: [REDACTED]			
August 2, 2021	Application to Strike			
	Lapinski, James F.		Intervenor	
	Document Name: Intervenor, Agen & Broker, J. Lapinski's Motion to Strike Joint Application for Approval of Settlemt			
August 10, 2021	Filed - Other			
	Hickok, Dorothy Alicia	National Organization of Life and He	Intervenor	
	Document Name: Objections to Errors in the Transcript of Proceedings			

REARGUMENT / RECONSIDERATION / REMITTAL

Filed Date: June 1, 2021
Disposition:
Disposition Date:
Record Remittal:

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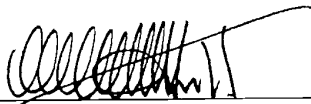
EXHIBIT F

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

IN RE: Senior Health Insurance :
Company of Pennsylvania :
In Rehabilitation : No. 1 SHP 2020

ORDER

AND NOW this 18th day of September, 2020, upon consideration of the Joinder of the Washington Insurance Commissioner in the Joint Application for Intervention of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance and Application to Intervene, which the Rehabilitator does not oppose, it is ORDERED that the Washington Insurance Commissioner is permitted to join with the intervention of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance in the above-captioned proceeding.



MARY HANNAH LEAVITT, President Judge

Certified from the Record

SEP 18 2020

And Order Exit

EXHIBIT G



South Carolina Department of Insurance
1201 Main Street, Suite 1000
Columbia, SC 29201

Mailing Address
P.O. Box 100105
Columbia, SC 29202

September 15, 2020

TRANSMITTED BY ELECTRONIC MAIL TO:
plan.comments@shipltc.com

The Honorable Jessica K. Altman
Insurance Commissioner
Pennsylvania Insurance Department
& Rehabilitator for SHIP, In
Rehabilitation
1311 Strawberry Square
Harrisburg, PA 17120

Patrick Cantilo, Esquire
Special Deputy Rehabilitator
SHIP, In Rehabilitation
550 Congressional Blvd., Suite 200
Carmel, IN 46032

RE: *Comments Opposing the Application for Approval of the Plan of Rehabilitation for Senior Health Insurance Company of Pennsylvania, In Rehabilitation*

Dear Commissioner Altman and Special Deputy Rehabilitator Cantilo:

The South Carolina Department of Insurance submits these comments opposing the approval of the current Plan of Rehabilitation for Senior Health Insurance Company of Pennsylvania, In Rehabilitation ("SHIP"), filed with the Court on or about April 22, 2020 ("Plan of Rehabilitation" or "Plan"). These comments are submitted pursuant to the Case Management Order issued by the Commonwealth Court of Pennsylvania (Commonwealth Court).

The South Carolina Department of Insurance is neither a creditor, policyholder nor certificate holder. It has not intervened, and does not intend to intervene or participate, in this action and is not a party. By submitting these comments, the Department neither consents nor submits to the jurisdiction of the courts of Pennsylvania.

As regulator of the South Carolina insurance industry, the Department provides these comments for the information of the Court (which is copied on the correspondence), the benefit of the Rehabilitator and the protection of South Carolina policyholders. The Department understands the complexity of the task before the Pennsylvania Department and appreciates the effort that has gone into the development of this Rehabilitation Plan. After reviewing the proposed plan, this Department has concluded that it cannot support the Plan in its current form because:

- 1) the proposed Plan of Rehabilitation constitutes an abuse of the Rehabilitator's discretion; violates the insurance laws of the states of South Carolina, Pennsylvania, and other states; and appears to usurp the authority conferred by the South Carolina Constitution and South Carolina General Assembly to the Director of Insurance to protect the insurance-buying public of this state;
- 2) the implementation strategy for the proposed Plan of Rehabilitation makes continued attempts to rehabilitate the insurer futile and wastes the limited assets of the insurer; and
- 3) the plan is overly complex and does not appear to be fair and equitable to all South Carolina policyholders.

I. THE PROPOSED PLAN OF REHABILITATION CONSTITUTES AN ABUSE OF THE REHABILITATOR'S DISCRETION.

The proposed Plan of Rehabilitation is to be accomplished in three distinct phases. Phase I proposes to eliminate the insurer's financial deficit through rate increases and policy modifications. In Phase I, policyholders have four options:

Option 1 allows policyholders to keep their premium and reduce benefits if the premium they are currently paying is below the If-Knew level. Under Option 1, benefits will be reduced by the insurer. Policyholders who choose this option will be subject to additional rate increases and policy modifications in Phase II.

Option 2 requires policyholders to agree to an endorsement created by the Rehabilitator. Policyholders will have a standard and enhanced benefit endorsement option from which to choose. Policyholders who choose this option are not supposed to receive additional policy modifications or rate increases in Phase II. However, there are exceptions to this general principle.

Option 3 is the nonforfeiture option. Policyholders are asked to elect a reduced, paid up nonforfeiture option that reduces the maximum benefit period. Policyholders who elect this option should not receive additional rate increases or policy modifications.

Option 4 allows policyholders to keep their existing benefits by significantly increasing their premiums to the If-Knew premium level. Policyholders selecting this option will be subject to additional rate increases and policy modifications in Phase II.

The Rehabilitator will choose the benefit option for any policyholder who fails to make a choice. The Rehabilitator does not plan to submit the policy modifications or rate increases to the states for review or approval prior to implementation, as required by most state laws, after approval of the Plan by the Court. Moreover, the Rehabilitator believes that approval of the proposed Plan gives her the authority to modify insurance contracts and rates in other states without seeking the requisite regulatory approval.

Phase II involves the imposition of additional rate increases and policy modifications. Policyholders who did not receive rate increases in Phase I may be subject to additional rate increases in Phase II. Phase III involves increasing insurance premiums to self-sustaining rates and will be focused on completing the run-off of the LTC business in force.

According to the proposed Plan of Rehabilitation, the Rehabilitator intends to impose rate increases and policy modifications for use nationwide through approval of the Plan of Rehabilitation by the Commonwealth Court in Pennsylvania ("Commonwealth Court"), bypassing individual state regulatory approvals even though long term care (LTC) insurers are required to comply with all rate approval statutes and regulations in most, if not all, states in which they do business. Similarly, the Rehabilitator also proposes to unilaterally and substantially reduce benefits nationwide without individual state regulatory approval, again through the Commonwealth Court. The Rehabilitator abuses her discretion by proposing a plan predicated upon authority she does not possess and that has not been specifically conferred upon her by law.

A. The Plan of Rehabilitation constitutes an abuse of discretion because the Plan unilaterally proposes to increase insurance rates and substantially modify policy forms contrary to the laws of Pennsylvania and South Carolina.

The Insurance Department Act, Section 40 P.S. 221.14 of the Pennsylvania statutes, governs the rehabilitation of SHIP. Pennsylvania law provides the Commissioner may exercise only those powers conferred by the legislature in clear and unmistakable language. See *Foster v. Mutual Fire, Marine and Inland Ins. Co.*, 531 Pa. 598, 614 A.2d 1086 (1992); *Koken v. Fidelity Mut. Life Ins. Co.*, 803 A.2d 807 (Pa. Commw. Ct. 2002); see also 15 Standard Pennsylvania Practice 2d § 84:88. Neither Pennsylvania statutory law nor its common law gives the Rehabilitator the authority to unilaterally set rates or to substantially modify insurance policy forms in the various states without first seeking the requisite regulatory approval from each state. While the Rehabilitator, in her role solely as Commissioner for the State of Pennsylvania, may exercise that regulatory authority in Pennsylvania, her authority to change rates ceases at the Pennsylvania state line. Pennsylvania laws do not give the Rehabilitator authority to unilaterally increase insurance rates of policyholders or to *substantially* modify their policy forms without the approval of the various state insurance directors and commissioners.

By law, the Rehabilitator stands in the shoes of management of the insurer and has no more authority than that conferred upon company management. The Rehabilitator only has that authority that has been conferred upon her by Pennsylvania statute. See Pa. Stat. 40 P.S. § 221.16. The management of an insurer cannot unilaterally set insurance rates or modify the insurance contracts of its policyholders without seeking the requisite regulatory approval from each state in which the insurer transacts business. Likewise, I am unable to find any statute or case in which the rehabilitator of an insolvent insurer has been conferred the authority to unilaterally increase rates or *substantially* modify policy forms without regulatory approval.

B. The proposed Plan appears to be an unconstitutional attempt to usurp the authority that has been conferred upon the Director of Insurance for the State of South Carolina to regulate the rates and service of insurers in this state.

Under the state-based system of insurance regulation, it is the legislature of each state that establishes policy for the regulation of insurance by enacting appropriate legislation. Only the legislature may delegate its police power (*i.e.*, regulatory and enforcement authority) to its state insurance regulator, and it alone writes the insurance laws it charges the regulator with administering and enforcing within its state.

State-based regulation of insurance works because each state's regulatory mechanism is accessible and accountable to the public and sensitive to local and economic conditions. The very essence of insurance regulation is consumer protection. State regulation has proven that it effectively protects consumers and ensures that promises made by insurers are kept. The review and approval of policy forms and rates is the exercise of the police power of the state because it protects those affected by the transactions of the insurance industry.

The South Carolina General Assembly established the state's regulatory policy through the South Carolina Insurance law, see S.C. Code Ann. Section 38-1-10 *et seq* (2015), and established the Department of Insurance and the Office of the Director to enforce that law. See S.C. Code Ann. § 38-3-10 (2015). The primary duty assigned to the Director of Insurance by the South Carolina General Assembly is to "supervise and regulate the rates and service of every insurer in this state and fix just and reasonable standards, classifications, regulations, practices and measurements of service to be observed and followed by every insurer doing business in this state." See S.C. Code Ann. § 38-3-110(1) (2015).

The proposed Plan to unilaterally impose rate increases and contract modifications seeks not only to usurp the regulatory authority of the democratically-elected General Assembly of the State of South Carolina, but also to co-opt the Director of Insurance into participating in this assault on the rule of law by asking him to defy the command of the South Carolina legislature to set service standards and to regulate insurance rates and policy forms. To support the proposed Plan of Rehabilitation in its current form would cause the Director to violate his oath to exercise the duties of his office to the best of his ability and to preserve, protect and defend the Constitution of the State of South Carolina and of the United States.

In South Carolina, no person other than the Director or his designee has the authority to exercise the regulatory authority conferred upon him by the state legislature except as specified by applicable South Carolina law. South Carolina law requires approval for policy forms and rates and precludes *insurers* from changing benefits or rates without regulatory approval. *See, e.g.*, S.C. Code Ann. Section 38-72-75 (2015); S.C. Code Ann. Section 38-61-20 (2015). Moreover, the Director of Insurance is precluded from delegating such authority to the rehabilitator or the regulator of another state without legislative approval.

The proposed Rehabilitation Plan seeks to legitimize this unconstitutional, arbitrary and capricious attempt to usurp the authority of insurance regulators by cloaking it with receivership court approval. However, approval by the receivership court does not cure the unconstitutional exercise of authority or abuse of discretion. The authority of the receivership court is also defined and limited by law, *see* 40 P.S. § 221.

While the receivership court may approve the Plan of Rehabilitation, it may not authorize the Rehabilitator to implement rates or substantial form modifications without first seeking the approval of the various state insurance commissioners. Courts do not have the authority to set rates or authorize the use of forms different from those filed and approved by state insurance commissioners. Additionally, any such order would not be entitled to full faith and credit because it conflicts with the insurance laws of states that require insurance rates and forms to be reviewed and approved by the state's insurance director or designee.

Moreover, any court order that approved a plan that purports to revise insurer policy forms and rates without the requisite regulatory approvals would also violate the separation of powers principles of the United States and South Carolina Constitutions. *See Foster v. Mutual Fire, Marine and Inland Ins.*, 531 Pa. 598, 610-611, 614 A.2d 1086 (1992) (circuit court erroneously exercises its discretion when it exceeds its statutory authority or unreasonably substitutes the rehabilitator's beliefs for its own). The role of the Court is to safeguard the Plan from any potential abuse and that includes abuse of the Rehabilitator's discretion. *See Mills v. Florida Asset Fin. Corp.*, 31 A.3d 849, 850, 818 N.Y.S.2d 333 (3d Dept. 2006).

II. THE PROPOSED IMPLEMENTATION OF THE REHABILITATION PLAN MAKES THE PLAN NOT FEASIBLE.

SHIP was created in 2008 to run-off the long-term care ("LTC") block of business formerly owned by Conseco Senior Life Insurance Company. In effect, it has been in run-off since that time. SHIP has been insolvent since at least December 31, 2018, when it reported a deficit of (\$466,872,971.00) as of that date. The deficit has grown substantially since that time.

An insurer's insolvency is grounds for placing it in receivership under Pennsylvania law. 40 Pa. Stat. Ann. §§ 221.14 & 221.19 (West). These proceedings generally include proactive measures to preserve the assets of the insurer for the protection of all policyholders. The primary purpose of a rehabilitation is the preservation of the insurer. Under the rehabilitation process, the rehabilitator manages the insolvent insurer for a definite period of time until the company can be returned to its prior management or new management. *See* 40 PA Stat. § 221.16 (under Pennsylvania law, the purpose of a rehabilitation plan is to revitalize and reform

the insurer). See, e.g., Couch on Insurance 3d, §§ 5:33 *et seq.* *Carpenter v. Pacific Mut. Life Ins. Co. of Cal.*, 10 Cal. 2d 307, 74 P.2d 761 (1937), judgment aff'd, 305 U.S. 297, 59 S. Ct. 170, 83 L. Ed. 182 (1938); *In re Executive Life Ins. Co.*, 32 Cal. App. 4th 344, 38 Cal. Rptr. 2d 453 (2d Dist. 1995), as modified on denial of reh'g, (Mar. 15, 1995); *Foster v. Mutual Fire, Marine and Inland Ins. Co.*, 531 Pa. 598, 614 A.2d 1086 (1992). The proposed Plan of Rehabilitation presented to this Court cannot revitalize or reform the insurer. By proposing a process that circumvents state regulatory processes, it invites legal challenges by regulators, consumers and other interested parties that wastes the insurer's assets.

Pennsylvania law provides that a rehabilitation proceeding may be terminated when it is apparent that rehabilitation is futile. See 40 PS § 221.18. In *Consedine v. Penn Treaty*, the Commonwealth court recognized that there are cases where a rate increase strategy would be futile in rehabilitation. It noted that it would have been futile in *Mutual Fire*, where the insurance company was not writing or renewing insurance policies. See *Foster v. Mutual Fire, Marine and Inland Insurance Co.*, 531 Pa. 598, 614 A.2d 1086 (1992) (*Mutual Fire II*), *affirming sub nom.*, *remanding in part*, *Grode v. Mutual Fire, Marine and Inland Insurance Co.*, 132 Pa.Cmwlth. 196, 572 A.2d 798 (1990) (*Mutual Fire I*). The company had claim liabilities of \$260.1 million and assets of \$99.4 million, and there was no way to address the surplus deficiency by rate increases in that case.

Likewise, the rate increase strategy is futile in this instance. It has been acknowledged that even if every policyholder paid the If-Knew premium, the sums collected would still not correct the multi-million surplus deficiency. Because the rate increases do not address the surplus deficiency, it appears that the rate increases proposed by the Plan are not designed to cover benefits, but to cover the cost of administration of the rehabilitation.¹

III. THE PROPOSED PLAN OF REHABILITATION DOES NOT APPEAR TO BE FAIR AND EQUITABLE TO SOUTH CAROLINA POLICYHOLDERS.

A. The proposed unilateral rate increases appear to be designed to force policyholders to lapse or drop their insurance coverage.

The proposed plan does not appear fair and equitable to all South Carolina policyholders. The increased premium rates are designed to force 86-year old South Carolina policyholders to drop or significantly modify their coverage. To maintain coverage, South Carolina policyholders must choose one of the four options set forth in the plan. Only the Basic Policy Endorsement and Nonforfeiture options described in the Plan indicate there will be no further premium increases depending on certain factors. The other options come with significant unilaterally-imposed rate increases. If a policyholder is unable to affirmatively make a choice due to age, health condition or factors beyond their control, the Rehabilitator will make the choice (i.e., through the default option(s)) effectively depriving the policyholder of any choice at all.

Many of South Carolina's LTC policyholders are on fixed incomes. They are retired police officers and teachers who purchased LTC policies to protect their assets should they require some form of long term care during their later years. The Proposed Rehabilitation Plan would require these 86-year old South Carolinians to pay increased premium rates (up to 500%) or lose the coverage for which they paid for years at the point in their lives when they will most likely need it the most without any concrete assurance from the Rehabilitator that there will not be additional premium increases or that this insurer will not be liquidated at

¹ It is estimated that the premiums from rate increases would result in the collection of an additional \$167 million and the cost of administering the rehabilitation is estimated to be approximately \$200 million.

some point in the not-to-distant future. Stated simply, this Plan appears to kick the proverbial can (i.e., liquidation) down-the-road.

B. The proposed contract modifications are complex, confusing and may impair the contractual rights of South Carolina policyholders.

Insurance policy forms are subject to prior approval in South Carolina. *See* S.C. Code Ann. § 38-61-20 (2015). The unilateral policy changes proposed by the Plan of Rehabilitation are more than just insubstantial modifications. The proposed policy modifications significantly alter the insurance contracts purchased by South Carolina consumers. Under the Plan, policyholders are sorted into eight main categories, four each in Phase One and in Phase Two: (1) Active - premium paying; (2) Active - not premium paying (further segregated between lifetime or dual Premium Waiver); (3) Disabled - premium paying; and (4) Disabled - not premium paying. The reductions in benefits will depend upon which of the categories above the policy falls under.

The examples included in the Plan of Rehabilitation illustrate its complexity. The policies of some South Carolina policyholders have life time benefit periods, premium waivers and no elimination period. The proposed changes for premium paying policyholders include conversion of the lifetime benefit period to a fixed period of 5 years or less for policies with lifetime benefit periods; capping the maximum daily benefit to \$300; elimination of the premium waiver and return of premium options and requiring a minimum elimination period of ninety 90 days before a policyholder would be eligible for benefits. Historically, courts have generally approved policy modifications by a Rehabilitator that were considered *insubstantial*. *See Grode v. Mutual Fire, Marine and Inland Ins. Co.*, 132 Pa.Cmwlth 196, 572 A.2d 798 (1990) (court approved *insubstantial* modifications of contracts). The proposed changes are not insubstantial and will significantly affect and potentially impair their contractual rights. Additionally, it is our understanding that the Rehabilitator is in the process of amending the Rehabilitation Plan but the amended Plan of Rehabilitation will not be available for review prior to the expiration of the comment deadline.

South Carolina Policyholders will feel coerced into selecting one or more of these options, because they cannot afford the rate increases. Even after the policyholder makes such a selection, there does not appear to be any guarantee in the Plan of Rehabilitation that the insurer will be able to avoid liquidation based on this planned implementation strategy.

Likewise, there is no assurance in the Plan of Rehabilitation that the policyholder will fare as well through this rehabilitation effort than he or she would under liquidation which is contrary to applicable receivership laws. In South Carolina, policyholders with benefits over and above the guaranty fund limits may have an excess claim permitted under Class 2 of the South Carolina Priority of Distribution statute. *See* S.C. Code Ann. § 38-27-610 (2015). Pennsylvania's order of distribution statute appears substantially similar to South Carolina's priority of distribution statute.

IV. CONCLUSION

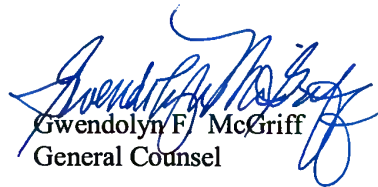
The proposed Rehabilitation Plan should not be approved by the Court in its current form. For the reasons explained above, we believe the proposed Rehabilitation Plan constitutes an abuse of the Rehabilitator's discretion, violates the insurance laws of the states of South Carolina, Pennsylvania and other states, and appears to usurp the authority conferred by the South Carolina Constitution and South Carolina General Assembly to the Director of Insurance to protect the insurance-buying public of this state. It does not appear to be fair and equitable to all South Carolina policyholders. The Director cannot delegate his regulatory authority without authorization of the South Carolina General Assembly.

Any implementation strategy that purports to unilaterally usurp the authority of the state insurance regulators charged with protecting the insurance consumers of their respective states will engender spirited debate and invite legal challenges that will only result in litigation and considerable delays. More importantly, it will deplete not preserve company assets which is contrary to the purpose of a rehabilitation proceeding.

The rehabilitation of a company that transacts business nationally will not be successful without the input and cooperation of the respective states. The proposed Plan for Rehabilitation must be modified to require the Special Deputy Rehabilitator to seek the requisite rate and policy form regulatory approvals via rate and form filings where required. If this proposed modification of the Rehabilitation Plan is not feasible, both the Rehabilitator and the Commonwealth Court must strongly consider converting this rehabilitation to a liquidation proceeding.

Thank you in advance for your consideration of these comments.

Respectfully Submitted


Gwendolyn F. McGriff
General Counsel

Cc: The Honorable Mary H. Leavitt
President Judge

James R. Potts, Esquire
shipcomments@cozen.com

Patrick Cantilo, Esquire
Cantilo & Bennett, LLP
service@cb-firm.com

EXHIBIT H



South Carolina Department of Insurance
1201 Main Street, Suite 1000
Columbia, SC 29201

Mailing Address
P.O. Box 100105
Columbia, SC 29202

November 30, 2020

TRANSMITTED BY ELECTRONIC MAIL TO:
plan.comments@shipltc.com

The Honorable Jessica K. Altman
Insurance Commissioner
Pennsylvania Insurance Department
& Rehabilitator for SHIP, In
Rehabilitation
1311 Strawberry Square
Harrisburg, PA 17120

Patrick Cantilo, Esquire
Special Deputy Rehabilitator
SHIP, In Rehabilitation
550 Congressional Blvd., Suite 200
Carmel, IN 46032

RE: *Informal Comments Opposing the Application for Approval of the Amended Plan of Rehabilitation for Senior Health Insurance Company of Pennsylvania, In Rehabilitation*

Dear Commissioner Altman and Special Deputy Rehabilitator Cantilo:

These informal comments are submitted in response to the Amended Plan of Rehabilitation filed with the Commonwealth Court on or about October 21, 2020. This letter supplements the informal comments submitted by the South Carolina Department of Insurance (Department) on September 15, 2020 opposing the approval of the Plan of Rehabilitation for Senior Health Insurance Company of Pennsylvania, In Rehabilitation ("SHIP"), filed with the Court on or about April 22, 2020 ("Plan of Rehabilitation" or "Plan"). Nothing in the Amended Plan alters the Department's opposition to the rehabilitation plans proposed for SHIP.

As previously noted, the South Carolina Department of Insurance is neither a creditor, policyholder nor certificate holder. It has not intervened and does not intend to intervene or participate as a party in this action. By submitting these informal comments, the Department neither consents nor submits to the jurisdiction of the courts of Pennsylvania. As regulator of the South Carolina insurance industry, the Department provides these comments for the Rehabilitator's consideration.

This Department acknowledges that some modifications were made to the Rehabilitation Plan including, but not limited to, the addition of: 1) an opt-out process for rate determinations; 2) a new Policy Restructuring Section; 3) a Liquidation Claims in Excess of Guaranty Association limits section; and 4) an Alternatives to the Plan section. Unfortunately, the changes do not correct or cure the constitutional or equity issues raised by this Department in its previous informal comments. Accordingly, this Department opposes the original and the Amended Plan on behalf of the policyholders and citizens of the State of South Carolina.

The South Carolina Department of Insurance takes no pleasure in opposing this Plan. It must because the Amended Plan continues to assert the exercise of authority the Rehabilitator does not possess. As such, it is an abuse of discretion. The Amended Plan also proposes an implementation strategy that bypasses the guaranty fund system and places the burden for curing SHIP's deficit squarely on the backs of 86-year olds who have the current misfortune of still being SHIP policyholders.

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This Department understands and recognizes the complexities of the issues involving long term care insurance, in general, and SHIP specifically. There may be situations where a rehabilitation for purposes of run-off may be feasible and in the best interests of policyholders, but this does not appear to be one of them. The deficit is too large. The insurance receivership system was not designed to require the insolvent insurer's policyholders to exclusively shoulder the burden of an insolvency. Historically, the system has spread losses over the largest base possible; the Amended Plan does not.

This Department is very concerned about the proposed approach and will encourage the intervenors to oppose the Amended Plan and to request its disapproval by the Commonwealth Court for the reasons set forth below.

A. The Rehabilitator does not have the authority to set insurance rates or significantly change policy forms without first seeking regulatory approval.

The Plan of Rehabilitation set forth the Rehabilitator's plans to impose rate increases and policy modifications for use nationwide through approval of the Plan of Rehabilitation by the Commonwealth Court in Pennsylvania ("Commonwealth Court"), bypassing individual state regulatory processes. This is the approach described in the Preliminary and Amended Plans of Rehabilitation (Plans).

The Rehabilitator intends to pursue this approach even though long term care (LTC) insurers like SHIP are required to comply with all rate approval statutes and regulations in most, if not all, states in which they do business. Neither Pennsylvania statutory law nor its common law gives the Rehabilitator the authority to unilaterally set rates or to substantially modify insurance policy forms in the various states without first seeking the requisite regulatory approval from each state.¹ As this Department noted in its previous comments, while the Rehabilitator, in her role solely as Commissioner for the State of Pennsylvania, may exercise that regulatory authority in Pennsylvania, her authority to change rates and modify forms ceases at the Pennsylvania state line.

B. The opt-out section of the Amended Plan does not cure the Rehabilitator's lack of authority to approve rates and substantially modify forms.

In its September 15 comments, this Department encouraged the Rehabilitator to seek the cooperation of other states on the regulatory issues (i.e., ratemaking and policy modifications) to avoid protracted litigation further wasting SHIP's assets. To address these ratemaking issues, the Rehabilitator added an opt-out section or rate determination process to the Rehabilitation Plan. On its face, it purports to give states that object to the Rehabilitator setting rates the option of determining rates, but it doesn't.² As I understand the Amended Plan, states must implement the rates developed by the Rehabilitator or the policyholders will be subject to benefit downgrades.

With the opt-out option, the Rehabilitator would file the IF-Knew premium rate with the states and give the states 60 days to review the filing. After the 60 days expires, the Rehabilitator would deem those rates disapproved and reduce the benefits of the policyholders in those states.³ If the regulator modifies the IF-

¹ By law, the Rehabilitator stands in the shoes of management of the insurer and has no more authority than that conferred upon company management. The Rehabilitator only has that authority that has been conferred upon her by Pennsylvania statute. See Pa. Stat. 40 P.S. § 221.16. The management of an insurer cannot unilaterally set insurance rates or modify the insurance contracts of its policyholders without seeking the requisite regulatory approval from each state in which the insurer transacts business. Likewise, I am unable to find any statute or case in which the rehabilitator of an insolvent insurer has been conferred the authority to unilaterally increase rates or *substantially* modify policy forms without regulatory approval.

² See Amended Rehabilitation Plan, p. 101.

³ See Amended Rehabilitation Plan, pp. 102-104.

Knew premium, policyholder benefits in that state would be reduced. In other words, the opt-out option requires the regulator to implement the IF-Knew premium or risk the downgrade of policyholder benefits if it doesn't. There is no indication in the Amended Plan that the benefit modifications will be filed with the state for regulatory approval before implementation.

Even though the opt-out section has been added, the Amended Plan still presumes the Rehabilitator has the authority to set rates and substantially modify policies via approval of the Plan by the receivership court.⁴ In fact, the Amended Plan indicates the Rehabilitator and the Court have the authority to unilaterally set rates for policies issued by SHIP in other states through approval of the Plan.⁵ This may be the desire of the Rehabilitator, but it is not consistent with applicable South Carolina law.

The South Carolina General Assembly established the state's regulatory policy through the South Carolina Insurance law. *See* S.C. Code Ann. § 38-1-10 *et seq* (2015) and established the Department of Insurance and the Office of the Director to enforce that law. *See* S.C. Code Ann. § 38-3-10 (2015). The primary duty assigned to the Director of Insurance by the South Carolina General Assembly is to "supervise and regulate the rates and service of every insurer in this state and fix just and reasonable standards, classifications, regulations, practices and measurements of service to be observed and followed by every insurer doing business in this state." *See* S.C. Code Ann. § 38-3-110(1) (2015). These Plan(s) attempt to usurp the regulatory authority of the democratically elected South Carolina General Assembly and the Director of Insurance to set service standards and to regulate insurance rates and policy forms. In South Carolina, no person other than the director or his designee has the authority to exercise the regulatory authority conferred upon him by the state legislature except as specified by applicable South Carolina law. The Director cannot and will not delegate this authority without statutory authorization of the South Carolina General Assembly.

Approval of the Plan by the receivership court will not cure any unconstitutional exercise of authority or abuse of discretion. The authority of the receivership court is also defined by Pennsylvania law, *see* 40 P.S. § 221. Prior regulatory approval is required to make substantial form modifications and rate changes in South Carolina. Courts do not have the authority to set rates or authorize the use of forms different from those filed and approved by state insurance commissioners. Such an order would not be entitled to full faith and credit because it conflicts with the insurance laws of states that require insurance rates and forms to be reviewed and approved by the state's insurance director or designee.

Moreover, any court order that approved a plan that purports to revise insurer policy forms and rates without the requisite regulatory approvals would also violate the separation of powers principles of the United States and South Carolina Constitutions. *See Foster v. Mutual Fire, Marine and Inland Ins.*, 531 Pa. 598, 610-611, 614 A.2d 1086 (1992) (circuit court erroneously exercises its discretion when it exceeds its statutory authority or unreasonably substitutes the rehabilitator's beliefs for its own). The role of the Court is to safeguard the Plan from any potential abuse and that includes abuse of the Rehabilitator's discretion. *See Mills v. Florida Asset Fin. Corp.*, 31 A.3d 849, 850, 818 N.Y.S.2d 333 (3d Dept. 2006).

C. Rehabilitation appears futile.

SHIP was created in 2008 to run-off the long-term care ("LTC") block of business formerly owned by Consecro Senior Life Insurance Company. It reported a deficit of (\$466,872,971) on December 31, 2018. As

⁴ *See* Amended Rehabilitation Plan, p. 29 (The Rehabilitator will not seek separate approval of rate increases or benefit downgrades from insurance regulators in the states in which the policies were issued.)

⁵ The Amended Rehabilitation Plan also provides that pending rate increases will be implemented on the date the Plan is approved by the receivership court. *See* Amended Rehabilitation Plan, p. 26.

of the date of these comments, the funding gap is projected to be \$1.2 billion. As the Amended Plan indicates, none of the options alone or in combination with another will succeed in raising sufficient funds or revenue to eliminate this funding gap.⁶

The Amended Plan acknowledges that "...the probability of the Plan's success increases materially the more policyholders elect to give up their benefit rich policies...". This means that even if every policyholder paid the If-Knew premium, the sums collected would not alleviate the \$1.2 billion deficiency.⁷ Because the rate increases cannot totally remedy the surplus deficiency, continued attempts to "rehabilitate" SHIP appear futile. *Foster v. Mutual Fire, Marine and Inland Insurance Co.*, 531 Pa. 598, 614 A.2d 1086 (1992) (*Mutual Fire II*), *affirming sub nom.*, *remanding in part*, *Grode v. Mutual Fire, Marine and Inland Insurance Co.*, 132 Pa.Cmwlth. 196, 572 A.2d 798 (1990) (*Mutual Fire I*).

Additionally, some of the risks cited in the Amended Plan are the reasons the Plan is not feasible. There are a lot of assumptions and projections associated with the Plan, but insufficient data. If the feasibility of the Plan was doubtful with a deficit of approximately \$467 million, it is hard to envision how the Plan can be successful with a \$1.2 billion funding gap based on the current information. Liquidation seems imminent. However, the implementation strategy appears to be an attempt to avoid liquidation for as long as possible with the hope that when SHIP is placed in liquidation, its liabilities will have been significantly reduced.⁸ The strategy does not benefit the policyholder and appears to be antithetical to the protections afforded by the guaranty fund system for policyholders.⁹

D. The Amended Plan does not appear to be fair and equitable to all South Carolina policyholders.

The Department raised the issue of the fairness of the proposed plan in its September 15 comments. Notably, the Amended Plan adds a Policy Restructuring section. In this section, the Rehabilitator makes clear that a policyholder whose policy is modified will *not* have a policy claim should the insurer go into liquidation.¹⁰ According to the Amended Plan, this policyholder will be treated as a general creditor of the receivership estate. The policyholder may not only lose some of the benefits he bargained and paid for, but also any potential excess claim when SHIP is placed in liquidation based upon this modification.

The Amended Plan states that policyholders will fare as well as they would in liquidation. However, it is unclear how they will. First, through rehabilitation, current policyholders with an average age of 86 are being asked to exclusively fund a \$1.2 billion funding gap (through significant rate increases and substantial policy modifications) they did not create. Second, policyholders are being encouraged to substantially modify their benefits to maintain their policies because rate increases alone will not be sufficient to close the funding gap, but if they do, they will be penalized and could lose (according to the Amended Plan) any policyholder

⁶ See Amended Rehabilitation Plan, p. 18.

⁷ Amended Rehabilitation Plan, p. 18.

⁸ See Amended Rehabilitation Plan, p. 89.

⁹ Insurance guaranty funds were created to protect the policyholders, claimants and other creditors by limiting the impact of the losses of insolvent insurers. The general purpose of the guaranty fund system is to place the insured in the position he would have been if the insurer had not become insolvent. See S.C. Code Ann. § 38-29-30 (2020) (the purpose... is to protect the persons specified in § 38-29-40 against the failure in the performance of contractual obligations of life, accident, health and annuity policies, plans or contracts due to the impairment of insolvency of a member...). The Guaranty Fund's principal responsibility is to pay the covered claims of insolvent insurers. See S.C. Code Ann. § 38-29-40 (2020). Its members must contribute to the amounts necessary to pay the guaranty fund's obligations. See S.C. Code Ann. § 38-29-30 (2020). Losses are spread over a broad base. Here, the losses will be borne primarily by certain SHIP policyholders.

¹⁰ See Amended Plan of Rehabilitation, p. 86.

claim to excess benefits they may have when SHIP is placed in liquidation.¹¹ Third, if the Director refuses to allow the Rehabilitator to violate South Carolina law by setting rates and modifying the policy forms issued in this state, policyholders in South Carolina will be penalized through the benefit downgrades described in the opt-out process outlined in the Amended Plan. Downgrades that would not be filed with the Department for review according to the terms of the Amended Plan.

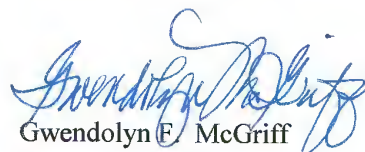
The Amended Plan does not treat all policyholder equitably. b In most insolvencies, the general assets of the insurer are used for the benefit of all policyholders. The Amended Plan appears to differentiate among policyholders to prevent some policyholders subsidizing others. This appears unusual. Other insolvencies where there have been profitable and unprofitable blocks of business have used general assets to provide benefits for all policyholders.

E. Conclusion

For the reasons above, we continue to believe the proposed Amended Plan constitutes an abuse of the Rehabilitator's discretion, violates the insurance laws of the states of South Carolina, Pennsylvania and other states, and attempts to usurp the authority conferred by the South Carolina Constitution and South Carolina General Assembly to the Director of Insurance to protect the insurance-buying public of this state. It is not fair and equitable to all South Carolina policyholders and appears to prolong the process to their detriment. We encourage the Rehabilitator to make additional modifications to remedy the concerns outlined in this letter.

Thank you in advance for your consideration of these comments.

Respectfully Submitted


Gwendolyn F. McGriff
General Counsel

Cc: The Honorable Mary H. Leavitt
President Judge

James R. Potts, Esquire
shipcomments@cozen.com

Patrick Cantilo, Esquire
Cantilo & Bennett, LLP
service@cb-firm.com

¹¹ See Amended Plan of Rehabilitation, pp. 92-95.

EXHIBIT I



South Carolina Department of Insurance
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Columbia, SC 29201

Mailing Address
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Columbia, SC 29202

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April 1, 2021

Eric A. Cioppa
Superintendent of Insurance
Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333-0034

Gary D. Anderson
Commissioner
Massachusetts Division of Insurance
1000 Washington Street
Boston, MA 02118

Mike Kreidler
Insurance Commissioner
State of Washington
5000 Capitol Blvd. SE
Tumwater, WA 98501

RE: IN RE: Senior Health Insurance Company of Pennsylvania, In Rehabilitation (No. 1 SHP 2020)

Dear Commissioners:

The South Carolina Department of Insurance (Department) has reviewed the Pre-Hearing Memorandum of the Maine Superintendent of Insurance, Massachusetts Commissioner of Insurance, and Insurance Commissioner of the State of Washington ("State Insurance Regulators"). Without consenting to the jurisdiction of the Pennsylvania courts, and reserving all its rights, the South Carolina Department of Insurance fully supports the positions of the State Insurance Regulators articulated in the Pre-Hearing Memorandum that the proposed Amended Plan of Rehabilitation: 1) is not in the best interest of policyholders because it treats them worse than in liquidation; 2) is inconsistent with the national scheme for protecting the policyholders of insolvent insurers in that it imposes the entire burden of the insolvency on SHIP's current policyholders; 3) does not appear viable; 4) is unlawful because it does not appear to be fair and equitable to all policyholders including the policyholders in this state; and 5) attempts to assert ratemaking authority in other states that the Rehabilitator does not have.

This Department has shared similar concerns about the proposed Plan(s) of Rehabilitation with the Rehabilitator and Special Deputy Rehabilitator on September 15, 2020 and November 30, 2020. Additionally, this Department has filed an action in South Carolina to enjoin the implementation of the Plan in this state because we have grave concerns about the viability of the proposed Plan and its impact on South Carolina policyholders. Copies of these documents are attached to this letter.

Governor Henry McMaster

Director Raymond G. Farmer



This Plan proposes something unprecedented that is created to circumvent the guaranty fund system designed to protect policyholders. It requires existing SHIP policyholders averaging 86+ years of age or older to shoulder the burden of filling the \$1.2 billion fund gap exclusively. We firmly believe that any Rehabilitation Plan approved by the Court should treat policyholders equally regardless of their state of residence. We have not seen any evidence that illustrates that either the proposed Rehabilitation Plan or the Amended Rehabilitation Plan does this.

South Carolina policyholders should not be penalized because the Director of Insurance will not sit idly by and allow another state regulator to violate its laws by exercising the authority to set rates in this state. That authority that has been conferred upon the South Carolina Insurance Director by the South Carolina General Assembly not the Rehabilitator. Said authority has not been delegated to the Rehabilitator by the General Assembly of this state or the Commonwealth of Pennsylvania. The Rehabilitator only has that authority that has been conferred upon her by Pennsylvania law.

Moreover, there is no assurance in the initial proposed Plan or the Amended Plan that liquidation can be avoided. Rehabilitation may be appropriate for another insurer, but not this one. SHIP has been in some form of run-off since 2008. Thus, we believe the proposed plans and strategies to rehabilitate this company are a waste of the insurer's limited assets. The proposed rehabilitation of this insurer appears futile; and for the reasons stated above, we find the proposed treatment of policyholders unconscionable.

The Rehabilitation plans submitted by the Rehabilitator must be disapproved. South Carolina fully supports the positions taken by the intervening state insurance regulators to protect SHIP policyholders.

Sincerely,


Gwendolyn F. McGriff
General Counsel

EXHIBIT J

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

IN RE: Senior Health Insurance : No. 1 SHP 2020
Company of Pennsylvania :
In Rehabilitation :

**APPLICATION FOR APPROVAL
OF THE PLAN OF REHABILITATION FOR
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA**

Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as statutory Rehabilitator of Senior Health Insurance Company of Pennsylvania (“SHIP”), hereby applies to this Court for approval of a plan of rehabilitation for SHIP, and in support thereof, avers the following:

1. In the exercise of her discretion as statutory Rehabilitator and pursuant to 40 P.S. § 221.16(d), and pursuant to the January 29, 2020 Order of this Court that the Rehabilitator develop and submit a preliminary plan of rehabilitation for SHIP, the Rehabilitator has developed a Plan of Rehabilitation for SHIP (the “Plan”), which is set forth and submitted herewith as Exhibit A.

2. Consistent with the purposes of Article V of The Insurance Department Act of 1921, Act of May 17, 1921, P.L. 789, *as amended*, 40 P.S.

§§ 221.1 – 221.63 the Plan endeavors to protect the interests of insureds, creditors, and the public by proposing corrective action to restore SHIP to a financially self-sustaining long-term care insurance company. Key features of the Plan include equitable apportionment of unavoidable loss and lessening the problems of interstate rehabilitation.

3. In addition to the definitions set forth in this Application, the Rehabilitator incorporates by reference the definitions set forth in the Plan with respect to the capitalized terms in this Application.

4. Significant features of the Plan (as further described therein) include the following:

- a) reduction of the Funding Gap by appropriately increasing, maintaining and, in some instances, reducing premium rates to more accurately reflect the cost of benefits;
- b) allowing policyholders to elect to maintain or reduce the level of benefits from their policy;
- c) allowing policyholders to choose between Option One, Option Two, Option Three and Option Four relating to the premium paid and level of benefit received;
- d) implementation of the corrective action in three distinct phases;
- e) the suspension of payments of commissions to Agents;
- f) investigation and analysis of the past operations and business dealings of the Company; and

- g) a streamlined process nationally implemented under the supervision of this Court.

5. The attached Plan provides the facts that demonstrate the need for the corrective action recommended by the Plan. The Court is directed to the following Sections of the Plan:

VI. OTHER MATTERS

- A. ABOUT SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA**
- B. LONG-TERM CARE INSURANCE**
- C. FINANCIAL CONDITION**
- D. REHABILITATION PROCEEDING**
- E. SENIOR HEALTHCARE OVERSIGHT TRUST**
- F. FUZION ANALYTICS**
- G. LTCG, INC.**
- L. REINSURANCE**
- M. COMMISSIONS**

Attached is a verification executed by Special Deputy Rehabilitator Patrick Cantilo certifying that the facts contained in these Sections are true and correct to the best of his knowledge, information, and belief.

6. By this Application, the Rehabilitator seeks approval of the terms, conditions, and provisions of the Plan.

7. The Rehabilitator reserves the right to amend or supplement the Plan and this Application and to proffer additional evidence and arguments in support of the Plan at any hearing thereon or by written submission.

8. Approval should issue only after due notice, opportunity to object, and a hearing on the Plan. A separate Application for Approval of a Form and Distribution of Notice of this Application and for Scheduling Order is being filed by the Rehabilitator.

9. The Plan satisfies the requirements of Article V of the Insurance Department Act of 1921, as amended, and represents a sound exercise of the Rehabilitator's broad discretion.

WHEREFORE, the Rehabilitator respectfully requests that the Court, in accordance with 40 P.S. § 221.16(d), enter an order approving and confirming the Plan.

Respectfully submitted,

/s/James R. Potts
James R. Potts
Attorney I.D. No. 73704
Dexter R. Hamilton
Attorney I.D. No. 50225
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and

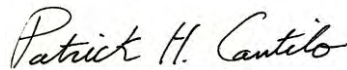
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Counsel for Applicant,
JESSICA K. ALTMAN, Insurance
Commissioner of the Commonwealth of
Pennsylvania as Rehabilitator of
SENIOR HEALTH INSURANCE
COMPANY OF PENNSYLVANIA

VERIFICATION

I, Patrick H. Cantilo, hereby state that I am the Special Deputy Rehabilitator for Senior Health Insurance Company of Pennsylvania, and I am authorized to make this Verification on behalf of the Court Appointed Rehabilitator. I hereby verify that the facts set forth in the foregoing application are true and correct to the best of my knowledge, information, and belief.

I understand that this Verification is made subject to the penalties of 18 Pa.C.S. § 4904 relating to unsworn falsification to authorities.



Patrick H. Cantilo
Special Deputy Rehabilitator

Dated: April 22, 2020

Received 4/23/2020 11:50:12 AM Commonwealth Court of Pennsylvania

Filed 4/23/2020 11:50:00 AM Commonwealth Court of Pennsylvania
1 SHP 2020

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EXHIBIT A

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

IN RE: Senior Health Insurance : No. 1 SHP 2020
 Company of Pennsylvania in :
 Rehabilitation :

REHABILITATION PLAN
 SENIOR HEALTH INSURANCE COMPANY
 OF PENNSYLVANIA, IN REHABILITATION

Wednesday, April 22, 2020

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SHIP REHABILITATION PLAN



SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, *IN REHABILITATION* REHABILITATION PLAN

JESSICA K. ALTMAN, REHABILITATOR
PATRICK H. CANTILO, SPECIAL DEPUTY REHABILITATOR

HOW TO PROVIDE COMMENTS AND OBJECTIONS

Comments may be addressed to Patrick H. Cantilo, Special Deputy Rehabilitator, at Senior Health Insurance Company of Pennsylvania, In Rehabilitation, 550 Congressional Blvd., Suite 200, Carmel, IN 46032, or by electronic mail to plan.comments@shipltc.com.

Formal objections must be made in compliance with the Order of the Commonwealth Court of Pennsylvania, which will be available at www.shipltc.com when the Court enters the Order.

THIS PLAN DOCUMENT PROVIDES DETAILS ABOUT THE PLAN PROPOSED FOR THE REHABILITATION OF SHIP. IT DESCRIBES IN DETAIL THE OPTIONS FROM AMONG WHICH SHIP POLICYHOLDERS CAN CHOOSE UNDER THE PLAN. EACH LONG-TERM CARE (“LTC”) POLICYHOLDER WILL RECEIVE PERSONALIZED INFORMATION BEFORE HE OR SHE IS ASKED TO CHOOSE AN OPTION UNDER THE PLAN. THIS INFORMATION WILL BE PROVIDED, IN A SIMPLIFIED FORMAT, AFTER A FINAL VERSION OF THE PLAN IS APPROVED BY THE COURT.

SHIP REHABILITATION PLAN

IMPORTANT NOTICE

THE PLAN DESCRIBED BELOW, IF APPROVED BY THE COURT, WILL AFFECT SUBSTANTIALLY THE RIGHTS AND BENEFITS OF SHIP'S POLICYHOLDERS, CREDITORS AND OTHERS. NOTHING IN THE PLAN OR RELATED DOCUMENTS CONSTITUTES, IS INTENDED AS, OR SHOULD BE TAKEN AS, LEGAL, TAX, OR OTHER ADVICE FROM THE REHABILITATOR, HER REPRESENTATIVES, OR HER CONSULTANTS. ALL PERSONS INTERESTED IN SHIP'S REHABILITATION SHOULD READ THE PLAN DOCUMENT CAREFULLY AND CONSULT WITH THEIR OWN LEGAL, BUSINESS, FINANCIAL, TAX AND OTHER ADVISORS AS TO MATTERS CONCERNING THE PLAN DOCUMENT.

THE PLAN PROPOSES THE IDENTIFICATION OF THOSE POLICIES OF LONG TERM CARE INSURANCE ISSUED OR ASSUMED BY SHIP THAT ARE ACTUARIALLY PROJECTED TO BE UNDERPRICED IN PHASE ONE AND NON-SELF-SUSTAINING IN PHASE TWO, AS DEFINED IN THE PLAN DOCUMENT, AND THE METHODOLOGY BY WHICH POLICYHOLDERS WHO HAVE SUCH LONG TERM CARE POLICIES MAY ELECT FROM AMONG SEVERAL OPTIONS TO MAKE SUCH POLICIES APPROPRIATELY PRICED OR SELF-SUSTAINING.

SOME POLICYHOLDERS WILL BE FOUND TO HAVE POLICIES THAT ARE PROPERLY PRICED OR SELF-SUSTAINING. THESE POLICYHOLDERS WILL NOT BE REQUIRED TO MODIFY THEIR POLICIES BUT WILL HAVE THE OPTION TO DO SO IF THEY SO CHOOSE. FOR POLICYHOLDERS WHO ARE REQUIRED TO MAKE SUCH ELECTIONS BUT FAIL TO DO SO, THE PLAN INCLUDES AUTOMATIC DEFAULT OPTIONS.

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THESE MODIFICATIONS TO MAKE LTC POLICIES PROPERLY PRICED OR SELF-SUSTAINING MAY INCLUDE PERMANENT REDUCTIONS IN THE BENEFITS AVAILABLE UNDER SUCH POLICIES, PERMANENT INCREASES IN THE PREMIUM RATES THAT MUST BE PAID TO MAINTAIN SUCH POLICIES IN FORCE, OR A COMBINATION OF PERMANENT BENEFIT REDUCTIONS AND RATE INCREASES. THE PLAN DOCUMENT DESCRIBES THE METHODOLOGY FOR SUCH MODIFICATIONS IN DETAIL BUT DOES NOT CONTAIN SPECIFIC INFORMATION ABOUT HOW THEY WOULD AFFECT ANY PARTICULAR POLICYHOLDER. THE SPECIFIC MANNER IN WHICH THE PLAN WOULD IMPACT A PARTICULAR POLICY CAN ONLY BE DETERMINED AFTER CALCULATIONS THAT WILL BE MADE DURING THE PERIOD AFTER THE PLAN IS APPROVED BY THE COURT AND BEFORE THE PLAN IS IMPLEMENTED, AND WILL DEPEND IN PART ON WHETHER AND TO WHAT EXTENT THE PLAN IS MODIFIED. ONCE THE CALCULATIONS ARE MADE, EACH LTC POLICYHOLDER WILL RECEIVE PERSONALIZED INFORMATION FOR PURPOSES OF MAKING ELECTIONS PERMITTED UNDER THE PLAN.

THE PLAN DOCUMENT DESCRIBES THE DETAILED PROCESS FOR DOWNGRADING POLICIES WHEN OPTION ONE IS ELECTED AND CHANGING BENEFITS WHEN OPTIONS TWO OR THREE ARE ELECTED. ALTHOUGH THESE CONSTRUCTS ARE THE PRODUCT OF EXTENSIVE ANALYSIS, THEIR EVALUATION CONTINUES AND IT IS POSSIBLE THAT THEY MAY BE FURTHER REFINED BEFORE THE PLAN IS IMPLEMENTED. IN ANY EVENT, BEFORE BEING REQUIRED TO ELECT FROM AMONG THE PLAN OPTIONS, EACH POLICYHOLDER WILL RECEIVE INDIVIDUALIZED DETAILED DATA ABOUT EACH OPTION AVAILABLE TO HIM OR HER.

SHIP REHABILITATION PLAN

THE PLAN IS DESIGNED TO REDUCE OR ELIMINATE THE SHORTFALL BETWEEN SHIP'S PROJECTED LIABILITIES AND THE ASSETS PROJECTED TO BE AVAILABLE TO FUND SUCH LIABILITIES. THERE CAN BE NO ASSURANCE THAT THE PLAN WILL SUCCEED IN THIS GOAL. IF THE PLAN FAILS IN THIS RESPECT, IT IS LIKELY THAT SHIP WILL BE PLACED IN LIQUIDATION.

IN THAT EVENT, THERE CAN BE NO ASSURANCE THAT SHIP WILL BE ABLE TO FULFILL THE CONTRACTUAL OBLIGATIONS ENTAILED IN LTC POLICIES MODIFIED UNDER THE PLAN TO THE EXTENT THAT SUCH OBLIGATIONS INCLUDE UNCOVERED BENEFITS AS DEFINED IN THE PLAN DOCUMENT.

THE PLAN DOCUMENT STRIVES TO PROVIDE A COMPLETE EXPLANATION OF EVERY SIGNIFICANT ELEMENT OF THE PROPOSED REHABILITATION. NONETHELESS, IT IS LIKELY THAT ISSUES WILL ARISE THAT HAVE NOT BEEN ENVISIONED IN THIS PLAN DOCUMENT, AND THAT CHANGES AND EVENTS OCCURRING AFTER THIS PLAN DOCUMENT IS FILED WITH THE COURT WILL REQUIRE ADDITIONAL ADJUSTMENTS TO THE PLAN. THE REHABILITATOR ANTICIPATES SEEKING FROM THE COURT AUTHORITY TO MAKE SUCH CHANGES, OR TAKE SUCH ADDITIONAL STEPS, IN IMPLEMENTING THE PLAN AS SHE CONCLUDES ARE NECESSARY TO GIVE EFFECT TO THE SPIRIT OF THE COURT'S ORDER APPROVING OR MODIFYING THE PLAN. THE FINAL PLAN AS IMPLEMENTED MAY THEREFORE VARY IN SOME MEASURE FROM THE DESCRIPTION IN THIS PLAN DOCUMENT.

SHIP REHABILITATION PLAN**REHABILITATION PLAN DOCUMENT****I. BASIC INFORMATION ABOUT THE PLAN**

As more fully detailed below, after reporting a very large deficit in capital and surplus, and having submitted no plan to restore required surplus, on January 29, 2020, Senior Health Insurance Company of Pennsylvania (“SHIP” or the “Company”) was placed in rehabilitation by order of the Commonwealth Court of Pennsylvania. The Court appointed Pennsylvania Insurance Commissioner, Jessica K. Altman, as Rehabilitator. Under the Court’s order and the applicable statutes, Commissioner Altman, as Rehabilitator, has broad authority to take remedial steps to address SHIP’s financial challenges. She has engaged a Special Deputy Rehabilitator and a group of consultants who have developed this rehabilitation plan for the protection of SHIP’s policyholders and creditors.

This document (“Plan Document”) is intended to provide a sufficient description of the proposed rehabilitation plan (the “Plan”) to:

1. Enable policyholders and interested parties to understand, provide meaningful comments about, and formal objections if any to, the Plan, and
2. Enable the Commonwealth Court to determine whether to approve, modify and approve, or disapprove the Plan.

Necessarily, many of the details of the Plan will have to be resolved during the implementation period. It is not possible to anticipate all of the implications of every aspect of the Plan before it is put in place. Nonetheless, this Plan Document provides a detailed description of how the Plan, if approved as proposed, is expected to be implemented.

The actual choices for, and projected impact upon, each policyholder will not be known until after the Plan is finalized and its provisions are calculated by the Company’s systems. Those calculations produce materially different results depending on the passage of time and changes in both general and policyholder-specific circumstances. The cost and delay attendant to making the calculations for every policyholder in advance of approval are not justified given that the results will be too inaccurate to be meaningful. However, at page 54 are presented illustrations of Plan options for several representative policyholders. This Plan Document therefore provides relative and directional guidance about Plan options rather than precise details for each one.

SHIP REHABILITATION PLAN

A. SUMMARY DESCRIPTION OF THE PLAN

The following description of the Plan is intended to provide policyholders the basic information required for them to make the required election(s) if the Plan is implemented as proposed. To that extent, it should also enable policyholders to decide what if any comments or formal objections they may offer in response to the request for approval of the Plan. Much more detail about the Plan and related matters is provided in the sections that follow.

1. GOAL AND PHASES OF THE PLAN

Recognizing that SHIP faces a substantial Funding Gap (described on page 72), the aim of the Plan is to increase revenues and reduce liabilities so as to narrow or eliminate that gap through a combination of Policy Modifications for most of the approximately 45,000 policies in force as of the filing of the Plan. Although the Plan has certain default provisions that apply when policyholders fail to make effective choices, it is structured to maximize policyholder choice, based on each person's individual circumstances and preferences. In structuring the Plan, the Rehabilitator recognizes that many policyholders have costly policies that provide far more coverage than the policyholders are reasonably likely to require. Accordingly, a key element of the Plan is to enable policyholders to remove coverages that are not essential or even necessary, thereby helping to narrow the Funding Gap and potentially reducing their own premium, or at least avoiding part or all of a necessary premium rate increase.

The Plan is designed to operate in three phases. Phase One, commencing immediately following final approval, is the principal phase and will strive to reduce substantially or eliminate the Funding Gap. In this phase it will be determined which policies require modification because their Current Premium is below the "***If Knew Premium***" for the benefits offered by the policy. The If Knew Premium is a widely accepted methodology for setting premiums for LTCI policies, more fully explained at page 16. Policyholders with Current Premium (see page 92) below the If Knew Premium will have to increase their premiums or reduce their benefits so that the premium will be adequate on an If Knew Premium basis. Policyholders whose Current Premium is at or above the If Knew Premium will not be required to modify their policies (increase their premiums or reduce their benefits) but may choose to make some such modifications if they prefer to do so, as explained below.

In Phase Two, the results of Phase One will be evaluated and additional Policy Modifications may be necessary for certain policies. Modifications in Phase Two will be based on Self-sustaining Premiums as explained at page 16. The goal of Phase Two will be to eliminate any Funding Gap not eliminated in Phase One. Only policies whose premiums are not already Self-sustaining, which are not ***Fully Covered*** (*i.e.*, they are not within the limits of, or otherwise not covered by, the applicable Guaranty Association - see page 93), and which have not selected Option Two or Option Three (described below) in Phase One, may be modified in Phase Two.

SHIP REHABILITATION PLAN

In Phase Three, the Company will complete the run-off of the LTCI business in force. If there are sufficient funds to do so, in Phase Three the Plan will also provide additional benefits to policyholders and make payments to unpaid creditors.

2. POLICYHOLDER ELECTIONS

This section describes the key elements of these policyholder options. They are described in full detail beginning on page 12. In Phase One every policyholder whose Current Premium is below the If Knew Premium for the policy's benefits will be required to elect one of four options. Those whose Current Premium is at or above the If Knew Premium may keep their current policies without premium increases or may elect Option Two or Option Three, described below.

- a. Option One will be to continue paying the Current Premium but (if it is less than the If Knew Premium) have benefits reduced so that the premium for the reduced benefits on an If Knew Premium basis is equal to the Current Premium. The benefit reductions will be selected automatically by the Plan.
- b. Option Two will be to select certain policy endorsements that in most cases provide greater benefits than Option One but at a lower premium than Option Four. This Option, of which an enhanced version will also be available, will not be subject to further rate increases or benefit reductions in Phase Two of the Plan. This Option is designed to provide reasonable coverage at reasonable premium rates.
- c. Option Three will be a ***Non-forfeiture Option*** through which the policyholder will receive a Reduced Paid-up (RPU) policy providing limited benefits but for which no future premiums will be charged. Under the Plan, this Option will include more generous benefits than the typical industry non-forfeiture option or reduced paid-up policy, most notably in that it will offer as much as a 30 month benefit period unless the current policy has a shorter benefit period. Moreover, policyholders who select this option will never have to pay additional premiums and this policy will never lapse.
- d. Option Four will be to retain the current policy benefits and pay the corresponding If Knew Premium (unless equal to or lower than the Current Premium that the policyholder is paying). For many policyholders this may require a very large increase in premiums.

Policyholders paying premium at or above the If Knew Premium may elect to make no changes (or make no election at all and leave their policies unchanged) or may elect Option Two or Three if preferable for their individual circumstances. Options One and Four would not result in any changes for such policyholders.

SHIP REHABILITATION PLAN

Before being required to make an election, each policyholder will receive information detailing the premiums and benefits of each option. Special rules apply to policyholders who are not currently paying premium due to a Premium Waiver provision in their or their spouses' policies. These are explained fully beginning at page 19. Generally, such policyholders who elect Option Two or Option Four and whose Current Premium (the premium they would be paying but for the waiver) is lower than the If Knew Premium, will be required to pay a Differential Premium. The Differential Premium consists of the difference between (1) the premium they would be paying if there were not a waiver in effect (the Current Premium), and (2) the If Knew Premium corresponding to the policy. See Section II.E.6, page 18. If the Premium Waiver terminates, such policyholders will be required to pay the full applicable If Knew Premium (or Self-sustaining Premium if in Phase Two). Substantially the same options will be offered to policyholders on claim.

Every policyholder will be offered at least one option in Phase One that will provide him or her potential benefits equal to the applicable Guaranty Association limits but no more than the current policy benefits. For every policyholder Option Two will do that and for many policyholders other options will do that as well. In that respect, the Plan is designed to place policyholders in no worse a position than they would face in a liquidation of SHIP.

For every policyholder whose Current Premium is below the If Knew Premium, there will be a Default Option that will be identified in the election materials (and is illustrated on page 53). In general, the Default Option will be Option One (the downgrade) for policyholders on Premium Waiver. However, if the Non-forfeiture Option (NFO) would provide these policyholders better benefits than the downgrade, the NFO will be the Default Option. For policyholders who are paying premium, Option Two (the Basic Policy Endorsements - see Section III.A.2.d, page 36) will be the Default Option. The Default Option will apply if the policyholder fails to make an election by the applicable deadline or submits an election form that does not clearly identify the policyholder's election (for example because two or more options is elected). For a policyholder whose Current Premium is equal to, or higher than, the If Knew Premium, no Default Option will apply and no changes will be made to the policy unless specifically elected, even if the policyholder does not submit a proper completed election form. The Rehabilitator believes that there are a substantial number of policyholders in these circumstances.

Similar options as those offered in Phase One will be offered to policyholders in Phase Two of the Plan, but the premium modification will be based on attaining Self-sustaining Premiums. It is important to note that policyholders who elect Option One or Option Four in Phase One, and whose policies after Phase One are not Self-sustaining or Fully Covered (*i.e.*, within Guaranty Association limits), may face additional premium rate increases or benefit reductions (sometimes substantial) in Phase Two. Policyholders who elect Option Two or Option Three will NOT face additional rate increases or benefit reductions in Phase Two of the Plan. In addition, policyholders who select Option Three will never pay any more premiums.

SHIP REHABILITATION PLAN

B. KEY CONSIDERATIONS FOR POLICYHOLDERS

For every policyholder there will always be two competing considerations: the anticipated need for LTC benefits and the cost of maintaining coverage for those benefits. As is true of many similar LTCI blocks in the market, many of SHIP's policies have historically been substantially underpriced and policyholders have not been asked to pay the premium that would be necessary to assure that those benefits will be available when needed. Obviously, this is not a sustainable model and is a key contributor to SHIP's present financial challenge. The Plan aims to enable policyholders to balance these competing considerations in the context of their individual circumstances. Put simply, not every policyholder will need the same level of benefits in the future and not every policyholder will be in a position to pay an appropriate premium for the most generous combinations of LTC benefits.

In determining which option to elect, each policyholder should endeavor to identify what is a reasonable level of benefits to be provided by his or her policy given his or her likely future needs, and the ability of the policyholder to pay for such benefits. For example, there is a very material difference in the cost of a policy that provides 5% Inflation Protection when compared to one that provides 2% Inflation Protection and one that provides no Inflation Protection at all. Similarly, there is a material difference between the cost of a policy with lifetime benefits, one with a five-year benefit period, and one with a two-year benefit period. Moreover, features like Premium Waivers, Restoration of Benefits, Return of Premium, short Elimination Periods, indemnity vs. reimbursement, and "traditional" benefit triggers can all add materially to the cost of a policy but may not be indispensable to every policyholder.

The Plan is constructed to offer policyholders an array of options that can be responsive to the widely divergent circumstances of SHIP's policyholders. For example, for policyholders who cannot afford any premium rate increases, Option One (maintaining Current Premium and reducing benefits) may be the best Option for those policyholders in that it eliminates rate increases in Phase One of the Plan. However, for some of those policyholders, the reduction in benefits necessary to achieve that goal may leave the policy with benefits deemed insufficient by the policyholders. Moreover, policyholders who select Option One may face additional rate increases or benefit reductions in Phase Two of the Plan. For such policyholders Options Two or Three may be preferable. Option Two is designed to provide a reasonable combination of benefits at a reasonable premium. For many policyholders it is likely that the premium required for Option Two will be less than what would be required for Option Four to maintain the current policy benefits. On the other hand for these policyholders, the benefits offered in Option Two may be more acceptable than those provided by Option One. An advantage of Option Two is that it would not present the possibility of rate increases or benefit reductions in Phase Two of the Plan. For other policyholders, Option Three (the Non-forfeiture Option) may be optimal. That would be a policy with modest benefits but for which no more premium would ever be required, even if the Company were placed in liquidation.

SHIP REHABILITATION PLAN

For those fortunate policyholders who can afford any rate increase, Option Four might be attractive in that it would enable them to retain the most generous benefits, even at very high premium rates. But many of these policyholders would face very large rate increases when selecting Option Four, sometimes as much as or more than ten-fold. This is because, in many cases, the premiums for those policies began below where they should have been and were never raised to adequate levels. Thus, such policies now have years, even decades, of underpricing embedded in their current premium rates. Moreover, policyholders selecting Option Four would face the possibility of additional substantial rate increases or benefit reductions in Phase Two of the Plan.

There will also be a number of policyholders whose Current Premiums are already appropriate. For these policyholders, selecting Option One or Option Four would be meaningless because neither their premiums nor benefits would change in either case. Such policyholders will not be required to make any election. However, they will be given the opportunity to select Option Two or Option Three if that would be better for their circumstances.

It is not practical to offer enough options to precisely meet every policyholder's expectations or preferences. Doing so would make the Plan too complicated and costly. The Special Deputy Rehabilitator has led a team that has devoted intense efforts to the development of a manageable number of options that recognize the major differences in policyholders' circumstances. While no one option may be ideal for a particular policyholder, the differences among the options are such that it is hoped that every policyholder will find at least one option that will enable that policyholder to emerge from SHIP's rehabilitation with adequate long-term care protection at reasonable premiums.

C. TIMELINE

The order placing SHIP in rehabilitation requires the Rehabilitator to submit to the Court a preliminary plan for SHIP's rehabilitation by April 22, 2020. At page 23 is a preliminary sequence of expected events in the presentation and implementation of the Plan. While it is difficult to predict future events in a matter of this complexity, the Rehabilitator expects that policyholders and other interested parties will be afforded an opportunity to comment on the Plan within the next few months. Because of the extraordinary circumstances facing our nation, the Rehabilitator will ask the Court to provide policyholders and others a prolonged period of time to review the Plan before such comments are due. Depending on the nature of such comments, and whether formal objections to the Plan are filed with the Court, a hearing on the Plan may occur as early as late summer or early fall of 2020. Depending on the outcome of that hearing, implementation of the Plan might commence in the fall of 2020. In that event, policyholders may be asked to make their elections before or shortly after year-end.

D. RATIONALE FOR THE PLAN

The Plan hinges on two essential assumptions: (1) in order to maximize policyholder

SHIP REHABILITATION PLAN

protection, the Plan must strive to reduce the Funding Gap by increasing revenue or reducing liabilities; and (2) while premium rate increases can increase revenue by some increment, elimination by policyholders of long-term care coverage they may not truly need or be able to afford will go much further in remedying the Company's dire financial situation. The Rehabilitator believes that the Plan structure, which is the product of extended analysis by industry experts, offers a reasonable prospect of success based on sound principles.

1. The Plan gives policyholders more control over their fates, allowing each to elect the path best suited to his or her circumstances.
2. All policyholders will have at least one option for preserving their current coverage and at least one option for preserving their Current Premium.
3. Target premiums under the Plan take rate increase history and product differences into account, improving the equity of the premium rate structure. Generally, policyholders whose policies were issued in states that have approved comparatively more rate increases over preceding years will face lower premium increases or benefit reductions under the Plan.
4. In every case, unless their policies are already below Guaranty Association limits, policyholders will have at least one option (Option Two) calibrated to Guaranty Association limits to provide outcomes no less favorable than liquidation.
5. The revenue from rate increases under the Plan will go to pay claims and expenses of implementing the Plan whereas, in liquidation, Guaranty Association rate increases are used to reduce assessment burdens for member insurers and not to increase the ability to pay claims.
6. Though certainly not guaranteed, the Plan structure inherently creates the possibility of greatly reducing, if not eliminating, the Company's deficit.

II. GENERAL PLAN DETAILS AND TECHNICAL INFORMATION

This Section of the Plan Document provides detailed and technical explanations of proposed Rehabilitation Plan provisions for modification of long-term care insurance policies issued or assumed or reinsured by Senior Health Insurance Company of Pennsylvania. As modeling and analysis continue, additional refinements are possible. However, the fundamental Plan structure is unlikely to change unless the Court requires it. The following notes may aid in understanding this structure.

SHIP REHABILITATION PLAN

A. PLAN PHASES

The Plan is contemplated to occur in three phases. In **Phase One**, all LTC policies that are not in Non-forfeiture Option status will be evaluated and their holders offered options to modify premiums or benefits, or some combination of the two. The results of this phase for the Company can vary materially depending on Policyholder Elections. They will be monitored and evaluated after Phase One becomes effective to gauge the results. In due course a decision will be made as to whether and, if so, how to implement Phase Two. **Phase Two** will be aimed at narrowing or eliminating any remaining deficit and its timing will depend on the results achieved in Phase One. Under the terms of the Plan, in Phase Two only policies which have not selected Option Two (Basic Policy Endorsements - see section III.A.2.d) or Option Three (Non-forfeiture Option - see Section III.A.3), that are not Self-sustaining in that they are notionally projected to create unfunded liability, and which would not be Fully Covered by Guaranty Associations, will be affected. Holders of these remaining policies will again be asked to “right-size” them by modifying premiums or benefits, or a combination of the two. For that purpose, they will be offered options very similar to those offered in Phase One. Depending on the results of Phase One, Phase Two may also include additional remedial measures. In **Phase Three** SHIP will conclude the run-off of its business in force, as modified by the Plan. The Plan is not designed to create a surplus for SHIP. However, in the unlikely event that the Plan actually does generate a surplus, in Phase Three that surplus will be distributed to policyholders, Agents and other creditors.

B. POLICYHOLDER CATEGORIES

1. For Plan implementation purposes, policyholders are sorted into eight main categories, four each in Phase One and in Phase Two:
 - (1) Active - premium paying;
 - (2) Active - not premium paying (further segregated between lifetime or dual Premium Waiver);
 - (3) Disabled - premium paying; and
 - (4) Disabled - not premium paying.
2. There may be some policyholders who do not fit neatly into the Plan’s defined policyholder categories in each Phase, though none have yet been identified. If so, those will be addressed on an *ad hoc* basis.

C. POLICYHOLDER OPTIONS

1. In each category, policyholders whose Current Premiums are below the If Knew Premium for their policies will have four options, including the option to take a Non-forfeiture Option (NFO) on which no additional premium will be due. No other cash-out or buy-back option will be included. Generally, the options provided by the Plan will be:

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- a. **Option One** - Keep the Current Premium (or Premium Waiver) and downgrade to specified reduced benefits in a manner determined automatically by the Plan. The **Downgrade Process** is explained beginning at page 30. This will be solely a benefit reduction option;
 - b. **Option Two** - Elect **Basic Policy Endorsements** (making the policy one designed to provide reasonable benefits and premiums - see Section III.A.2.d, page 36) at If Knew Premium (as defined below) in Phase One or at Self-sustaining Premium if elected in Phase Two. This option may entail both premium increases and benefit reductions for many policyholders, but premium increases will always be lower than under Option Four. For some policyholders it may entail a premium reduction. Policyholders will be offered two variations of this option, a standard version and an enhanced alternative. As explained below, policyholders who select this option in Phase One will not be asked to make Policy Modifications in Phase Two;
 - c. **Option Three** - Elect a Non-forfeiture Option on which no additional premium will ever be paid (see Section III.A.3, page 37); or
 - d. **Option Four** - Keep the current policy benefits and accept a premium increase. The new premium will be (as defined below) the **Phase One Premium** in Phase One and the **Self-sustaining Premium** in Phase Two. This will be solely a premium increase option.
2. Thus, policyholders whose Current Premiums are below the If Knew Premium for their policies will be able to: (a) keep their current premium with downgraded benefits, (b) choose Basic Policy Endorsements, (c) take a NFO, or (d) to keep their current benefits and pay additional premium.
 - a. The Basic Policy Endorsements modify the existing policy to one with generally more affordable premiums than would be charged for the current policy benefits on an If Knew basis and more limited benefits when compared to the current policy, but generally richer than those in Option One, the downgrade. Details of its provisions are laid out in Section III.A.2.d, page 36, below. As noted, to maximize policyholder choice, two variations of this option will be offered, standard and enhanced.
 - b. The NFO is a reduced paid up policy more fully described in Section III.A.3, page 37, below. No more premium is ever due on the NFO and it will never lapse.
 3. These will be the only options available under the Plan. Other options that are sometimes available in particular states in response to approved rate increases are not offered under the Plan.

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4. In Phase One, policyholders whose Current Premium on the Determination Date (see page 92) is at or above the If Knew Premium for the benefits offered by their policies need not modify their policies, and their policies would not be changed by selecting Option One or Option Four. Such policyholders may do nothing or they may select Option Two or Option Three if they wish to do so to accommodate their individual circumstances, for example to reduce their premiums or to avoid the possibility of a Phase Two rate increase. The Default Option for these policyholders will be that their policies remain unchanged.
5. Subject to the orders of the Commonwealth Court of Pennsylvania (*Commonwealth Court* - which is the rehabilitation court), the Plan contemplates that Basic Policy Endorsements elected in Phase One (Option Two) will be immune from Phase Two changes unless the Company is placed in liquidation. Policyholders who elect this option in Phase One generally will not face premium rate increases or additional benefit reductions in Phase Two of the Plan.
6. However, certain policyholders paying the lower *Phase One Differential Premium* or *If Knew Differential Premium* due to a Premium Waiver may be required to begin paying the full Phase One Premium or If Knew Premium if the Premium Waiver no longer applies (for example because a policyholder on claim recovers). Similarly, in Phase Two certain policyholders paying the *Self-sustaining Differential Premium* due to a Premium Waiver may be required to begin paying the full Self-sustaining Premium if the Premium Waiver no longer applies (for example because a policyholder on claim recovers). See Section III.A.2.c, page 35.
7. Non-forfeiture Options elected in Phase One will not be subject to change thereafter, including in Phase Two or if the Company is placed in liquidation.
8. It is important to note, and policyholders will be advised before making such elections, that policies for which Options One or Option Four are chosen in Phase One may be subject to additional modifications in Phase Two. Moreover, the timing and details of the modifications that may be required in Phase Two will not be known to policyholders when they make their Phase One elections. In particular, policyholders will be advised that options to retain benefits that generate low premium rate increases in Phase One may result in premium rate increases or benefit reductions in Phase Two due to differences in the methodologies used to calculate premium rates in each phase.
9. The exceptions to this possibility of changes in Phase Two are the election of Basic Policy Endorsements or NFO (Options Two and Three, respectively) in Phase One. As noted below (see Section III.A.2.c, page 35), so long as the Plan remains in effect, and unless the Commonwealth Court orders otherwise, the Basic Policy Endorsements elected in Phase One will be immune from Phase Two changes except that (as explained above in Section II.C.5)

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certain policyholders on claim (or their spouses) may be required to pay full Phase One Premium or If Knew Premium when they recover. The NFO is expected to remain permanent through policy termination.

10. The approximately 10,500 policyholders who have already chosen to replace their policies with Non-forfeiture Options before the Plan is implemented will not be asked, or have the ability, to make any changes to their policies as part of the Plan.
11. Beginning on the applicable Effective Date and while the Rehabilitation Plan is in effect, policyholders who fail to pay their premiums when due, or who otherwise terminate or lapse their policies voluntarily, will receive a notice that, as of the date on which the unpaid premium was due, or as of the date of their termination request or lapse notice, their policies will be converted to Non-forfeiture Options. However, they may request in writing that their policies be fully terminated. This would not apply to policyholders who have converted their policies to NFOs, from whom no premium is due.

D. CLAIM STATUS

For purposes of Policyholder Elections:

1. After the Plan is approved, a policyholder will be deemed to be on claim if he or she is receiving health care services that would be reimbursable by the Company were it not for an ***Elimination Period*** (EP) that has not been satisfied. Such a policyholder will be expected to begin receiving indemnity or reimbursement payments as soon as the EP is satisfied.
2. The Company may also determine that a policyholder has been on claim as of an earlier date when that policyholder has been receiving health care services reimbursable by the Company but has not reported such services to the Company. Such a policyholder is expected to be reimbursed for prior covered services when they are reported to the Company, subject to policy terms and conditions and applicable law.

E. PREMIUM RATE DETERMINATIONS

1. The Plan contemplates using different target premium rates in each phase. In the first phase, the target premium will be the Phase One Premium (a variation of If Knew Premium that can be no less than the Current Premium) for policyholders electing Option Four (retain their current benefits). Since in Option One, the premium remains the same, benefits are reduced to what that premium would “buy” at If Knew Premium rates as explained on page 29. For policyholders selecting Option One (retain Current Premium) or Option Two (Basic Policy Endorsements), the target premium will be the If Knew Premium. In Phase Two the target premium will be the Self-sustaining Premium.

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2. The **If Knew Premium** rate is the rate that, if charged from inception, would have produced the greater of the initial target loss ratio or the minimum loss ratio applicable to the policy form. For the sake of simplicity, this will be assumed to be 60%. If Knew Premium rates are intended to price policies adequately on a lifetime basis, but not to recoup losses due to inadequate pricing in the past.
3. For each policy for which the Current Premium is more than the If Knew Premium, the Current Premium will be the Phase One Premium required to maintain the current benefits. In short, that policyholder can (but is not required to) retain the current policy at Current Premium without change in Phase One. Correspondingly, for policies with a Phase One Premium higher than the Current Premium (which in this case would be the same as the If Knew Premium), the downgrade required to maintain the Current Premium will be a reduction in benefits to a level that produces an If Knew Premium equal to the Current Premium as explained beginning on page 29.
4. **Self-sustaining Premium** is the premium calculated by determining the amount of premium required to eliminate a policy's **Shortfall Amount**.
 - a. The Shortfall Amount is the difference between its **Projected Benefit Amount** (PBA) and its **Projected Credit Amount** (PCA) where the difference is more than zero. The Shortfall Amount can also be expressed as a policy's **Gross Premium Reserve** (GPR) less its **Allocated Assets**. If the difference is zero or less there is no shortfall and the policy is Self-sustaining.
 - b. The PBA is the present value as of the valuation date of the sum of (1) unpaid expected policy benefits and (2) unpaid expected policy expenses. For purposes of this determination "expected" consists of best estimate assumptions.
 - c. The PCA is the sum of (1) the present value as of the valuation date of expected premiums, adjusted for future premium increases reasonably expected to be put into effect and (2) the assets allocated to that policy as described below in subparagraph II.E.4.e, page 17. Again, for purposes of this determination "expected" consists of best estimate assumptions.
 - d. **Total Allocable Assets** is a notional determination consisting of the Company's invested assets less reserves for costs of administration, contingencies, and certain debts of higher priority. **Active Allocable Assets** is a notional determination consisting of the Company's Total Allocable Assets less the amount required to fund fully the Claims Reserves for Disabled Lives under the Plan. For the purpose of these calculations, NFO policies will be treated as Disabled Lives and their GPR will be included with Claims Reserves for Disabled Lives. **Disabled Allocable Assets** is a notional allocation consisting of the product of the Active Asset Premium Ratio

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times the Accumulated Premium for Disabled lives. The **Active Asset Premium Ratio** is the ratio of Active Allocable Assets to the aggregate Accumulated Premiums for all Active Lives. For purposes of this calculation, policyholders who have selected an NFO will not be considered Active Lives. **Accumulated Premium** is the total Gross Premiums paid, and premiums waived, under a policy or group of policies from inception until the valuation date. This approach is designed to allocate assets equitably between active and disabled policyholders solely for the purpose of calculating Phase Two premiums.

- e. **Allocated Assets** are the portion of the Company's Allocable Assets notionally allocated to a particular policy in accordance with the terms of, and solely for the purposes of calculations described in, the Plan. Such asset allocations are nominal and do not give a policyholder a right to any Allocated Assets or any particular sum of money. Allocated Assets are determined separately for active lives and disabled lives.
- (1) For each Active Policy, Allocated Assets is the portion of Active Allocable Assets equal to the percentage of total Accumulated Premium for active lives represented by that policy's Accumulated Premium.
 - (2) For a policy on claim, the Allocated Assets is the portion of Disabled Allocable Assets equal to the percentage of total Accumulated Premium for policies on claim represented by that policy's Accumulated Premium.

TABLE 1: ASSET ALLOCATION

1	Total Invested Assets	\$2,500,000,000
2	Reserve for Costs of Administration	\$200,000,000
3	Contingencies	\$10,000,000
4	Priority Debts	\$50,000,000
5	Total Allocable Assets (L1 - (L2...L4))	\$2,240,000,000
6	Claims Reserves for Disabled Lives under the Plan	\$900,000,000
7	Active Allocable Assets (L5 - L6)	\$1,340,000,000
8	Accumulated Premium - All Active Lives	\$4,500,000,000
9	Accumulated Premium - All Disabled Lives	\$480,000,000
10	Accumulated Premium Hypothetical Active Policy	\$40,000

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11	Accumulated Premium Hypothetical Disabled Policy	\$50,000
12	Active Asset Premium Ratio (L7/L8)	30%
13	Disabled Allocable Assets (L9 X L12)	\$142,933,333
14	Allocated Assets Hypothetical Active Policy (L7 X (L10/L8))	\$11,911
15	Allocated Assets Hypothetical Disabled Policy (L13 X (L11/L9))	\$14,889

5. For policyholders on claim in Phase Two, the Self-sustaining Premium will be determined as if they were not on claim. For this purpose, assets will be allocated notionally to policies on claim as explained above.
6. In certain instances the Plan uses a ***Differential Premium***, which in each case is the difference between the target rate (Phase One Premium, If Knew Premium, or Self-sustaining Premium, depending on the option elected and whether this occurs in Phase One or Phase Two) and the Current Premium the policyholder would be paying if not on waiver. Differential Premium can never be less than zero. In cases in which the Current Premium is higher than the target rate, there would be no Differential Premium.
 - a. Thus, in Phase One the Plan requires policyholders not paying premium, who elected Option Four (retain current benefits), to pay the Phase One Differential Premium consisting of the Phase One Premium less the Current Premium they would be paying if they were not on waiver (but not less than zero).
 - b. Policyholders not paying premium who chose Option Two (Basic Policy Endorsements) in Phase One and whose current (waived) premium before making that election was lower than the If Knew Premium for the Basic Policy Endorsements will be required to pay the If Knew Differential Premium. This is the difference between the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements and the Current Premium for the policy, both of which are set as if the policyholder did not have a Premium Waiver in effect.
 - c. Similarly, in Phase Two the Plan requires policyholders not paying premium who selected Option Two (Basic Policy Endorsements) or Option Four (retain current benefits) to pay the Self-sustaining Differential Premium consisting of the Self-sustaining Premium less the Current Premium they would be paying if they were not on waiver (but not less than zero).

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TABLE 2: DIFFERENTIAL PREMIUM			
		CASE 1	CASE 2
1	CURRENT PREMIUM	\$2,300	\$3,200
2	IF KNEW PREMIUM	\$2,250	\$3,500
3	IF KNEW DIFFERENTIAL PREMIUM (L2-L1, BUT NOT <0)	\$0	\$300
4	PHASE ONE PREMIUM	\$2,300	\$3,500
5	PHASE ONE DIFFERENTIAL PREMIUM (L4-L1, BUT NOT <0)	\$0	\$300
6	SELF-SUSTAINING PREMIUMS	\$3,100	\$5,000
7	SELF-SUSTAINING DIFFERENTIAL PREMIUM (L6-L1, BUT NOT <0)	\$800	\$1,800

F. PREMIUM WAIVERS

1. SHIP LTC policies may contain one or more *Premium Waiver* provisions under which a policyholder is permitted to discontinue paying premiums and maintain the policy in force during a period of covered care or under circumstances specified in the policy.
 - a. Under a *Claim Waiver of Premium* (WOP) provision, a policyholder who receives benefits under his or her policy for a specified period of time (such as 90 days) is no longer required to pay premiums for coverage after that time period as long as the policyholder remains eligible for benefits and/or receives a specified level of care. Once the policyholder's eligibility for benefits ends, the policyholder is required to recommence paying premiums in order to keep the policy in force.
 - b. Under a *Dual Waiver of Premium* (DWOP) provision, also called "Spousal Waiver of Premium", a policyholder may suspend premium payments during the time that a spouse qualifies for waiver of premium.
 - c. The *Lifetime Waiver of Premium* provision permits suspension of premium payments upon the death of a covered spouse after a qualifying period (typically five, seven, or ten years). The Lifetime Waiver of Premium provision, as the name implies, is permanent.
2. The Plan affects these Waiver of Premium provisions in specific ways. Policyholders who took a Non-forfeiture Option before the Plan became effective, or who do so under the Plan, do not pay premium and are not affected by Waiver of Premium provisions.
 - a. **Claim Waiver of Premium.** Policyholders on Claim Waiver of Premium on the

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Policyholder Election Date will be treated as if that waiver continues with respect to the premium in effect at that time (the Current Premium).

- (1) If such policyholders elect Option One, which does not entail a premium increase, the Current Premium remains waived and no Differential Premium is applicable. If such policyholders recover, their Current Premium must again be paid but their policies will remain downgraded.
 - (2) If such policyholders make an election under the Plan that increases their premiums (Option Two or Option Four, see page 12), the waiver does not apply to the increase and they will be required to pay Differential Premium consisting of the difference between the Current Premium and the premium under the elected Plan Option. When such policyholders recover and the Claim Waiver of Premium terminates, they must begin paying the full Plan premium. If such policyholders go on claim again following a specified period of recovery and their policy retains the Claim Waiver of Premium provision, the full **Plan Premium** (Phase One Premium, If Knew Premium, or Self-Sustaining Premium, depending on the circumstances) is waived while they are on claim.
 - (3) Policyholders who elect Option Three, the NFO, are unaffected by Premium Waiver provisions because they do not pay premium.
- b. **Dual Waiver of Premium.** Policyholders whose premiums are waived under a Dual Waiver of Premium (DWOP) provision will be treated in the same way as policyholders under a Claim Waiver of Premium. However, it is the status of the spouse on claim that determines whether they pay the Differential Premium or the full Plan premium when they select Option Two or Option Four.
- (1) If a policyholder has selected Option One, is not paying any premium due to the waiver, and his or her spouse recovers, he or she must begin paying the Current Premium but his or her policy will remain downgraded.
 - (2) If a policyholder has selected Option Two, is paying only the If Knew Differential Premium due to the waiver, and his or her spouse recovers, such a policyholder must begin paying the full If Knew Premium. Of course, if the If Knew Differential Premium for that policyholder is zero, he or she need not pay any additional premium.
 - (3) If a policyholder has selected Option Four, is paying only the Phase One Differential Premium due to the waiver, and his or her spouse recovers, such policyholder must begin paying the full Phase One Premium.

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- (4) If a policyholder is on Dual Waiver, has a policy with Claim Waiver of Premium, selects Option Two or Option Four, is paying Phase One Differential Premium or If Knew Differential Premium, and goes on claim after the Effective Date, the Differential Premium will then be waived under the Claim Waiver of Premium provision so that the policyholder will not have to pay any premium while on claim, even if the spouse recovers during that period. Once the policyholder recovers, he or she will be required to resume paying the Differential Premium if the spouse remains on claim and the dual waiver of premium is still effective. If the spouse has also recovered or the dual waiver of premium is otherwise no longer effective, the policyholder will be required to pay the full Phase One Premium or If Knew Premium upon recovery. If both policies with Dual Waiver select Option Four, and one goes on claim after the Effective Date, the full Phase One Premium for both policies would be waived.
- c. **Lifetime Waiver of Premium.** Policyholders who are on Lifetime Waiver of Premium on the Policyholder Election Date will retain that waiver after the Plan Effective Date.
- (1) If such a policyholder makes an election under the Plan that increases his or her premiums (Option Two or Option Four), the Lifetime Waiver of Premium does not apply to the increased portion of the premium and he or she will be required to pay Differential Premium consisting of the difference between the Current Premium and the premium under the elected Plan Option.
 - (2) If a policyholder is on lifetime waiver, has a policy with Claim Waiver of Premium benefit, selects Option Four, and goes on claim after the Effective Date, the Differential Premium will then be waived under the Claim Waiver of Premium provision so that the policyholder will not have to pay any premium while on claim.

G. CERTAIN “NON-CORE” POLICY BENEFITS

Many SHIP LTC policies provide one or more “Non-core” benefits such as:

1. Bed Reservation Benefit,
2. Respite Care,
3. Caregiver Training,
4. Medic Alert,
5. Prescription Drug Benefit,
6. Homemaker Services,

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7. Personal Needs Benefit,
8. Accidental Death Benefit,
9. Helping Hands Benefit,
10. Adult Foster Care,
11. Ambulance Services,
12. Transportation Benefit,
13. Home Delivered Meals,
14. Assistive Equipment, and
15. Remodeling.

The Plan is not intended to affect these benefits and they will continue once the Plan becomes effective unless the policyholder elects Option Three, the Non-forfeiture Option.

H. RATE APPROVALS

1. Rate increases and Policy Modifications will be submitted to Commonwealth Court of Pennsylvania for approval as part of the Plan. The Rehabilitator will not seek separate approval of rate increases or Benefit reductions.
2. The rate increases will not necessarily be limited by, or adhere to, filed rate cards. Rate cards are issued by insurers and approved by regulators to describe the premium rates applicable under specified circumstances or for specific types of coverage. They are inapplicable to the Plan.
3. Premium increases and Policy Modifications will not be submitted to individual insurance departments for approval. This is consistent with the established insurance rehabilitation practice in the U.S. under which the domiciliary regulator as domiciliary rehabilitator may, with only rehabilitation court approval and no approval from individual states, modify or terminate insurance policies issued by the delinquent insurer throughout the country. If its premium rates were subject to approval in each state, the Plan could not meet its goal of eliminating “subsidies” by having policyholders with substantially similar policies generally pay substantially similar premium regardless of the state in which the policyholder resides or in which the policy was issued. Moreover, the delay and expense of state-by-state rate approval would make the Plan unfeasible. Finally, the state-by-state approval process might perpetuate or increase the nation-wide premium rate variations the Plan strives to eliminate.

I. NFOs AND PAID-UP POLICIES

The Plan will not affect the approximately 10,500 policyholders who have already taken NFOs. Their policies will never pay premium and their benefits will not be reduced further by the Plan. The Plan also will not affect paid-up policies for which only a specified number of premium payments were required, including those for which some of those payments remain to be made.

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NFOs selected under the Plan (Option Three) will differ materially from pre-Plan NFOs, principally by providing longer benefit periods.

J. PARTNERSHIP-QUALIFIED POLICIES

Under the Deficit Reduction Act of 2006, certain LTC insurance policies called “*Partnership-Qualified*” (PQ), entitle the policyholder to a dollar of asset disregard or spend-down credit with respect to Medicaid eligibility for every dollar of benefit received under the LTC policy. The provisions of PQ policies vary from state to state but many require a minimum amount of cost of living adjustment (COLA) or Inflation Protection. The Plan will not reduce COLA or inflation protection features for PQ policies below those required for PQ status.

K. PLAN TIMING

1. The Plan is designed for implementation of Phase One as rapidly as possible, with more time available for implementation of Phase Two. At the conclusion of Phase One and continuously thereafter its results will be evaluated and, in due course, a determination will be made as to whether and, if so how, Phase Two should be implemented.
2. The anticipated timeline provides for a fair opportunity for policyholders and interested parties to evaluate and object to, or comment upon, the Plan if they choose to do so. The Rehabilitator may suggest modifications of the Plan as a result of those comments and objections, if any. Illustration 4 provides a high-level sequence for the Plan.

TABLE 3: PLAN SEQUENCE	
1.	Filing of Proposed Rehabilitation Plan and request for approval of notice
2.	Notice to Policyholders and Interested Parties
3.	Deadline for Objections and Comments
4.	Hearing on Rehabilitation Plan, if necessary
5.	Order Approving, Modifying or Disapproving Plan
6.	Final Approval Date (assuming approval)
7.	Plan Preparation Period
8.	Determination Date
9.	Policyholder Election Package

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10.	Policyholder Election Deadline
11.	Begin Policyholder Transition Period
12.	Evaluation of Policyholder Elections
13.	End Policyholder Transition Period
14.	Initial Plan Effective Date
15.	Supplemental Policyholder Election Package
16.	Supplemental Policyholder Election Date
17.	Supplemental Plan Effective Date
18.	Evaluation of Phase One
19.	Decision on Phase Two
20.	Phase Two Policyholder Election Package
21.	Phase Two Policyholder Election Deadline
22.	Phase Two Effective Date
23.	Evaluation of Plan performance
24.	Phase Three, if justified.

- a. The Plan will be submitted to the Commonwealth Court for approval, modification, or disapproval. Policyholders and interested parties will have an opportunity to offer comments about, or object to, the Plan. The Commonwealth Court may then hold a hearing on the Plan. Following the hearing, the Court will approve, modify or disapprove the proposed Plan. If the Plan is approved (with or without modification), the date upon which such approval becomes final (including exhaustion of appeals, if any) will be the ***Final Approval Date***. It will commence the ***Plan Preparation Period***, which will end with the ***Initial Plan Effective Date***. During the Plan Preparation Period:

- (1) The Company will make all the determinations and perform the calculations required to construct the options available to each policyholder. All determinations will be made as of a ***Determination Date*** which may vary from policyholder to policyholder but which will always be before the Policyholder Election Date defined below.
- (2) The ***Policyholder Election Package*** (containing the information required for

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policyholders to make their elections) and the ***Policyholder Election Forms*** (upon which they will do so) will be prepared and distributed.

- (3) Except as noted below in Section II.K.3, page 25, the Policyholder Elections must be made by the ***Policyholder Election Date*** and will be collected and evaluated by the Company as received.
- (4) On the ***Initial Plan Effective Date*** all the Policyholder Elections, other than those addressed in Section II.K.3.c, below, will be implemented and the premium and policy changes will take effect.
- (5) The Initial Plan Effective Date may vary from policyholder to policyholder. For each policyholder the Initial Plan Effective Date will be the policy's ***Monthiversary Date*** occurring during the ***Initial Plan Effective Month***. See definitions, pages 95 and 97.

- b. The Plan Preparation Period may be several months long in order to provide time for the calculations and other steps necessary to implement the Plan. This includes the period necessary to advise policyholders of their options and to enable them to make the necessary elections.

3. Changes in policyholder circumstances occurring between the Policyholder Election Date and the Initial Plan Effective Date (the ***Policyholder Transition Period***) will not affect policyholders' elections except as follows:

- a. Policyholders who have qualified for a Premium Waiver which has not yet become effective as of the Policyholder Election Date due to a waiting period or premium paying modal factor will be treated as if they were not paying premium on the ***Policyholder Election Date*** and will be required to elect from among the options available to policyholders not paying premiums. If their policies have ***Dual Waiver of Premium*** (DWOP) the same will be true for their spouses. If such policyholders (or their spouses eligible for DWOP) elect Option Two (Basic Policy Endorsements - see Section II.C.1.b, page 13), or Option Four (retain current benefits at Phase One Premium - see Section II.C.1.d, page 13), they will be required to pay the full Phase One Premium or If Knew Premium, respectively, until the waiver becomes effective and to pay the Phase One Differential Premium or If Knew Differential Premium, respectively, thereafter.
- b. Policyholders who have been deemed eligible for benefits, but the benefits are pending and they have therefore not yet gone on claim, will be treated as if they were on claim and be required to elect from among the options available to policyholders on claim, including the availability of Premium Waiver. Note that during the

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Policyholder Transition Period, when policyholders whose policies contain DWOP are deemed eligible for benefits, are pending and have not yet gone on claim, and are treated as if on claim, their spouses will also be treated as if on Dual Waiver of Premium.

- c. Policyholders who, during the Policyholder Transition Period,
 - (1) discontinue paying premium due to the activation of a Premium Waiver other than those described in subparagraph (a), above), or
 - (2) go on claim (other than those described in subparagraph (b), above), or
 - (3) recover and cease being on claim, or
 - (4) commence paying premium due to the deactivation of a Premium Waiver, and
 - (5) the DWOP spouses of such policyholders

will all be required to elect new options from among those available to policyholders in their new circumstances. They will be provided new Policyholder Election Forms after the Policyholder Election Date, will have an opportunity to make new elections from among options applicable to policyholders in their new circumstances, and will have those elections implemented on a ***Supplemental Plan Effective Date***.

L. POLICYHOLDER INFORMATION

1. Phase One - Before being required to make an election in Phase One of the Plan, each eligible policyholder will receive a ***Policyholder Election Package*** that includes notice and details of the Plan, including a detailed description of Phase One and preliminary descriptions of Phase Two and Phase Three. As to Phase One, these details will include the premium amount and/or benefit reductions that will apply to the policyholder's specific policy under each applicable option in Phase One of the Plan. The notice will make clear that whether or not Phase Two will be implemented, and if so its exact details, may be subject to change depending on the circumstances following Phase One. It will also note that the entire Plan is subject to the orders of the Commonwealth Court and that, if the Company is placed in liquidation, some or all of the Plan's provisions may be changed in accordance with the law applicable to liquidations. Policyholders with more than one policy will be advised that they are required to make independent elections for each policy.
2. Phase Two - Before being required to make any elections in Phase Two of the Plan, each policyholder eligible to make elections in this Phase will receive a ***Phase Two Policyholder Election Package*** that includes notice and details of Phase Two of the Plan. These details will include the premium amount and/or benefit reductions that will apply to the policyholder's specific policy under each applicable option of the Plan in Phase Two.

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M. CALCULATION NOTES

1. The assets allocated on an Accumulated Premium basis for determination of Self-sustaining Premium will be those remaining after provision is made for administrative costs and contingencies as more fully explained above at Section II.E.4.d, page 16.
2. Whenever the Plan calls for adjustment of the **Maximum Benefit Period** (MBP) it will be calculated in increments of whole days.
3. Whenever the Plan calls for matching an existing premium rate, it may be by rounding the premium to the nearest dollar.
4. In calculating the Phase One Premium, the If Knew Premium, and other Plan provisions, periods on claim (including those followed by recovery) prior to the Initial Plan Effective Date will be taken into account and reduce the remaining benefit period. The operative benefit period for the policy will be what remains on the Determination Date. Thus, a policyholder whose initial Maximum Benefit Period was eight years when the policy was issued, but who has used five years of benefits (whether in one or more periods on claim) that were not restored or eligible for restoration and therefore has three years remaining as of the Determination Date, will be deemed to have a Maximum Benefit Period of three years for Plan calculation purposes. The Phase One Premium and If Knew Premium will be calculated using the remaining benefit period without regard to prior periods on claim. Thus, for this hypothetical policyholder the premium will be calculated for a policy with a three year MBP.
5. In calculating reductions of the Maximum Benefit Period, for policies with two different pools of money, one (typically of two years) for Home Health Care and one (typically longer, part of which may have been utilized) for Assisted Living Facility Care or Nursing Home Care:
 - a. The Plan will treat the policy as having a single benefit period equal to the longer of those provided by the pools. The benefit periods provided by the pools will not be aggregated. Thus, the Maximum Benefit Period for Assisted Living Facility Care cannot be increased by adding the unused benefit period for Home Health or *vice versa*.
 - b. Benefits paid under the policy regardless of site of care, will reduce the new single benefit period.
 - c. Pools shorter than four years will not be adjusted by the Plan. If benefits have reduced the benefit period below four years as of the Effective Date, it will remain at that level for Plan calculation purposes.

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6. Policies that share a pool of benefits before the Policyholder Election Date, so that a policyholder whose benefit period is exhausted may continue receiving benefits under the shared pool until it is exhausted, will be treated for purposes of calculating premiums under the Plan as having a benefit period equal to the sum of the policy's benefit period and half of the shared pool's benefit period. Such policies will continue sharing a pool after the Plan and elections made under the Plan will affect only the policy's benefit period, not the value of the shared pool. When such a policyholder goes on claim after the applicable Plan Effective Date, the claim will reduce the policy's benefit period first and then the shared pool. Policyholders sharing a pool need not make the same elections under the Plan.
 - a. For a policyholder who elects Option One, the downgrade will affect only the policy's benefit period (which cannot be reduced below four years unless it is already below that) and not the shared pool.
 - b. For a policyholder who elects Option Two, the policy's benefit period may be reduced but it will retain the possibility of benefits under the shared pool.
 - c. Thus, the premium for such a policyholder who elects Option Four will be calculated as if the policy had a benefit period equal to the sum of the policy's current benefit period plus half of the shared pool.
7. A policy with an unlimited benefit period will be deemed to have an unlimited **Maximum Policy Value** (MPV - the product of a policy's **Maximum Benefit Period** times its **Maximum Daily Benefit** - MDB).
8. The Plan contemplates that the minimum premium for Basic Policy Endorsements in Phase Two will be 110% of the If Knew Premium to discourage delaying the selection of Basic Policy Endorsements to Phase Two. See Sections IV.B.2.c, IV.C.1.b, IV.C.2.b.(4), IV.E.2.b, and IV.D.1.b.
9. Premium paying modalities (*i.e.*, monthly or quarterly payments) in effect before the Plan will be unchanged by the Plan unless necessary to give effect to a policyholder's election. If a policyholder is not paying premium prior to the applicable Plan Effective Date due to a waiver, and under the Plan he or she must begin paying a premium (such as a differential premium), the premium modality in effect prior to the waiver becoming effective will apply to the premium under the Plan.
10. Fees charged before commencement of the rehabilitation to premium payments based on modality (such as additional fees for monthly premiums) will continue to apply to premiums paid under the Plan on the same basis.

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N. DRAFTING NOTES

1. As endorsements are drafted to implement policy changes, provisions not intended to be substantively affected will be left unchanged unless editing is necessary to implement the modifications selected.
2. As a result, for example, if a policy has an unlimited benefit period and a Restoration of Benefit provision, shortening the benefit period will not remove the Restoration of Benefit provision. However, the Restoration of Benefits provision cannot extend the benefit period beyond the newly shortened Maximum Benefit Period. Similarly, policies with limits in terms of days-of-care will remain so and not be converted to pool-of-money policies except by operation of the Downgrade Process or if the Basic Policy Endorsement is elected.
3. Replacement language to implement modifications will strive to eliminate ambiguities and add clarity.
4. If the language of the current policy does not differentiate clearly between Nursing Home and Assisted Living Facilities (ALF) coverage so that SHIP is now covering ALF care within the Nursing Home provision in those policies, electing the Basic Policy Endorsements will not eliminate ALF coverage but Maximum Daily Benefits for ALF care will be limited to 75% of the policy's MDB.

III. DETAILS OF PHASE ONE OF THE PLAN

A. ACTIVE LIVES PAYING PREMIUM (*ACTIVE - PAYING*)

1. OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS.
 - a. Policyholders can keep their Current Premium but will have policy benefits reduced if the Current Premium is less than the If Knew Premium for their policy benefits.
 - b. The target premium for this Option is the Phase One Premium, which is the higher of the Current Premium and the If Knew Premium. For policyholders whose Current Premiums equal or exceed the If Knew Premium for their policies, no downgrade will be necessary because they are already paying the target premium and Options One and Four will produce the same result - no change in their policies. For other policyholders (those whose Current Premiums are lower than the If Knew Premium for their current policies), the benefit reductions applied to each policyholder who elects this option will be calibrated to produce benefits for which the premium on an If Knew Premium basis will be within 2% of the Current Premium, determined as follows:

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- (1) The Downgrade Process, as described below at Section III.A.1.c, page 30, will reduce benefits so that the downgraded benefits will produce a premium on an If Knew Premium basis within 2% of the Current Premium, *i.e.*, no lower than 98% nor higher than 102% of the Current Premium.

TABLE 4: IS DOWNGRADE NECESSARY?

IF:	CASE 1	CASE 2
1. THE CURRENT PREMIUM IS	\$3,000	\$3,200
and		
2. THE IF KNEW PREMIUM FOR THE CURRENT BENEFITS IS	\$2,800	\$5,000
THEN:		
IN CASE 1, SINCE THE IF KNEW PREMIUM IS LOWER THAN THE CURRENT PREMIUM, THERE WILL BE NO BENEFIT REDUCTIONS.		
IN CASE 2, SINCE THE IF KNEW PREMIUM IS MORE THAN THE CURRENT PREMIUM, BENEFITS WILL BE REDUCED 36% TO THE CURRENT PREMIUM.		

- c. DOWNGRADE PROCESS: A single combination of one or more of the benefit reductions described in Section III.A.1.f, page 32 below, will be selected by the Rehabilitator in accordance with the Plan provisions to reduce the policy's benefits to a combination with an If Knew Premium within 2% of the Current Premium. Policyholders will not have the option of electing specific benefit reductions.
- (1) Not all of the benefit reductions on the list below will be applicable to all policies. For example, eliminating inflation protection features would not be applicable to a policy that has no such benefits. Similarly, shortening the Maximum Benefit Period would not be applicable to a policy with a benefit period that does not exceed four years. Thus, the list of potentially applicable benefit reductions may vary from policy to policy.
- (2) Each benefit reduction option is expected to have a materially different effect on premiums, some reducing the If Knew Premium more than others. The result of a particular benefit reduction may vary among different policies. Benefit reductions will be selected sequentially, beginning with the first potentially applicable benefit reduction for the policy in question. However, in some cases the Rehabilitator may skip over one or more possible benefit reductions (for example, because they are inapplicable, produce too large a reduction, or are non-scalable) in order to produce the If Knew Premium closest to the Current Premium.

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- (3) The Rehabilitator may also scale a potentially applicable scalable benefit reduction up or down to simplify the process, for example by enabling fewer benefit reductions to be effected to achieve the desired premium level. For the sake of simplicity, efforts will be made to minimize the number of benefit reductions effected.
 - (4) Benefits will not be scaled above or below Plan Limits (a range of four to six years for MBP and \$300 to \$600 for MDB) unless current benefits already fall short of or exceed these limits.
- d. The default mode will be to evaluate the potentially applicable benefit reductions in the order in which they are included in the Plan.
- (1) If the first potentially applicable benefit reduction produces an If Knew Premium that is higher than 98% of the Current Premium it will be selected. If it produces a premium lower than 98% of the Current Premium, it would implement too deep a benefit reduction and would not be selected.
 - (a) If that first potentially applicable benefit reduction produces an If Knew Premium that is between 98% and 102% of the Current Premium, that will be the only benefit reduction and downgrade necessary for the policy in order to implement Option One.
 - (b) If the benefit reduction produces an If Knew Premium above 102 % of the Current Premium, is scalable, and can be scaled down sufficiently to produce an If Knew Premium no higher than 102% of the Current Premium without going below Plan Limits for MDB and MBP, then it will be scaled down sufficiently to achieve that result and that will be the only benefit reduction for the policy.
 - (2) If the first potentially applicable benefit reduction will not suffice (with or without scaling, if applicable) to reach an If Knew Premium within 2% of the Current Premium, the next potentially applicable benefit reduction will then be evaluated in the same manner, taking into account the effect of the previously selected potentially applicable benefit reduction.
 - (3) If the result is still an If Knew Premium that is higher than 102% of the Current Premium, that reduction will also be selected and the next potentially applicable benefit reduction will then be evaluated, again taking into account the effects of the previously selected potentially applicable benefit reductions.
 - (4) This process will continue until the resulting If Knew Premium is within 2%

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of the Current Premium. If it is within 2% of the Current Premium the process is complete and the potentially applicable benefit reductions selected will constitute the downgrade option for that policy.

- (5) If the benefit reductions selected, in combination, produce an If Knew Premium that is lower than 98% of the Current Premium, the policy's MDB and MBP can be increased (subject to Plan Limits) to produce (in combination with previously selected benefit reductions) an If Knew Premium within 2% of the Current Premium. If raising the MBP and MDB (in combination with previously selected benefit reductions) still does not produce an If Knew Premium within 2% of the Current Premium, the policy's premium can be reduced so that the resulting If Knew Premium is within 2% of the Current Premium.
 - (6) If all of the benefit reductions selected in combination produce an If Knew Premium that is higher than 102% of the Current Premium, then in addition, the Maximum Benefit Period will be shortened (but not below Plan Limits) to the extent necessary to produce an If Knew Premium within 2% of the Current Premium.
 - (7) If the resulting If Knew Premium is still higher than 102% of the Current Premium, then the Maximum Daily Benefit will be reduced (but not below Plan Limits) to the extent necessary to produce an If Knew Premium within 2% of the Current Premium.
 - (8) In the unlikely event that after all these steps the If Knew Premium for the reduced benefits remains higher than 102% of the Current Premium, there will be no further reductions and those will be the downgraded benefits and the premium charged for those benefits will be the Current Premium.
- e. Each policyholder will only receive one downgrade option, calculated as described in this Section. The Rehabilitator may develop algorithms, tables or other tools that will facilitate implementation of this process through classification of the existing policies. Policy provisions not identified in this Section will not be affected by the Downgrade unless necessary to implement the specified option.
- f. ***Possible Active Benefit Reductions:***
- (1) ***Benefit Reduction One:*** Adjustment of the "recovery period" for Restoration of Benefits provisions so that to be eligible for the benefit period restoration the policyholder must not be eligible for health benefits during a continuous and uninterrupted period of not less than six months. This is a binary and

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non-scalable benefit reduction.

- (2) **Benefit Reduction Two:** For policies with less restrictive triggers, adoption of the TQ Trigger. See Section III.A.2.d.(8), page 36. This is a binary and non-scalable benefit reduction.
- (3) **Benefit Reduction Three:** Elimination of Return of Premium (ROP) provisions. However, accrued ROP benefits, for policies which provide that they accrue over several years and are then paid, will not be lost and will be calculated as of the applicable Plan Effective Date and repaid within a reasonable time after that date or when due. This is a binary and non-scalable benefit reduction.
- (4) **Benefit Reduction Four:** Removal of inflation and “locking” of MDB at their current levels. This is a scalable benefit reduction because the MDB can be increased or decreased within Plan Limits as necessary.
- (5) **Benefit Reduction Five:** Conversion of indemnity to reimbursement. See Section VI.B.1.f, page 71. This is a binary and non-scalable benefit reduction.
- (6) **Benefit Reduction Six:** Reduction of MBP to no more than four years (from the applicable Plan Effective Date). If the current MBP is less than four years it will not be modified. As long as the resulting MBP is above the lesser of (a) the current period, or (b) four years, this is a scalable benefit reduction.
- (7) **Benefit Reduction Seven:** Extension of the EP to 90 days. If the current EP is 90 days or more it will not be modified. The EP will apply to each period of care. This will be treated as a binary and non-scalable benefit reduction.
- (8) **Benefit Reduction Eight:** Reduction of the policy’s MDB to \$300. This is a scalable benefit reduction (that can be increased or decreased) so long as the resulting MDB is within Plan Limits. For comprehensive policies, this benefit reduction will also reduce the MDB available for Assisted Living Facilities to 75%, and for Home Health Care to 50% of the nominal MDB.
- (9) **Benefit Reduction Nine:** Elimination of all Waiver of Premium provisions. For purposes of the Plan this is a binary and non-scalable benefit reduction. The Plan will not allow elimination of fewer than all available Premium Waiver provisions.

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- (10) ***Benefit Reduction Ten:*** Elimination of Restoration of Benefits (ROB) provisions. This is a binary and non-scalable benefit reduction.
 - (11) ***Benefit Reduction Eleven:*** Removal of Alternative Plan of Care (APOC) provisions. This is a binary and non-scalable benefit reduction.
 - (12) ***Benefit Reduction Twelve:*** Convert to pool of money and reduce maximum benefit amount to amount required to achieve the Current Premium subject to Plan Limits.
- g. The Downgrade is generally the Default Option for policyholders on Premium Waiver. However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than the benefits offered by the NFO, the NFO will be the Default Option.

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TABLE 5: DOWNGRADE PROCESS

Assume that the policy at issue has a current annual premium of \$2,000 but that the If Knew Premium for the benefits it provides would be \$3,200. Because it is more than the Current Premium, benefits will be downgraded so that the If Knew Premium for such benefits is within 2% of the Current Premium. Reduction to the Current Premium requires a target benefit reduction of 37.5% ($\$2,000/\$3,200$). Furthermore, assume that the policy has Inflation Protection, is Tax Qualified, has a recovery period of six months, and reimbursement, not indemnity benefits. The following illustrates the Downgrade Process for this hypothetical policy. Each potentially applicable benefit reduction would be evaluated as follows:

1. Hypothetically, Benefit reductions One, Two and Three (BR1, BR2, and BR3) are inapplicable because the policy already has a recovery period of six months, TQ Triggers, and no ROP benefits. Benefit reduction Four (BR4) - Removal of inflation and "locking" of MDB at current level - hypothetically produces an If Knew Premium of \$2,720, a 15% reduction. The If Knew Premium is still above \$2,040, 102% of the Current Premium. This benefit reduction would be selected.
2. BR5 would be inapplicable because this is already a reimbursement policy. Benefit reduction Six (BR6) - reduction of MBP to no more than four years (from the Plan Effective Date) - is evaluated in combination with previously selected BR4 and the result of reducing the MBP to four years is hypothetically an If Knew Premium of \$2,144 (a combined 33% reduction). The If Knew Premium remains above \$2,040, 102% of the Current Premium. BR6 would also be selected and BR7 would be the next to be evaluated.
4. Benefit reduction Seven (BR7) - Extension of the EP to not less than 90 days - is then evaluated in combination with BR4 and BR6, and the result of extending the EP to 90 days (in combination with BR4 and BR6) is hypothetically an If Knew Premium of \$1,920 (a combined reduction of 40%). This reduces the premium below the target of 37.5%.
5. BR4 is then scaled up by increasing the MDB (but not above \$600) to the point at which the If Knew Premium is \$2,000, equal to the Current Premium, amounting to a 4% increase in the If Knew Premium of \$1,920 produced by BR4, BR6, and BR7.

2. **OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT CORRESPONDING IF KNEW PREMIUM.**
 - a. Policyholders will have the option to have their current policy endorsed to provide benefits substantially similar to a newly designed Basic Policy.
 - b. The new premium for the policy will be the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements.
 - c. **THIS OPTION WILL BE IMMUNE FROM PHASE TWO CHANGES. Policyholders who elect this option will not face premium rate increases or**

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benefit reductions in Phase Two of the Plan. However, under certain circumstances a policyholder who is paying the If Knew Differential Premium for the Basic Policy Endorsements because he or she is on Premium Waiver may be required to pay the full If Knew Premium if the waiver ceases to apply, for example due to recovery of the policyholder on claim.

- d. Key provisions of the Basic Policy Endorsements are:
- (1) MBP equal to the lesser of (a) the current benefit period, and (b) four years (beginning on the applicable Plan Effective Date);
 - (2) Minimum EP equal to the longer of (a) 90 calendar days, or (b) the current EP;
 - (3) Minimum 6-month Recovery Period;
 - (4) Removal of Return of Premium (ROP) benefit. However, accrued ROP benefits, for policies which provide that it accrues over several years and is then paid, will not be lost and will be calculated as of the applicable Plan Effective Date and repaid within a reasonable time after that date or when due.
 - (5) Reduction of Inflation to 1.5% for policies with inflation above that level;
 - (6) Initial MDB set at lesser of 80% of current level or \$300;
 - (7) Adjusting MDB by site of care: 100% of MDB available for Nursing Home Care, 75% of MDB available for Assisted Living Facility Care, and 50% of MDB available for Home Health Care;
 - (8) Adopting ***Tax Qualified*** (TQ) Triggers. Tax Qualified or TQ Triggers require that a person 1) be expected to require care for at least 90 days, and be unable to perform 2 or more Activities of Daily Living (ADL - eating, dressing, bathing, transferring, toileting, and continence) without substantial assistance (hands on or standby); or 2) for at least 90 days, need substantial assistance due to a severe cognitive impairment. In either case a licensed healthcare professional must certify a plan of care;
 - (9) Conversion of reimbursement policies to indemnity;
 - (10) Removal of Restoration of Benefits (ROB) provisions;

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(11) Conversion of “Days of Care” policies to “Pool of Money;” and

(12) Elimination of all Premium Waivers.

- e. This will be the Default Option for policyholders in this category (active, paying premium) whose Current Premium is lower than the If Knew Premium.
- f. Unless the benefits of their current policies are lower, policyholders will also be offered an “Enhanced Basic Policy Endorsement” with the terms described above but caps at a five-year benefit period and 2% inflation at higher If Knew Premium. In Phase Two the premium for the Enhanced Basic Policy Endorsements will be at Self-sustaining Premium rates. For a policyholder whose current policy has a Maximum Benefit Period of less than five years but inflation above 2%, the Enhanced Basic Policy Endorsements will only affect the inflation benefit. For a policyholder whose current policy has a inflation below 2% but a Maximum Benefit Period of more than five years, the Enhanced Basic Policy Endorsements will only affect the Maximum Benefit Period.
- g. With the exception of the change from reimbursement to indemnity, benefits in the Basic Policy Endorsements (even in the Enhanced Basic Policy Endorsements) cannot exceed those in the current policy. If a particular component of the Basic Policy Endorsements provides more coverage than the current policy’s corresponding provision, that provision of the current policy will not be modified by endorsement. Thus, for example, if the MBP of the current policy is three years, the Basic Policy Endorsements for that policy will incorporate a Maximum Benefit Period of three, not four or five years.
- h. For those policies with an MPV that is currently above their applicable Guaranty Association (GA) limits, the endorsed policy’s MPV will be adjusted so that it is at least equal to the applicable GA limit. The adjustment will be made by lengthening the MBP.

3. **OPTION THREE - NFO.**

- a. Policyholders can elect a Non-forfeiture option (NFO) policy under which the MBP will be the lesser of 2.5 years and the policy’s current MBP. Like the Basic Policy Endorsements, this will be an indemnity policy (not reimbursement) with no ROP or ROB benefits, a minimum 90-day EP, and TQ triggers. The policy will not have an inflation protection feature and the MDB will be set at the lesser of 80% of the current level or \$300. The MDB will be adjusted by site of care at 100% of MDB available for Nursing Home Care, 75% of MDB available for Assisted Living Facility Care, and 50% of MDB available for Home Health Care.

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- b. No additional premiums will be due for this policy and it will never lapse.
 - c. This policy is much more generous than traditional NFOs. It cannot be upgraded later.
 - d. The selection of indemnity, rather than reimbursement, modality for Options Two and Three is expected to be of significant value to policyholders.
4. **OPTION FOUR - KEEP CURRENT BENEFITS AND PAY PHASE ONE PREMIUM.**
- a. Policyholders can elect to keep their current benefits and their premiums will increase to the Phase One Premium. See Section II.E.1, page 15, above. Policyholders whose Current Premiums equal or exceed the If Knew Premium for their policies will continue to pay their Current Premiums. For those policyholders, this option, like Option One, does not result in any change.
 - b. Policyholders selecting this option may also face substantial rate increases or Benefit reductions in Phase Two.

B. ACTIVE LIVES NOT PAYING PREMIUM (*ACTIVE - WAIVER*)

1. **LIFETIME WAIVER** - Policyholders not paying premium due to Lifetime Waiver of Premium (because of the death of a spouse) will have essentially the same four options as premium paying active lives (see Section, III.A, page 29) with the following modifications:
- a. **OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS.** If the Current (waived) Premium is equal to or greater than the If Knew Premium, there will be no downgrade and Options One and Four will produce the same result - no change in their policies. If the Current Premium is less than the If Knew Premium the policy will be downgraded as follows.
 - (1) Due to the Premium Waiver the policyholder will continue not paying premium.
 - (2) The Downgrade Process will be the same as for premium-paying active lives (see Section III.A.1.c, page 30, above).
 - (3) The specific possible benefit reductions will be the ones described in Section III.A.1.f, page 32, above.
 - (4) The benefit reductions will be calibrated to the Current Premium as explained

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in Section III.A.1.b, page 29.

- (5) This will be the Default Option for these policyholders. However, for those policyholders for whom the benefits that result from the Downgrade Process in Option One are lower than those offered by the NFO, the NFO will be the Default Option.

b. **OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT IF KNEW DIFFERENTIAL PREMIUM (rather than the If Knew Premium).**

- (1) The If Knew Differential Premium for this option is the difference between the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements and the Current Premium for the policy, both of which are set as if the policyholder did not have a Premium Waiver in effect. If the If Knew Differential Premium is less than zero, the policyholder will not be required to pay any additional premium for the Basic Policy Endorsements.
- (2) Policyholders will also be offered an “Enhanced Basic Policy Endorsement” at higher If Knew Premiums. See Section III.A.2.f, page 37.
- (3) Policyholders who elect this option in Phase One will not face premium rate increases or additional benefit reductions in Phase Two of the Plan.
- (4) The Guaranty Association floor on benefit reductions will be applied to these policyholders as described in Section III.A.2.h, page 37.

c. **OPTION THREE - NFO (see Section III.A.3, page 37).**

d. **OPTION FOUR - KEEP THE CURRENT BENEFITS AND PAY PHASE ONE DIFFERENTIAL PREMIUM.**

- (1) The If Knew Differential Premium for this option is the difference between the If Knew Premium and the Current Premium for the policy, both of which are set as if the policyholder did not have a Premium Waiver in effect. If the If Knew Differential Premium is less than zero, the policyholder will not be required to pay any additional premium.
- (2) Policyholders who elect this Option may also face substantial rate increases in Phase Two.

2. **DUAL WAIVER - The options for a policyholder not on claim but not paying premium due**

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to a Dual Waiver (because his or her spouse is on claim) will be the same as for a policyholder not on claim with a Lifetime Waiver except that the premium he or she must pay will be determined in part by the spouse's claim status. The default for these policyholders will be Option One (Downgrade). However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, Option Three, the NFO, will be the Default Option.

- a. **OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS.** The policyholder will retain the Current Premium Waiver. If the Current Premium the policyholder would be paying in the absence of waiver is equal to or greater than the If Knew Premium the policy will not be downgraded. If the If Knew Premium is greater than the Current Premium the policyholder would be paying in the absence of waiver, the policy will be downgraded as follows:
 - (1) The Downgrade Process will be as described in Section III.A.1.c, page 30 subject to the following provisions.
 - (2) The Possible Active Benefit Reductions will apply, as described in Section III.A.1.f, page 32. Benefit reductions for each policyholder to whom this option applies will be calibrated to produce an If Knew Premium within 2% of the Current Premium for the policy (see Section III.A.1.b, page 29). However, because of the waiver, the policyholder will not be required to pay any premium.
 - (3) If the disabled spouse resumes paying premiums, the active spouse will also be required to resume paying premiums at the premium rate he or she would be paying if not on waiver, but if the policy has been downgraded it will remain downgraded.
- b. **OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT IF KNEW DIFFERENTIAL PREMIUM.**
 - (1) The policy will be modified through the Basic Policy Endorsements (See Section III.A.2.d, page 36). The policyholder will be required to pay the If Knew Differential Premium. The If Knew Differential Premium for this Option is the difference between the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements and the Current Premium for the policy, both of which are set as if the policyholder did not have a Premium Waiver in effect. If the If Knew Differential Premium is less than zero, the policyholder will not be required to pay any additional premium for the Basic Policy Endorsements.

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- (2) Policyholders will also be offered an “Enhanced Basic Policy Endorsement” at higher If Knew Premiums. See Section III.A.2.f, page 37.
 - (3) The Guaranty Association floor on benefit reductions will be applied to these policyholders as described in Section III.A.2.h, page 37.
 - (4) Policyholders who elect this option in Phase One will not face premium rate increases or additional benefit reductions in Phase Two of the Plan, except as noted below.
 - (5) If the disabled spouse recovers, the active spouse will be required to begin paying the full If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements.
- c. **OPTION THREE - NFO.**
- (1) The policyholder can select a NFO. See Section III.A.3.
- d. **OPTION FOUR - KEEP CURRENT BENEFITS AND PAY PHASE ONE DIFFERENTIAL PREMIUM:** The policyholder will retain the current policy benefits and pay the Phase One Differential Premium (see Section II.E.6.b, page 18). However, if the disabled spouse recovers, the active spouse will be required to begin paying the full Phase One Premium. As noted, if the Current Premium is equal to or greater than the If Knew Premium, the policyholder will not be required to pay a Differential Premium.

C. **DISABLED LIVES PAYING PREMIUM (ON CLAIM - PAYING)**

Policyholders on claim, who are paying premiums, will have the same options as active lives paying premiums (see Section III.A, page 29), subject to the following conditions:

- 1. **OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS.**
 - a. Policyholders will preserve their Current Premium. For policyholders whose Current Premiums equal or exceed the If Knew Premium for their policies, no downgrade will be necessary because they are already paying the target premium and Options One and Four will produce the same result - no change in their policies. However, if the Current Premium is less than the If Knew Premium, the policy will be downgraded using the Downgrade Process described in Section III.A.1.c, page 30, above, subject to the following provisions.
 - b. The following *Possible on Claim Benefit Reductions* will apply instead of the Possible Active Benefit Reductions:

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- (1) **Benefit Reduction One:** Removal of inflation and locking of MDB at current level. This reduction will be implemented as describe in Section III.A.1.f.(4), page 33, above.
 - (2) **Benefit Reduction Two:** Conversion of indemnity policies to reimbursement policies.
 - (3) **Benefit Reduction Three:** Reduction of MBP to no more than four years (from the applicable Plan Effective Date). If the current MBP is less than four years, the policy will retain its current MBP.
 - (4) **Benefit Reduction Four:** Elimination of Restoration of Benefits provision.
 - (5) **Benefit Reduction Five:** Reduction of the policy's MDB to \$300 if it is above \$300. This is a scalable benefit reduction (that can be increased or decreased) so long as the resulting MDB is within Plan Limits.
- c. The reductions will be calibrated to produce an If Knew Premium within 2% of the Current Premium for the policy (see Section III.A.1.b, page 29).
 - d. Note that the Downgrade Process does not change the premium being paid prior to the downgrade.
 - e. If the policyholder regains active status, for future periods of care:
 - (1) The EP will be no less than 90 days. If the current EP is more than 90 days the policy will retain the current EP;
 - (2) The EP will apply to each period of care; and
 - (3) TQ triggers will apply. See Section III.A.2.d.(8), page 36.
2. **OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT IF KNEW PREMIUM.** The policy will be endorsed as described in Section III.A.2.d, page 36, at If Knew Premium.
 - a. For those policies with an MPV that is currently above their applicable GA limits, the endorsed policy's MPV will be adjusted to be at least equal to the applicable Guaranty Association limits. The adjustment will be made by lengthening the MBP.
 - b. Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher If Knew Premiums. See Section III.A.2.f, page 37.

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- c. Changes in EP and benefit trigger would apply to subsequent periods of care following recovery. This will be the default for these policyholders if their Current Premium is lower than the If Knew Premium.
- 3. OPTION THREE - NFO. See Section III.A.3.
- 4. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY PHASE ONE PREMIUM. Policyholders can elect to keep their current benefits and their premiums will increase to the Phase One Premium. Policyholders whose Current Premiums equal or exceed the If Knew Premium for their policies will continue to pay their Current Premiums. Policyholders who elect this Option may also face substantial rate increases in Phase Two.
- 5. In some cases, options like the downgrade or Basic Policy Endorsements may result in a reduction of the benefits being received by the policyholder on claim at the time of the election. It is also possible that the If Knew Premium for the Basic Policy Endorsements will be lower than the policyholder's Current Premium.

D. DISABLED LIVES NOT PAYING PREMIUM (*ON CLAIM - WAIVER*)

- 1. OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS.
 - a. These policyholders will preserve their Premium Waiver but, if the Current Premium they would be paying in the absence of waiver is less than the If Knew Premium, the policies will be downgraded. The Downgrade Process will be as described in Section III.A.1.c, page 30, but the Possible on Claim Benefit Reductions described in Section III.C.1.b, page 41 will apply.
 - b. This is the Default Option for policyholders on claim with waiver of premium in Phase One. However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, the NFO (Option Three) will be the Default Option.
 - c. The reductions will be calibrated to produce an If Knew Premium within 2% of the Current Premium for the policy (see Section III.A.1.b, page 29). However, because of the waiver, the policyholder will not be required to pay any premium.
 - d. If the policyholder resumes paying premiums, the premiums will be at the rate the policyholder would be paying if not on waiver, but the policy will remain downgraded. Note that the Downgrade Process does not change the premium being paid prior to the downgrade.

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- e. If the policyholder regains active status, for future periods of care:
 - (1) The EP will be no less than 90 days. If the current EP is more than 90 days, the policy will retain the current EP;
 - (2) The EP will apply to each period of care; and
 - (3) TQ Triggers will apply. See Section III.A.2.d.(8), page 36.

2. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT IF KNEW DIFFERENTIAL PREMIUM.

- a. The policyholder will have the option to have the current policy endorsed to provide benefits substantially similar to a newly designed Basic Policy. See Section III.A.2.d, page 36, above.
- b. Policyholders will also be offered an “Enhanced Basic Policy Endorsement” at higher If Knew Premiums. See Section III.A.2.f, page 37.
- c. Changes in EP and benefit trigger would apply to subsequent periods of care following recovery.
- d. With the exception of the change from reimbursement to indemnity, no component of the endorsed policy can be richer than the current policy.
- e. If the Current Premium the policyholder would be paying but for the waiver is less than the If Knew Premium for this policy, the policyholder must begin paying the If Knew Differential Premium. The If Knew Differential Premium for this option is the difference between the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements and the current premium for the policy, both of which are set as if the policyholder did not have a premium waiver in effect. As noted, if the If Knew Differential Premium is less than zero, the policyholder will not be required to pay any additional premium for the Basic Policy Endorsements.
- f. If the disabled policyholder recovers, the waiver of premium benefit will no longer be applicable or available in the future, and he or she will be required to begin paying the full If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements, even if it is lower than the current waived premium.
- g. Except upon recovery, policyholders who elect this option in Phase One will not face

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premium rate increases or additional benefit reductions in Phase Two of the Plan.

- h. For those policies with an MPV that is currently above their applicable GA limits, the endorsed policy's MPV will be adjusted to be at least equal to the applicable Guaranty Association limits. The adjustment will be made by lengthening the MBP.
- 3. **OPTION THREE - NFO.** Policyholders can elect a Non-forfeiture Option (NFO). See Section III.A.3.
- 4. **OPTION FOUR - KEEP CURRENT BENEFITS AND PAY PHASE ONE DIFFERENTIAL PREMIUM.** If the Current Premium the policyholder would be paying in the absence of waiver is equal to or greater than the If Knew Premium, the policyholder will not be required to pay a Differential Premium.
 - a. Policyholders on claim with Premium Waiver can keep their current policy benefits.
 - b. Their Premium Waiver (including Lifetime and Dual) will apply only to the Current Premium they would be paying absent the waiver. If the Current Premium the policyholders would be paying but for the waiver is less than the If Knew Premium for this policy, they will be required to begin paying the corresponding Phase One Differential Premium, if any. (See Section II.E.6.b, page 18).
 - c. If the policyholders recover, they will be required to begin paying the full Phase One Premium.

IV. DETAILS OF PHASE TWO OF THE PLAN

A. APPLICATION

- 1. Throughout the period that follows implementation of Phase One the Company's financial condition will be monitored with emphasis on projected changes in the Company's deficit.
- 2. The evaluation of the Company's condition will include a determination of the magnitude of additional remedial measures required to eliminate any projected remaining deficit. The evaluation will include projections of the effect of Phase One over time.
- 3. A decision will then be made as to whether, when, and how Phase Two should be implemented.
- 4. Phase Two adjustments will only be made to policies that:
 - a. Are not Fully Covered by the applicable Guaranty Association limits (*i.e.*, have

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Uncovered Benefits),

- b. Are not Self-sustaining (because the sum of projected benefits and expenses exceeds the sum of allocated assets and projected premium), and
 - c. Did not elect Option Two (Basic Policy Endorsements) or Option Three (NFO) in Phase One.
5. Phase Two adjustments will be calculated after the results of Phase One adjustments have been incorporated.

B. ACTIVE LIVES PAYING PREMIUM (*ACTIVE - PAYING*)

- 1. **OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS.**
 - a. Policyholders not on claim paying premium can elect in Phase Two to keep the premium rate resulting from Phase One and reduce benefits to eliminate the policy shortfall.
 - b. The benefit reduction process and options will be the same as in Phase One (see Section III.A.1.c page 30) but the current benefits will be reduced so that they produce a Self-sustaining Premium that is within 2% of the policyholder's Current Premium.
 - c. As in Phase One, each policyholder will only receive one downgrade option, calculated as described in Section III.A.1.c.
- 2. **OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING PREMIUM.**
 - a. Policyholders can choose to have their current policy endorsed to provide benefits substantially similar to a newly designed Basic Policy. See Section III.A.2.d, page 36.
 - b. This is the Default Option for premium paying active lives in Phase Two.
 - c. Premiums will be set to the corresponding Self-sustaining Premium level. The premium for this option will be no less than 110% of the If Knew Premium for this policy reflecting the cost of delay in making this election in Phase Two.
 - d. Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 37.

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- e. With the exception of the change from reimbursement to indemnity, post-endorsement benefits cannot exceed those in the current policy. If a particular component of the Basic Policy Endorsements provides more coverage than the current policy's corresponding provision, that provision of the current policy will not be modified by endorsement.
 - f. For those policies with an MPV that is currently above their applicable GA limits, the endorsed policy's MPV will be adjusted to be at least equal to the applicable Guaranty Association limits. The adjustment will be made by lengthening the MBP.
- 3. OPTION THREE - NFO. Policyholders can elect a Non-forfeiture Option. See Section III.A.3.
 - 4. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING PREMIUM.
 - a. The policyholder can elect to maintain the current policy benefits but will be required to pay Self-sustaining Premiums.
 - b. The *Self-sustaining Premium* is the premium calculated to eliminate any shortfall in the policy. The shortfall is the excess of the sum of projected benefits and expenses (the PBA) over the sum of projected premiums and assets allocated on an accumulated premium basis (the PCA). See Section II.E.4, page 16, above.

C. ACTIVE LIVES NOT PAYING PREMIUM (*ACTIVE - WAIVER*)

- 1. LIFETIME WAIVER - Policyholders on lifetime waiver (due to the death of a spouse) will have essentially the same four options as premium paying policyholders not on claim (See Section IV.B, page 46) with the following modifications:
 - a. OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS. This will be the Default Option for these policyholders. However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, the NFO (Option Three) will be the Default Option.
 - (1) Due to the Premium Waiver the policyholder will continue not paying premium.
 - (2) The Downgrade Process will be the same as for premium-paying active lives in Phase One (see Section III.A.1.c, page 30, above).

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- (3) The specific possible benefit reductions will be the ones described in Section III.A.1.f, page 32, above,
 - (4) In this case the benefit reductions will be calibrated such that the projected benefits and expenses (the PBA) is equal to the assets allocated to the policy on an accumulated premium basis (the PCA).
 - b. **OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING DIFFERENTIAL PREMIUM.** The Guaranty Association floor on benefit reductions will be applied to these policyholders as described in Section III.A.2.h, page 37.
 - (1) The Self-sustaining Premium used for the calculation for this option will be no less than 110% of the If Knew Premium for this policy reflecting the cost of delay in making this election in Phase Two.
 - (2) Policyholders will also be offered an “Enhanced Basic Policy Endorsement”. See Section III.A.2.f, page 37 at higher Self-sustaining Premiums.
 - c. **OPTION THREE - NFO** (see Section III.A.3, page 37).
 - d. **OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING DIFFERENTIAL PREMIUM.** The new premium will be the Self-sustaining Differential Premium described in the next paragraph.
 - e. The ***Self-sustaining Differential Premium*** is the difference between (1) the corresponding Self Sustaining Premium set as if the policyholder were not on claim and (2) the Current Premium the policyholder would be paying if he or she were not on Premium Waiver. Because these policies are not Self-sustaining the Self-sustaining Differential Premium will never be less than zero.
2. **DUAL WAIVER** - The options for a policyholder not on claim but not paying premium due to a dual waiver (because his or her spouse is on claim) will be the same as for a policyholder not on claim with a lifetime waiver except that the premium he or she must pay will be determined in part by the spouse’s claim status. The default for these policyholders will be Option One (Downgrade). However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, the NFO (Option Three) will be the Default Option.
- a. **OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS.** The policyholder will retain the Current Premium Waiver but the policy

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will be downgraded.

- (1) The Downgrade Process will be as described in Section III.A.1.c, page 30 subject to the following provisions.
 - (2) The Possible Active Benefit Reductions will apply, as described in Section III.A.1.f, page 32. Benefit reductions for each policyholder to whom this option applies will be calibrated to produce a Self-sustaining Premium equal to the premium the policyholder would be paying if not on waiver. However, because of the waiver, the policyholder will not be required to pay any premium.
 - (3) If the disabled spouse resumes paying premiums, the active spouse will also be required to resume paying premiums at the premium rate he or she would be paying if not on waiver, but the policy will remain downgraded.
- b. **OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING DIFFERENTIAL PREMIUM.**
- (1) The policy will be modified through the Basic Policy Endorsements (See Section III.A.2.d, page 36). The policyholder will be required to pay the Self-sustaining Differential Premium.
 - (2) The Guaranty Association floor on benefit reductions will be applied to these policyholders as described in Section III.A.2.h, page 37.
 - (3) Policyholders will also be offered an “Enhanced Basic Policy Endorsement” at higher Self-sustaining Premiums. See Section III.A.2.f, page 37.
 - (4) The Self-sustaining Premium used for the calculation for this option will be no less than 110% of the If Knew Premium for this policy, reflecting the cost of delay in making this election in Phase Two
 - (5) If the disabled spouse recovers the active spouse will be required to begin paying the full Self-Sustaining Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements.
- c. **OPTION THREE - NFO.** The policyholders can elect a Non-forfeiture Option. See Section III.A.3.
- d. **OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING DIFFERENTIAL PREMIUM.** The policyholder will retain the current policy

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benefits and pay the Self-sustaining Differential Premium (see Section IV.C.1.e, page 48).

- (1) If the disabled spouse recovers the active spouse will be required to begin paying the full Self-sustaining Premium.
- (2) Because these policies are not Self-sustaining, the Current Premium will always be lower than the Self-sustaining Premium and the Self-sustaining Differential Premium will always be greater than zero.

D. DISABLED LIVES PAYING PREMIUM (*ON CLAIM - PAYING*)

1. Policyholders on claim who are paying premiums will have the same options as active lives paying premiums (see Section IV.B, page 46) subject to the following conditions:
 - a. **OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS.** Keep the Current Premium rates but accept specified downgrades. The Downgrade process will be as described in Section III.A.1.c, page 30. The Possible on Claim Benefit Reductions described in Section III.C.1.b, page 41 will apply, but the benefits will be reduced so that they produce a Self-Sustaining Premium within 2% of the Current Premium.
 - b. **OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING PREMIUM.** The policy will be endorsed as described in Section III.A.2.d, page 36, at Self-sustaining Premium
 - (1) The Self-sustaining Premium used for the calculation for this option will be no less than 110% of the If Knew Premium for this policy reflecting the cost of delay in making this election in Phase Two.
 - (2) Changes in EP and benefit trigger would apply to subsequent periods of care following recovery.
 - (3) For those policies with an MPV that is currently above their applicable GA limits, the endorsed policy's MPV will be adjusted to be at least equal to the applicable GA limits. The adjustment will be made by lengthening the MBP.
 - (4) This will be the default for these policyholders.
 - (5) Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 37.

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- c. OPTION THREE - NFO. See Section III.A.3.
 - d. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING PREMIUM. The Self-sustaining Premium will be set as if the policyholder were not on claim. However, in so doing assets will be allocated to the policyholders according to the method previously described for Disabled Lives.
2. In some cases, options like the downgrade or Basic Policy Endorsements may result in a reduction of the benefits being received by the policyholder on claim at the time of the election.

E. DISABLED LIVES NOT PAYING PREMIUM (*ON CLAIM - WAIVER*)

- 1. OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS.
 - a. This is the Default Option for policyholders on claim with Premium Waiver in Phase Two. However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, the NFO (Option Three) will be the Default Option.
 - b. Policyholders may preserve their Premium Waiver and the policy will be downgraded. The Downgrade Process will be as described in Section III.A.1.c, page 30. The Possible on Claim Benefit Reductions will apply as explained in Section III.D.1, page 41 but benefits will be reduced so that they produce a Self-sustaining premium that is within 2% of the Current Premium.
 - c. If the policyholder resumes paying premiums, the premiums will be at the rate the policyholder would be paying if not on waiver, but the policy will remain downgraded. Note that the Downgrade Process made that premium equal to the Self-sustaining Premium for the downgraded policy at the time of implementation of Phase Two.
 - d. If the policyholder regains active status, for future periods of care:
 - (1) The EP will be no less than 90 days. If the current EP is more than 90 days, the policy will retain the current EP;
 - (2) The EP will apply to each period of care; and
 - (3) TQ Triggers will apply. See Section III.A.2.d.(8), page 36.

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2. **OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING DIFFERENTIAL PREMIUM.**
 - a. The policyholder will have the option to have the current policy endorsed to provide benefits substantially similar to a newly designed Basic Policy. See Section III.A.2.d, page 36.
 - b. The policyholder must begin paying the Self-sustaining Differential Premium corresponding to the Self-sustaining premium for the Basic Policy Endorsements set as if the policyholder were not on claim. The Self-sustaining Premium used for the calculation for this option will be no less than 110% of the If Knew Premium for this policy reflecting the cost of delay in making this election in Phase Two.
 - c. With the exception of the change from reimbursement to indemnity, no component of the endorsed policy can be richer than the current policy.
 - d. For those policies with an MPV that is currently above their applicable GA limits, the endorsed policy's MPV will be adjusted to be at least equal to the applicable Guaranty Association limits. The adjustment will be made by lengthening the MBP.
 - e. Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 37.
 - f. Changes in EP and benefit trigger would apply to subsequent periods of care following recovery.
 - g. If he or she recovers, the policyholder will be required to begin paying the full Self-sustaining Premium.
3. **OPTION THREE - NFO.** Policyholders can elect a Non-forfeiture Option. See Section III.A.3.
4. **OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING DIFFERENTIAL PREMIUM.**
 - a. A policyholder on claim with Premium Waiver can keep the current policy benefits.
 - b. The Premium Waiver (including lifetime and dual) will apply only to the Current Premium. The policyholder will be required to begin paying the corresponding Self-sustaining Differential Premium (see Section IV.C.1.e, page 48). If the policyholder recovers he or she will be required to begin paying the full Self-sustaining Premium.

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TABLE 6: POLICYHOLDER OPTIONS		
	PHASE ONE	PHASE TWO
ACTIVE PAYING	1. KEEP PREMIUM - DOWNGRADE 2. BASIC POLICY - IF KNEW PREMIUM* 3. NFO 4. KEEP BENEFITS - PHASE ONE PREMIUM	1. KEEP PREMIUM - DOWNGRADE 2. BASIC POLICY - SELF SUSTAINING PREMIUM* 3. NFO 4. KEEP BENEFITS - SELF-SUSTAINING PREMIUM
ACTIVE WAIVER	1. DOWNGRADE - RETAIN PREMIUM WAIVER*‡ 2. BASIC POLICY - IF KNEW DIFFERENTIAL PREMIUM 3. NFO 4. KEEP BENEFITS - PHASE ONE DIFFERENTIAL PREMIUM DUAL WAIVER PREMIUM GOVERNED IN PART BY SPOUSE'S STATUS	1. DOWNGRADE - RETAIN PREMIUM WAIVER*‡ 2. BASIC POLICY - SELF SUSTAINING DIFFERENTIAL PREMIUM† 3. NFO 4. KEEP BENEFITS - SELF SUSTAINING DIFFERENTIAL PREMIUM† DUAL WAIVER PREMIUM GOVERNED IN PART BY SPOUSE'S STATUS
ON CLAIM PAYING	1. KEEP PREMIUM - DOWNGRADE 2. BASIC POLICY - IF KNEW PREMIUM* 3. NFO 4. KEEP BENEFITS - PHASE ONE PREMIUM	1. KEEP PREMIUM - DOWNGRADE 2. BASIC POLICY - SELF SUSTAINING PREMIUM*† 3. NFO 4. KEEP BENEFITS - SELF SUSTAINING PREMIUM†
ON CLAIM WAIVER	1. DOWNGRADE - RETAIN PREMIUM WAIVER*‡ 2. BASIC POLICY - IF KNEW DIFFERENTIAL PREMIUM 3. NFO 4. KEEP BENEFITS - PHASE ONE DIFFERENTIAL PREMIUM	1. - DOWNGRADE - RETAIN PREMIUM WAIVER*‡ 2. BASIC POLICY - SELF-SUSTAINING DIFFERENTIAL PREMIUM† 3. NFO 4. KEEP BENEFITS - SELF SUSTAINING DIFFERENTIAL PREMIUM†
*Default Option. †Self-sustaining premium calculated as if policyholder not on claim. ‡If the NFO provides greater benefits, that will be the Default Option. In Phase One, policyholders whose Current Premium is not less than the If Knew Premium need not change premiums or benefits.		

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POLICY ILLUSTRATIONS

The following twelve examples illustrate how these options work for some representative policies. The policies selected are actual in-force SHIP policies. The SHIP SAMPLE POLICY TABLE describes the key attributes of each of the twelve sample policies, enabling the reader to locate easily the samples most similar to a particular policy. They were selected to provide a representative variety of policy features. Reviewing sample policies resembling a particular policy will provide an indication of how the Plan will result in modifications to that policy. Because of the differences among the features in the sample policies, it may be helpful to review several sample policies to see how particular features are affected by the Plan.

SHIP SAMPLE POLICY TABLE

ILLUSTRATION	1	2	3	4	5	6	7	8	9	10	11	12
Gender	F	F	F	F	F	M	M	F	F	F	M	F
Issue Age	56	56	63	67	62	64	64	64	57	64	65	60
Issue Year	1992	1988	1997	1999	1996	1997	1994	1995	1988	2001	1993	1991
Attained Age	84	88	86	88	86	87	90	89	89	83	92	89
State Resident	IN	TX	IL	TX	PA	OK	NE	OH	PA	FL	SD	TX
State Issue	IN	TX	IL	TX	PA	OK	NE	OH	PA	PA	SD	OK
Guaranty Association Coverage Limit	300K	300K	300K	300K	300K	300K	300K	300K	300K	300K	300K	300K
Premium Paying Status	PP	PP	PP	LW	PP	PP	CW	PP	PP	PP	LW	PP
Disability Status	Active	Active	Active	Active	Active	Active	Disabled	Active	Active	Active	Disabled	Active
CODE	32324	37446	12220	19570	09746	13538	33210	05000	00002	03255	01285	00561
Nursing Home: Reimbursement Method	I	I	I	R	I	I	I	I	N/A	R	I	I
Nursing Home: Benefit Period (years)	U	4.0	3.0	3.0	3.0	5.0	U	3.0	N/A	4.0	5.0	U
Nursing Home: Current Maximum Daily Benefit ¹	\$212	\$80	\$234	\$60	\$307	\$205	\$203	\$323	N/A	\$246	\$159	\$133
Nursing Home: Elimination Period ² (days)	N/A	0	100	0	0	0	0	0	N/A	0	0	100
Home Health Care: Reimbursement Method	N/A	N/A	N/A	R	R	R	N/A	N/A	R	R	R	R
Home Health Care: Benefit Period (years)	N/A	N/A	N/A	3.0	3.0	5.0	N/A	N/A	2.0	4.0	5.0	U
Home Health Care: Current Maximum Daily Benefit ¹	N/A	N/A	N/A	\$60	\$307	\$205	N/A	N/A	\$160	\$246	\$159	\$133
Home Health Care: Elimination Period ² (days)	N/A	N/A	N/A	0	0	0	N/A	N/A	0	0	0	100
Assisted Living Facility: Reimbursement Method	N/A	N/A	R	R	R	R	N/A	R	N/A	N/A	R	R
Assisted Living Facility: Benefit Period (years)	N/A	N/A	3	3.0	3.0	5.0	N/A	3	N/A	N/A	5.0	U
Assisted Living Facility: Current Maximum Daily Benefit	N/A	N/A	\$234	\$60	\$307	\$205	N/A	\$323	N/A	N/A	\$159	\$133
Assisted Living Facility: Elimination Period ² (days)	N/A	N/A	100	0	0	0	N/A	0	N/A	N/A	0	100
Daily Benefit Annual Inflation	0.0%	0.0%	5.0%	0.0%	5.0%	5.0%	5.0%	5.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	Yes	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	Yes	Yes	Yes	No	No	No	No	Yes	Yes
Return of Premium Coverage ³	No	No	No	No	No	No	No	Yes	No	No	Yes	Yes
Benefit Trigger	TQ	TQ	TQ	NTQ	TQ	NTQ	TQ	TQ	TQ	TQ	TQ	TQ
Maximum Policy Value ⁴	U	117K	256K	65,700	336K	374K	U	353K	117K	357K	291K	U
Annual Premium ⁵	3,089	1,198	2,216	0	2,642	2,995	0	6,306	529	2,614	0	4,116
Active Life Reserve (if applicable)	101K	26,142	61,244	16,972	78,126	45,601	N/A	112K	25,553	79,383	N/A	67,820

PP = Premium paying
I = Indemnity
U = Unlimited

TQ = Tax Qualified
R = Reimbursement
LW = Lifetime waiver

NTQ = Not Tax Qualified
CW = Claim waiver
\$ OMITTED

Gender	F
Issue Age	56
Issue Year	1992
Attained Age	84
State Resident	IN
State Issue	IN
Guaranty Association Coverage Limit	\$300,000
Premium Paying Status	Premium paying
Disability Status	Active

ILLUSTRATION NO. 1

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 32324)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Indemnity	Reimbursement	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	Unlimited	4.0	4.0	5.0	2.5	Unlimited
Nursing Home: Current Maximum Daily Benefit ¹	\$212	\$261	\$170	\$170	\$170	\$212
Nursing Home: Elimination Period ² (days)	0	0	90	90	90	0
Home Health Care: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Current Maximum Daily Benefit ¹	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Elimination Period ² (days)	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Current Maximum Daily Benefit ¹	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Elimination Period ² (days)	N/A	N/A	N/A	N/A	N/A	N/A
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	Yes	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	No	No	No
Return of Premium Coverage ³	No	No	No	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value ⁴	Unlimited	\$381,060	\$247,931	\$309,914	\$154,957	Unlimited
Annual Premium ⁵	\$3,089	\$3,089	\$1,431	\$1,537	\$0	\$3,967

¹ Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

² Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

³ The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

⁴ Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

⁵ Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

Gender	F
Issue Age	56
Issue Year	1988
Attained Age	88
State Resident	TX
State Issue	TX
Guaranty Association Coverage Limit	\$300,000
Premium Paying Status	Premium paying
Disability Status	Active

ILLUSTRATION NO. 2

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 37446)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Indemnity	Indemnity	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	4.0	4.0	4.0	4.0	2.5	4.0
Nursing Home: Current Maximum Daily Benefit ¹	\$80	\$80	\$64	\$64	\$64	\$80
Nursing Home: Elimination Period ² (days)	0	0	90	90	90	0
Home Health Care: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Current Maximum Daily Benefit ¹	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Elimination Period ² (days)	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Current Maximum Daily Benefit ¹	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Elimination Period ² (days)	N/A	N/A	N/A	N/A	N/A	N/A
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	Yes	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	No	No	No
Return of Premium Coverage ³	No	No	No	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value ⁴	\$116,800	\$116,800	\$93,440	\$93,440	\$58,400	\$116,800
Annual Premium ⁵	\$1,198	\$1,198	\$508	\$508	\$0	\$1,198

1 Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

2 Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

3 The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

4 Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

5 Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

Gender	F
Issue Age	63
Issue Year	1997
Attained Age	86
State Resident	IL
State Issue	IL
Guaranty Association Coverage Limit	\$300,000
Premium Paying Status	Premium paying
Disability Status	Active

ILLUSTRATION NO. 3

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 12220)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Indemnity	Reimbursement	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	3.0	3.0	3.0	3.0	2.5	3.0
Nursing Home: Current Maximum Daily Benefit ¹	\$234	\$234	\$187	\$187	\$187	\$234
Nursing Home: Elimination Period ² (days)	100	100	100	100	100	100
Home Health Care: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Current Maximum Daily Benefit ¹	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Elimination Period ² (days)	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Assisted Living Facility: Benefit Period (years)	3.0	3.0	3.0	3.0	2.5	3.0
Assisted Living Facility: Current Maximum Daily Benefit ¹	\$234	\$176	\$187	\$187	\$187	\$234
Assisted Living Facility: Elimination Period ² (days)	100	100	100	100	100	100
Daily Benefit Annual Inflation	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
Claim Waiver of Premium Coverage	Yes	No	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	No	No	No
Return of Premium Coverage ³	No	No	No	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value ⁴	\$256,274	\$256,230	\$205,019	\$205,019	\$170,849	\$256,274
Annual Premium ⁵	\$2,216	\$2,216	\$2,102	\$2,137	\$0	\$3,029

¹ Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

² Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

³ The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

⁴ Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

⁵ Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

Gender	F
Issue Age	67
Issue Year	1999
Attained Age	88
State Resident	TX
State Issue	TX
Guaranty Association Coverage Limit	\$300,000
Premium Paying Status	Lifetime waiver
Disability Status	Active

ILLUSTRATION NO. 4

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 19570)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Nursing Home: Benefit Period (years)	3.0	3.0	3.0	3.0	2.5	3.0
Nursing Home: Current Maximum Daily Benefit ¹	\$60	\$60	\$48	\$48	\$48	\$60
Nursing Home: Elimination Period ¹ (days)	0	0	90	90	90	0
Home Health Care: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Home Health Care: Benefit Period (years)	3.0	3.0	3.0	3.0	2.5	3.0
Home Health Care: Current Maximum Daily Benefit ¹	\$60	\$60	\$48	\$48	\$48	\$60
Home Health Care: Elimination Period ² (days)	0	0	90	90	90	0
Assisted Living Facility: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Assisted Living Facility: Benefit Period (years)	3.0	3.0	3.0	3.0	2.5	3.0
Assisted Living Facility: Current Maximum Daily Benefit ¹	\$60	\$60	\$48	\$48	\$48	\$60
Assisted Living Facility: Elimination Period ¹ (days)	0	0	90	90	90	0
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	Yes	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	Yes	Yes	No	No	No	Yes
Return of Premium Coverage ³	No	No	No	No	No	No
Benefit Trigger	Non Tax Qualified	Non Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Non Tax Qualified
Maximum Policy Value ⁴	\$65,700	\$65,700	\$52,560	\$52,560	\$43,800	\$65,700
Annual Premium ⁵	\$0	\$0	\$0	\$0	\$0	\$0

¹ Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

² Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

³ The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

⁴ Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

⁵ Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

Gender	F
Issue Age	62
Issue Year	1996
Attained Age	86
State Resident	PA
State Issue	PA
Guaranty Association Coverage Limit	\$300,000
Premium Paying Status	Premium paying
Disability Status	Active

ILLUSTRATION NO. 5

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 09746)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Indemnity	Reimbursement	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	3.0	3.0	3.0	3.0	2.5	3.0
Nursing Home: Current Maximum Daily Benefit ¹	\$307	\$312	\$246	\$246	\$246	\$307
Nursing Home: Elimination Period ² (days)	0	90	90	90	90	0
Home Health Care: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Home Health Care: Benefit Period (years)	3.0	3.0	3.0	3.0	2.5	3.0
Home Health Care: Current Maximum Daily Benefit ¹	\$307	\$312	\$150	\$150	\$150	\$307
Home Health Care: Elimination Period ² (days)	0	90	90	90	90	0
Assisted Living Facility: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Assisted Living Facility: Benefit Period (years)	3.0	3.0	3.0	3.0	2.5	3.0
Assisted Living Facility: Current Maximum Daily Benefit ¹	\$307	\$312	\$225	\$225	\$225	\$307
Assisted Living Facility: Elimination Period ² (days)	0	90	90	90	90	0
Daily Benefit Annual Inflation	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
Claim Waiver of Premium Coverage	Yes	Yes	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	Yes	Yes	No	No	No	Yes
Return of Premium Coverage ³	No	No	No	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value ⁴	\$336,340	\$341,640	\$269,072	\$269,072	\$224,227	\$336,340
Annual Premium ⁵	\$2,642	\$2,642	\$1,934	\$1,965	\$0	\$3,799

¹ Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

² Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

³ The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

⁴ Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

⁵ Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

Gender	M
Issue Age	64
Issue Year	1997
Attained Age	87
State Resident	OK
State Issue	OK
Guaranty Association Coverage Limit	\$300,000
Premium Paying Status	Premium paying
Disability Status	Active

ILLUSTRATION NO. 6

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 13538)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Indemnity	Indemnity	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	5.0	5.0	4.0	5.0	2.5	5.0
Nursing Home: Current Maximum Daily Benefit ¹	\$205	\$205	\$164	\$164	\$164	\$205
Nursing Home: Elimination Period ² (days)	0	0	90	90	90	0
Home Health Care: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Home Health Care: Benefit Period (years)	5.0	5.0	4.0	5.0	2.5	5.0
Home Health Care: Current Maximum Daily Benefit ¹	\$205	\$205	\$150	\$150	\$150	\$205
Home Health Care: Elimination Period ² (days)	0	0	90	90	90	0
Assisted Living Facility: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Assisted Living Facility: Benefit Period (years)	5.0	5.0	4.0	5.0	2.5	5.0
Assisted Living Facility: Current Maximum Daily Benefit ¹	\$205	\$205	\$164	\$164	\$164	\$205
Assisted Living Facility: Elimination Period ² (days)	0	0	90	90	90	0
Daily Benefit Annual Inflation	5.0%	5.0%	1.5%	2.0%	0.0%	5.0%
Claim Waiver of Premium Coverage	Yes	Yes	No	No	No	Yes
Dual Premium Waiver Coverage	Yes	Yes	No	No	No	Yes
Survivorship Premium Waiver Coverage	Yes	Yes	No	No	No	Yes
Return of Premium Coverage ³	No	No	No	No	No	No
Benefit Trigger	Non Tax Qualified	Non Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Non Tax Qualified
Maximum Policy Value ⁴	\$373,724	\$374,125	\$239,183	\$298,979	\$149,489	\$373,724
Annual Premium ⁵	\$2,995	\$2,995	\$1,171	\$1,232	\$0	\$2,995

¹ Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

² Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

³ The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

⁴ Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

⁵ Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

Gender	M
Issue Age	64
Issue Year	1994
Attained Age	90
State Resident	NE
State Issue	NE
Guaranty Association Coverage Limit	\$300,000
Premium Paying Status	Claim waiver
Disability Status	Disabled

ILLUSTRATION NO. 7

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 33210)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Indemnity	Indemnity	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	Unlimited	Unlimited	4.0	5.0	2.5	Unlimited
Nursing Home: Current Maximum Daily Benefit ¹	\$203	\$212	\$163	\$163	\$163	\$203
Nursing Home: Elimination Period ² (days)	0	0	90	90	90	0
Home Health Care: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Current Maximum Daily Benefit ¹	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Elimination Period ² (days)	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Current Maximum Daily Benefit ¹	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Elimination Period ² (days)	N/A	N/A	N/A	N/A	N/A	N/A
Daily Benefit Annual Inflation	5.0%	5.0%	1.5%	2.0%	0.0%	5.0%
Claim Waiver of Premium Coverage	Yes	Yes	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	No	No	No
Return of Premium Coverage ³	No	No	No	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value ⁴	Unlimited	Unlimited	\$237,314	\$296,643	\$148,321	Unlimited
Annual Premium ⁵	\$0	\$0	\$0	\$0	\$0	\$0

¹ Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

² Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

³ The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

⁴ Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

⁵ Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

Gender	F
Issue Age	64
Issue Year	1995
Attained Age	89
State Resident	OH
State Issue	OH
Guaranty Association Coverage Limit	\$300,000
Premium Paying Status	Premium paying
Disability Status	Active

ILLUSTRATION NO. 8

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 05000)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Indemnity	Reimbursement	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	3.0	3.1	3.0	3.0	2.5	3.0
Nursing Home: Current Maximum Daily Benefit ¹	\$323	\$600	\$258	\$258	\$258	\$323
Nursing Home: Elimination Period ² (days)	0	90	90	90	90	0
Home Health Care: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Current Maximum Daily Benefit ¹	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Elimination Period ² (days)	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Assisted Living Facility: Benefit Period (years)	3.0	3.1	3.0	3.0	2.5	3.0
Assisted Living Facility: Current Maximum Daily Benefit ¹	\$323	\$450	\$225	\$225	\$225	\$323
Assisted Living Facility: Elimination Period ² (days)	0	90	90	90	90	0
Daily Benefit Annual Inflation	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
Claim Waiver of Premium Coverage	Yes	No	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	No	No	No
Return of Premium Coverage ³	Yes	No	No	No	No	Yes
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value ⁴	\$353,148	\$679,800	\$282,519	\$282,519	\$235,432	\$353,148
Annual Premium ⁵	\$6,306	\$6,306	\$2,988	\$3,012	\$0	\$11,166

¹ Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

² Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

³ The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

⁴ Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

⁵ Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

Gender	F
Issue Age	57
Issue Year	1988
Attained Age	89
State Resident	PA
State Issue	PA
Guaranty Association Coverage Limit	\$300,000
Premium Paying Status	Premium paying
Disability Status	Active

ILLUSTRATION NO. 9

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 00002)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Nursing Home: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Nursing Home: Current Maximum Daily Benefit ¹	N/A	N/A	N/A	N/A	N/A	N/A
Nursing Home: Elimination Period ² (days)	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Home Health Care: Benefit Period (years)	2.0	2.0	2.0	2.0	2.0	2.0
Home Health Care: Current Maximum Daily Benefit ¹	\$160	\$80	\$128	\$128	\$128	\$160
Home Health Care: Elimination Period ² (days)	0	90	90	90	90	0
Assisted Living Facility: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Current Maximum Daily Benefit ¹	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Elimination Period ² (days)	N/A	N/A	N/A	N/A	N/A	N/A
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	No	No	No	No	No	No
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	No	No	No
Return of Premium Coverage ³	No	No	No	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value ⁴	\$116,800	\$58,400	\$93,440	\$93,440	\$93,440	\$116,800
Annual Premium ⁵	\$529	\$529	\$593	\$593	\$0	\$761

1 Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

2 Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

3 The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

4 Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

5 Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

Gender	F
Issue Age	64
Issue Year	2001
Attained Age	83
State Resident	FL
State Issue	PA
Guaranty Association Coverage Limit	\$300,000
Premium Paying Status	Premium paying
Disability Status	Active

ILLUSTRATION NO. 10

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 03255)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Nursing Home: Benefit Period (years)	4.0	4.0	4.0	4.0	2.5	4.0
Nursing Home: Current Maximum Daily Benefit ¹	\$246	\$246	\$197	\$197	\$197	\$246
Nursing Home: Elimination Period ² (days)	0	90	90	90	90	0
Home Health Care: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Home Health Care: Benefit Period (years)	4.0	4.0	4.0	4.0	2.5	4.0
Home Health Care: Current Maximum Daily Benefit ¹	\$246	\$123	\$150	\$150	\$150	\$246
Home Health Care: Elimination Period ² (days)	0	90	90	90	90	0
Assisted Living Facility: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Current Maximum Daily Benefit ¹	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Elimination Period ² (days)	N/A	N/A	N/A	N/A	N/A	N/A
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	No	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	No	No	No
Return of Premium Coverage ³	No	No	No	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value ⁴	\$356,829	\$357,192	\$285,463	\$285,463	\$179,398	\$356,829
Annual Premium ⁵	\$2,614	\$2,614	\$3,031	\$3,031	\$0	\$6,208

¹ Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

² Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

³ The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

⁴ Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

⁵ Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

Gender	M
Issue Age	65
Issue Year	1993
Attained Age	92
State Resident	SD
State Issue	SD
Guaranty Association Coverage Limit	\$300,000
Premium Paying Status	Lifetime waiver
Disability Status	Disabled

ILLUSTRATION NO. 11

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 01285)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Indemnity	Reimbursement	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	5.0	4.0	4.0	5.0	2.5	5.0
Nursing Home: Current Maximum Daily Benefit ¹	\$159	\$159	\$127	\$127	\$127	\$159
Nursing Home: Elimination Period ² (days)	0	0	90	90	90	0
Home Health Care: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Home Health Care: Benefit Period (years)	5.0	4.0	4.0	5.0	2.5	5.0
Home Health Care: Current Maximum Daily Benefit ¹	\$159	\$159	\$127	\$127	\$127	\$159
Home Health Care: Elimination Period ² (days)	0	0	90	90	90	0
Assisted Living Facility: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Assisted Living Facility: Benefit Period (years)	5.0	4.0	4.0	5.0	2.5	5.0
Assisted Living Facility: Current Maximum Daily Benefit ¹	\$159	\$159	\$127	\$127	\$127	\$159
Assisted Living Facility: Elimination Period ² (days)	0	0	90	90	90	0
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	Yes	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	Yes	Yes	No	No	No	Yes
Return of Premium Coverage ³	Yes	Yes	No	No	No	Yes
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value ⁴	\$290,522	\$232,140	\$185,934	\$232,417	\$116,209	\$290,522
Annual Premium ⁵	\$0	\$0	\$0	\$0	\$0	\$2,183

¹ Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019.

² Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits.

³ The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3).

⁴ Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions.

⁵ Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4.

Gender	F
Issue Age	60
Issue Year	1991
Attained Age	89
State Resident	TX
State Issue	OK
Guaranty Association Coverage Limit	\$300,000
Premium Paying Status	Premium paying
Disability Status	Active

ILLUSTRATION NO. 12

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 00561)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Indemnity	Reimbursement	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	Unlimited	4.0	4.0	5.0	2.5	Unlimited
Nursing Home: Current Maximum Daily Benefit ¹	\$133	\$467	\$106	\$106	\$106	\$133
Nursing Home: Elimination Period ² (days)	100	100	100	100	100	100
Home Health Care: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Home Health Care: Benefit Period (years)	Unlimited	4.0	4.0	5.0	2.5	Unlimited
Home Health Care: Current Maximum Daily Benefit ¹	\$133	\$234	\$106	\$106	\$106	\$133
Home Health Care: Elimination Period ² (days)	100	100	100	100	100	100
Assisted Living Facility: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Assisted Living Facility: Benefit Period (years)	Unlimited	4.0	4.0	5.0	2.5	Unlimited
Assisted Living Facility: Current Maximum Daily Benefit ¹	\$133	\$350	\$106	\$106	\$106	\$133
Assisted Living Facility: Elimination Period ² (days)	100	100	100	100	100	100
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	No	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	Yes	No	No	No	No	Yes
Return of Premium Coverage ³	Yes	No	No	No	No	Yes
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value ⁴	Unlimited	\$681,820	\$154,959	\$193,698	\$96,849	Unlimited
Annual Premium ⁵	\$4,116	\$4,116	\$1,172	\$1,242	\$0	\$7,269

¹ Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

² Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

³ The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

⁴ Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

⁵ Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

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V. PHASE THREE

Following implementation of Phase One and Phase Two, SHIP will continue managing its LTCI in a run-off mode. If the company has improved to the point of having excess assets, the Plan provides for distributions to policyholders and creditors. While some aspects of Phase Three will be developed in the future, one component will be distributions to policyholders on account of benefits they eliminated through Policy Modifications under the Plan. As more fully explained at Section VI.H, page 77, as part of the Plan some of SHIP's policies will be restructured in a way that identifies these eliminated benefits separately. These amounts, called *Unfunded Benefit Liabilities* (UBL), will be tracked by the Rehabilitator. To the extent assets are available in Phase Three, they will be applied to the UBL along with other unpaid liabilities, such as agent commissions. It is possible that in Phase Three SHIP will not be able to pay off all remaining liabilities in full. In that event, it is likely that it will then be placed in Liquidation in accordance with Article V. To the extent that at that time some policy benefits may remain unfunded, the Guaranty Associations may be triggered to assist in the resolution of those remaining policy liabilities. See Section VI.J, page 78.

VI. OTHER MATTERS

A. ABOUT SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

SHIP commenced business on July 5, 1887, as the Home Beneficial Society. It underwent many transactions and transformations in the ensuing century, culminating in the adoption of the current name in October 2008, when it was transferred by its then owner, Consec, to the newly formed, nonprofit, *Senior Health Care Oversight Trust* (the "Trust" - see page 75) so it could continue running off its long-term care insurance ("LTCI") business independently. At the time, SHIP had 152,000 policies in force. As of year-end 2019 that number was down to close to 45,000. It is a Pennsylvania life and health insurance company. Prior to Rehabilitation, SHIP was licensed in 46 states (excluding Connecticut, New York, Rhode Island, and Vermont), the District of Columbia, and the U.S. Virgin Islands. Since SHIP's creation in 2008, it has utilized an outsourcing model for select functions, specifically: Long Term Care Group ("LTCG") for lower-level claims administration functions; Milliman for rate increase analyses and valuations; Conning (and recently now New England Asset Management) for investment services; KPMG for tax services; and external law firms for specific legal issues. Beginning in 2018, the Company engaged Ernst & Young for internal audit services.

Table 7 summarizes the Company's corporate history.

SHIP REHABILITATION PLAN

TABLE 7



B. LONG-TERM CARE INSURANCE

At the time this proposed Rehabilitation Plan is filed, the insurance business of SHIP consists entirely of LTCI, much of it issued many decades ago, and none issued any later than 2003, when the Company ceased writing new business. Of approximately 645,000 LTCI policies sold by SHIP and its predecessors since the late 1970s, fewer than 50,000 remain in force. The key characteristic of this remaining "legacy" block of LTCI policies as a group is that the premiums being paid, when added to the Company's assets, are projected to be grossly insufficient to pay the benefits expected to be due under those policies. This anticipated "Funding Gap" led to the Company being placed in Rehabilitation on January 29, 2020, and is the key challenge sought to be addressed by the Plan.

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SHIP's long-term care insurance policies cover long-term care services, including confinement to nursing facilities and assisted living facilities, as well as home health care and adult day care for individuals who meet specified requirements. These requirements vary among the Company's policies but typically include things like the policyholder requiring care for at least 90 days, and being unable to perform 2 or more Activities of Daily Living (eating, dressing, bathing, transferring, toileting, and continence) without substantial assistance (hands on or standby).

The Company's business is comprised of both LTCI policies written by the Company and assumed reinsurance. For the policies written by the Company, average LTC policyholder age is 86 and the average claimant is 89 years old. SHIP's policies are approximately 13% Home Health Care coverage, 18% Facility Care coverage (nursing home and/or assisted living facility), and 69% Comprehensive coverage covering multiple levels of care. The following paragraphs provide a general description of certain terms and features that are included in many of the Company's LTC Policies:

- a. Tax Qualified v. Non-Tax Qualified - In order to trigger coverage under a policy, the policyholder generally must satisfy certain needs-based tests that vary depending on whether the policy is Tax Qualified or Non-Tax Qualified. Under Section 213 of the Internal Revenue Code ("IRC"), premiums paid for a Tax Qualified LTC policy are deductible medical expenses. According to Section 7702B of the IRC, a Tax Qualified policy is one that:
 - (1) provides insurance coverage only for qualified LTC services;
 - (2) does not pay or reimburse expenses that are reimbursable under Medicare;
 - (3) is guaranteed renewable;
 - (4) does not provide for a cash surrender value or other money that can be paid, assigned or pledged as collateral for a loan, or borrowed;
 - (5) provides that all refunds of premiums (other than refunds on the death of the insured or on a complete surrender or cancellation of the policy, which cannot exceed the aggregate premiums paid under the policy) and the policyholder dividends, or similar amounts, are applied as a reduction of future premiums or to increase future benefits; and
 - (6) satisfies certain consumer protection requirements as well as disclosure and nonforfeitability requirements.
- b. "Qualified long-term care services" are defined as necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and other rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual and are provided pursuant to a plan of care prescribed by a licensed health care practitioner. A "chronically ill individual" is defined as one who has been

SHIP REHABILITATION PLAN

certified within the previous twelve (12) months by a licensed health care provider as:

- (1) being unable to perform (without substantial assistance from another individual) at least two (2) Activities of Daily Living (eating, toileting, transferring, bathing, dressing and continence) for a period of at least 90 days due to a loss of functional capacity;
 - (2) having a level of disability similar to the level of disability described in the clause above, as determined by the Internal Revenue Service in consultation with the Department of Health and Human Services; or
 - (3) requiring substantial supervision to protect such an individual from threats to health and safety due to severe cognitive impairment.
- c. A Non-Tax Qualified Policy generally contains eligibility standards, such a Medical Necessity, which is a lower threshold to trigger coverage. For example, some policy forms contain the following conditions for eligibility:
- (1) Your Physician certifies Your care to be Medically Necessary; or
 - (2) You are unable to perform two (2) or more Activities of Daily Living without assistance or supervision; or
 - (3) You are afflicted with Cognitive Impairment.

Approximately 85% of the Company's policies are Non-Tax Qualified policies, and approximately 66% of the in-force policies are eligible to qualify for care through the Medical Necessity provision.

- d. Daily Benefit Amount - The Company's LTC policies are subject to a Maximum Daily Benefit that was selected by the policyholder when he or she purchased the coverage. The Maximum Daily Benefit available ranged from \$10 to \$300 per day, with many policies subject to annual percentage increases. Some policies, known as "indemnity", pay the full Maximum Daily Benefit, regardless of actual expenses incurred. With the annual percentage increases, in some cases the Maximum Daily Benefit has accumulated to over \$700. The Company's average Maximum Daily Benefit for in-force policyholders is \$173.
- e. Inflation Benefit - Some of the Company's LTC policies were issued with an inflation benefit (referred to as "Inflation Protection"). Inflation Protection may increase a policy's Maximum Daily Benefit by a fixed percentage, often 3% or 5% each year, and inflate the Maximum Lifetime Benefit or Benefit Account Value proportionately. The inflation may be simple (increase by the fixed percentage of the original benefit each year) or compound (increase by the fixed percentage of the current benefit each year). The duration of the inflation may be limited to 20 years, or until a policyholder attained age of 85, but many policies have Inflation Protection

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for the life of the policy. Approximately 32% of the in-force policyholders have lifetime 5% compound inflation.

- f. Indemnification - Indemnity and reimbursement denote the method by which the Maximum Daily Benefit will be paid out. Some policies provide coverage for the actual expenses of care (reimbursement), while others pay the full daily benefit amount regardless of actual expenses incurred (indemnity) much like disability insurance policies. The payment method can vary on comprehensive policies, between Assisted Living Facility Care or Home Health Services. Approximately 63% of in-force policyholders have the indemnity benefit for their main coverage.
- g. Benefit Period - Most of the Company's LTC policies are subject to a Maximum Benefit Period. The Maximum Benefit Periods range from one year to six years. Some policies, however, have an unlimited benefit period ("lifetime policies") while others are subject to a maximum dollar amount. Approximately 72% of the in-force policyholders have a limited benefit period while approximately 29% of policyholders have lifetime policies.
- h. Elimination Period - Some of the Company's LTC policies have an Elimination Period, which is a period of time during which the Company is not required to pay benefits to an otherwise eligible policyholder receiving covered care or services. Some policies were issued with a zero-day Elimination Period. Approximately 66% of the in-force policyholders have a zero-day Elimination Period.
- i. Waiver of Premium - Approximately 99% of the Company's LTC policies provide that a policyholder who receives benefits under his or her policy for a specified period of time (such as 90 days) is no longer required to pay premiums for coverage after that time period as long as the policyholder remains eligible for benefits and/or receives a specified level of care. Once the policyholder's eligibility for benefits ends, the policyholder is required to recommence paying premiums. Approximately 14% of policyholders who otherwise would pay premiums are currently receiving the Waiver of Premium benefit.
- j. Restoration of Benefits - The Restoration of Benefits ("ROB") provision provides that the policy's Maximum Benefit Period will restore to the original Maximum Benefit after receiving some or all claim benefits if the policyholder does not need or receive care during a specified period of time such as 180 days. In most instances, partial benefits were utilized prior to the restoration period. Some policies may restore an unlimited number of times, while others are restricted in the number of times the policy can be restored. Approximately 76% of the in-force policyholders have a ROB benefit.
- k. Return of Premium - Approximately 5% of the Company's LTC policies were issued with a Return of Premium ("ROP") benefit. This benefit provides for the return of a percentage of premium paid by the policyholder if the policyholder does not have

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a claim or has a limited amount of benefits paid under the policy. The ROP typically occurs upon termination or upon ten-year incremental anniversaries. Since 2011, over \$53 million has been returned through the ROP benefit.

C. FINANCIAL CONDITION

The Company has been in a declining financial condition for many years. Its reported surplus is reflected in the following table:

TABLE 8: FINANCIAL CONDITION (IN DOLLARS)

YEAR	ASSETS	LIABILITIES	CAPITAL & SURPLUS/ (DEFICIT)
2009	3,251,994,962	3,058,545,856	193,449,106
2010	3,317,023,144	3,139,706,226	177,314,918
2011	3,161,093,979	3,046,696,672	114,397,307
2012	3,080,745,346	2,975,278,318	105,467,028
2013	2,985,938,782	2,887,736,889	98,201,892
2014	2,906,965,242	2,826,959,318	80,005,924
2015	2,879,794,716	2,824,037,145	55,757,570
2016	2,744,535,287	2,716,512,099	28,023,187
2017	2,688,468,510	2,675,819,343	12,649,166
2018	2,186,058,273	2,652,931,248	(466,814,972)
2019	1,907,181,137	2,823,279,366	(915,731,212)

It is estimated that SHIP's Funding Gap is between \$500 million and \$1 billion. That is to say, based on Current Premium payments and the current value of SHIP's assets, in the absence of rehabilitation, by the time all of SHIP's policies terminate about twenty to twenty-five years from now, it will have incurred liability for covered benefits costing between \$500 million and \$1 billion more than the money that will be available to pay for those benefits. It is important to note that these are estimates or projections for events that will occur over a long period of time. Any of a multitude of factors can change during that time affecting materially the accuracy of those projections.

There are many reasons that SHIP finds itself in this dilemma, some understood better than others. The Rehabilitator will be conducting thorough and exhaustive investigations and analyses

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of the reasons for SHIP's current financial condition. The areas of investigation and analysis will include, but not be limited to, industry wide challenges, common industry practices, volatility in the financial markets and the conduct of SHIP's management, business partners, consultants and other service providers. The Rehabilitator, in consultation with her advisors and experts, will determine how these forces may have contributed to SHIP's current financial condition. Actions will be taken as appropriate.

Industry wide challenges may have played a role. The LTCI industry or line of insurance business is relatively young, significant numbers of such policies being sold for the first time in the late 1970s and early 1980s. When the products were first designed, there did not exist a robust data base of historical LTCI experience of the type on which actuaries rely to calculate what benefits will cost, how the policies will "behave" over time, and what level of premium will be required to make them financially safe. There was insufficient historical data on which to base expectations about benefit costs and required premiums. The industry therefore referred to experience in other lines of insurance, such as life and disability, to make such projections. Soon, the industry came to understand that the characteristics of LTCI policies are materially different in key respects from those in other lines of insurance. For example, many fewer policyholders voluntarily surrender their LTCI policies before expiration than is true of other types of insurance. Similarly, the length of time during which LTCI policyholders will require benefits is materially longer than had been projected. In short, many factors affecting projected liabilities turned out materially different from what had been assumed when the policies were first issued and premium rates set for them.

This problem was compounded by a decision by the industry to structure these policies as level-premium guaranteed-renewable contracts. In summary, this meant that, as long as the policyholders paid their premiums, the policies could not be cancelled despite changes in age, health condition, and other circumstances. Moreover, the premiums could only be increased if they were increased by the same percentage for all policyholders who had the same type of policy, and then only if the state insurance regulator approved the increase. Over time, a large percentage of these policies were found to be substantially underpriced in that the premiums paid for a given group of such policies could be projected to fall far short of what the company would need for the benefits due under the policies for that group. Obtaining the required approval for rate increases from state regulators proved difficult over time, resulting in two key problems. First, for many LTCI companies, the entire block of such policies were projected to create liabilities far in excess of what the companies would be able to pay. In fact, for many companies like SHIP, this became a serious threat or contributing cause of insolvency. Second, because of differences in the responses by different states to requests for authorization to increase premium rates, over time there emerged wide divergence in the premiums policyholders holding similar policies would pay in different states. Some critics characterized this phenomenon as resulting in policyholders in rate-increase-approving states subsidizing those in states that rejected such requests. All of this can be contrasted with typical health insurance policies that generally last only a year or less, and the premiums for which are adjusted at least annually.

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Adding to these challenges were material changes in the economic environment in which these policies were required to perform. For example, when early LTCI policies were sold, there did not exist a robust assisted living facility (“ALF”) or continuing care retirement center (“CCRC”) industry. When one became incapable of caring for oneself, the principal choices were internment in a nursing home, widely viewed as undesirable unless absolutely necessary, or (at much lower cost) having family or hired help care for one at home. However, as LTCI policies began becoming more popular and provided a funding source for other alternatives, there emerged a vibrant industry of desirable retirement homes providing varying level of care, but typically in much more enticing surroundings and with attractive amenities. These ALFs and CCRCs increased the cost of caring for those who qualified for long-term care benefits but preferred not to remain at home to be cared for by their families or hired care-givers. In many other ways, the cost of caring for those who could not fend for themselves also increased beyond what had been projected by some companies and their consultants when early LTCI policies were priced.

Another major development affected a different key source of funding for future benefits. LTCI policies are designed to generate far more premium than needed to pay benefits in their early years, with those amounts to be invested and generate a material investment income that will be added to the premium and be used in later years when benefit costs are expected to exceed premiums being collected at that later time. In short, the notion is that the company will build-up a fund of premium and investment income that will suffice to pay the large claims expected in the future. In addition to premium being inadequately low when first set, and claims costing more than expected, income earned on the invested premium has also turned out to be much less than anticipated. Changes in the capital market and the broader economy, especially the “great recession” of 2008, dramatically suppressed investment returns below expectations. Current economic circumstances are exacerbating this problem. Many LTCI insurers have amassed billions of dollars in invested premiums. A decline of 1% in yield on each \$1 billion of invested premium amounts to a loss every year of \$10 million in funds to be reinvested and be available for future claims. It is not hard to see how a decline in market yields of even just 3% for five years for a company with \$2 billion in invested assets could be a major event. That would entail a loss of at least \$300 million! This is the nature of lost investment income experienced by SHIP and the rest of the LTCI industry, but on more invested assets for many more years. As a point of reference, the Wall Street Journal Prime Rate was at: 8.25% on March 5, 1975; **17.25%** on March 4, 1980; 10% on January 8, 1990; 9% on March 22, 2000; 5.75% on March 22, 2005; 3.25% on December 16, 2008; 5.50% on December 20, 2018; and back down to 3.25% on April 10, 2020.

These and other challenges faced by SHIP over the eleven years since it was separated from Consecro have combined to create the Funding Gap described above. The purpose of the Plan is to narrow or eliminate that Funding Gap by a combination of an increase in revenue through rate increases and a reduction in liabilities through benefit modifications.

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D. REHABILITATION PROCEEDING

Since the fall of 2008, SHIP has been owned and overseen by the Senior Health Care Oversight Trust (“Trust” - see paragraph VI.E, page 75) and its Trustees. As SHIP’s domiciliary regulator, the Pennsylvania Insurance Department (“PID”) regulates SHIP’s affairs and monitors its financial condition. On May 7, 2015, the PID concluded a financial examination of SHIP for the five-year period ending on December 31, 2013. The results were detailed in the Report of Examination dated as of that date, which concluded that, as of December 31, 2013, SHIP had capital & surplus of \$98,201,892 and made no recommendations.

As surplus continued to decline (see Table 7, at page 72, above), the PID became substantially concerned about SHIP’s financial situation. The Department engaged in an intense regulatory focus aimed in part at encouraging management and the Trustees to review and revise the actuarial and other assumptions on which they were basing their financial projections and reports of SHIP’s financial condition. In 2017 the PID commenced a limited examination of SHIP’s affairs and engaged an independent consulting actuary to assist, especially, in evaluation of the adequacy of the Company’s reserves. This work, though continuing, revealed a number of areas of concern and the PID appointed a Special Representative to work with SHIP management, the Trustees, and consultant for both the Company and the PID, to ascertain SHIP’s financial condition and to determine whether it would be able to fulfill the contractual promises inherent in the LTCI block the Company was running off. As this work progressed it became evident that SHIP was in a more hazardous financial condition even than suggested by the 2017 statutory annual statement filed in March 2018, which reported a decline in surplus to just over \$12.6 million from over \$28 million a year earlier and almost twice that the year before.

SHIP and its consultants, in communication with the PID and its representatives and advisors, re-evaluated their underlying assumptions, and, in early 2019, SHIP completed an annual statement for 2018 that reported a \$467 million deficit. Management was provided an opportunity to develop a corrective action plan to eliminate this deficit and restore the Company’s surplus to acceptable levels but failed to do so. On January 29, 2020, at the request of Pennsylvania Insurance Commissioner Jessica K. Altman, and with the consent of a majority of the Trustees and SHIP’s directors, the Commonwealth Court of Pennsylvania entered an order (the “Rehabilitation Order”) placing SHIP in rehabilitation and appointing Commissioner Altman as Rehabilitator. The order directed the Rehabilitator to file a preliminary plan for SHIP’s rehabilitation on or before April 22, 2020. Commissioner Altman appointed Patrick H. Cantilo as Special Deputy Rehabilitator (SDR) to comply with the Court’s requirement. This Plan Document is the plan required by the Court.

E. SENIOR HEALTH CARE OVERSIGHT TRUST

As mentioned above, SHIP had been a subsidiary of Consecro, Inc. (“Consecro”) until 2008 when it agreed with PID’s approval to transfer it to a newly created independent nonprofit trust. For that purpose the Senior Health Care Oversight Trust (the Trust) was formed as a Pennsylvania

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business trust and the following served as its trustees (the “Trustees”) as of the date the Company was placed in Rehabilitation and for at least seven years before that date:

1. Julianne Marie Bowler (Chair), since 2009 the Chief Underwriting Officer, and also the Chief Compliance and Administrative Officer, of Narragansett Bay Insurance Company. Ms. Bowler had served as the Massachusetts Insurance Commissioner from 2002 to 2007;
2. Cecil Dale Bykerk, President of CDBykerk Consulting, LLC, a life and health insurance consulting actuary;
3. Thomas Edward Hampton, Senior Advisor to Dentons US LLP, a Certified Public Accountant and former commissioner of the District of Columbia Department of Insurance, Securities, and Banking;
4. John Martin Morrison, senior Partner at Morrison, Sherwood, Wilson, Deola, PLLP, and former Montana State Auditor and Insurance Commissioner; and
5. Gregory Vincent Serio, Partner and Managing Director of New York lobbying firm Park Strategies, and former New York Superintendent of Insurance.

The transaction transferring SHIP to the Trust was memorialized in an August 1, 2008, Transfer Agreement between Conseco and the Trust. The Trust has been (and continues to be) governed by the board of trustees identified above, who have also served as directors of SHIP and Fuzion, along with certain senior officers of the companies. Their authority to oversee the Company has been effectively suspended by the rehabilitation proceedings.

F. FUZION ANALYTICS

Fuzion Analytics, Inc. (“Fuzion”), is a Delaware corporation formed in 2012 as a subsidiary of the Senior Health Care Oversight Trust ostensibly to provide LTCI data mining, analytical and other services to long-term care insurers, including SHIP. Beginning in 2012, SHIP entered into several agreements with Fuzion under which, over time, it paid Fuzion millions of dollars. In 2014, SHIP conveyed essentially all of its infrastructure to Fuzion in exchange for agreed-upon cash consideration consisting initially of a payment of \$367,806. In due course, Fuzion began providing SHIP all of the services necessary to administer SHIP’s affairs, other than those being performed by other vendors. Since that conveyance, SHIP has had no facilities or employees, relying instead on Fuzion to perform all of the functions necessary to run-off SHIP’s LTCI business. On August 20, 2019, the Senior Health Care Oversight Trust conveyed all of its interest in Fuzion to SHIP as a capital contribution, so that Fuzion is now a wholly owned subsidiary of SHIP. In addition to the services provided to SHIP, Fuzion continues to provide Fraud Waste and Abuse and other services to customers in the long-term care industry.

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G. LTCG, INC.

In 2008 SHIP entered into a Master Services Agreement with Univita for a broad array of claims and administrative services, excluding complaints. Univita has since become the Long Term Group (“LTCG”) and continues providing these services to SHIP.

H. POLICY RESTRUCTURING

Before the Effective Date and potentially again after Phase One, the Rehabilitator will determine which of SHIP’s policies are Impaired Policies (under priced and/or Non-self-sustaining). For purposes of implementing the Plan, the Rehabilitator will request that the Court deem SHIP’s Impaired Policies to have been restructured first as of the Effective Date and before giving effect to Policyholder Elections or modifications under the Plan, and potentially again between Phase One and Phase Two. However, these restructurings will not affect the elections available to or made by policyholders. The restructuring will be for the purpose of separating the liabilities arising under those policies that SHIP is projected to have sufficient assets to fund from those that it is projected to be unable to fund in the absence of the Plan. This initial restructuring will consist of reducing the liability arising under each such policy (equal to its GPR) to its Initial Funded Restructured Policy Value (IFRPV), being the amount of that liability that the Company can be reasonably expected to fund before it is further modified under the Plan. The Company will retain indebtedness to the policyholders for the amount by which the liabilities have been reduced, *i.e.*, the Unfunded Benefit Liability (UBL). It is possible that realization by SHIP of additional assets could reduce its aggregate UBL. In any case, as explained below, the Rehabilitator will take steps so that the portion of SHIP’s UBL that it will not be able to fund will be discharged as part of the Plan.

Allocated Assets and premiums paid as to each policy determined under the Plan as described in Section II.E.4.e, page 17, will suffice to enable the Company to fund its IFRPV. As a result, after the Effective Date SHIP will have assets at least equal to the funded liabilities (or IFRPVs) remaining under the Restructured Policies. Further, SHIP will also have indebtedness to policyholders for the UBL created by the restructuring process described in this Section. The modification of Impaired Policies under the Plan will result in contractual changes to eliminate liabilities that had been converted to UBL in the initial restructuring. That UBL will be equal to the difference between the policy’s GPR before modification and its GPR after such modification. SHIP will retain indebtedness to the policyholder equal to that UBL. In due course, however, that UBL will be paid or be discharged by the Court. Because SHIP is unable to fund the UBL, the Rehabilitator will request that, in due course, the Court’s Order approving the Plan discharge SHIP’s liability for any unpaid UBL.

I. GAUGING PLAN PERFORMANCE

During the pendency of the Plan, the Company’s financial condition will be monitored closely with emphasis on changes in the projected deficit. Elections by policyholders to increase

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premiums and reduce benefits in the aggregate are expected to have a material effect on that projected deficit. Various aspects of the Plan are also expected to have material effects on key trends such as average claim cost, claim incidence, claim duration and policy terminations. Most of these are heavily dependent on policyholder behavior that is difficult to predict with certainty. As time passes following implementation of each phase of the Plan, however, changes in these key trends will become more evident and the effects of the Plan as a whole will be more susceptible of quantification.

J. GUARANTY ASSOCIATIONS

This is a general summary of the state Guaranty Association system. Readers must review the individual state laws to understand how individual Guaranty Associations operate in each jurisdiction and the protections they afford. The Plan does not contemplate involvement by Guaranty Associations in the Plan's operations. This information is provided solely in the interest of addressing anticipated questions.

All U.S. states and the District of Columbia have legislatively established entities, commonly referred to as "Insurance Guaranty Associations," which protect policyholders of licensed insurance companies in the event their insurance company fails. These Guaranty Associations generally are required to provide for the continuation of the life and health insurance coverage provided by the failed insurer, in most cases up to statutory maximum coverage amounts and subject to specified conditions.

Virtually all of SHIP's LTC insurance policies would be covered under the state Guaranty Association system, subject to individual state statutory maxima and conditions, if SHIP were placed into liquidation with a finding that it is insolvent. Policies held by residents of countries other than the U.S. may not be covered by Guaranty Associations.

In most states, Guaranty Association benefits can be "triggered" in one of several ways. Some "triggers" are permissive, authorizing the Guaranty Association to guarantee, assume or reinsure, or cause to be guaranteed, assumed, or reinsured, the covered contractual obligations arising under the insurer's policies or contracts (or to provide loans or other assistance). Other "triggers" are mandatory, requiring the Guaranty Association to take such measures. When triggered, the Guaranty Associations generally provide such protections to the residents of their states, though the contracts may have been issued in other states. In most states, the permissive trigger can be used when an insurer is deemed "impaired" but has not been found insolvent or ordered liquidated. As the term implies permissive triggers are optional with the Guaranty Associations and very rarely used.

Mandatory triggers generally include an insurer not paying claims on time and being placed in liquidation with a finding of insolvency. These provisions vary somewhat among the several states. The Rehabilitator has concluded that SHIP does not now qualify for mandatory triggers

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largely because there has not been an order of liquidation with a finding of insolvency and it is currently paying claims on time. However, though SHIP is currently paying claims on time as required by the Rehabilitation Order, its financial condition is so dire that it is a virtual certainty that it cannot continue paying claims in full and on time for as long as required by its LTC insurance contracts without remedial measures. In the absence of a rehabilitation plan, the continuation of full benefit payments to current claimants virtually assures that policyholders who go on claim in the future will not be able to receive full, or in some cases any, benefits from SHIP.

Generally, if a policyholder is entitled to receive benefits from the Guaranty Association of his or her state of residence no further inquiry is necessary to determine which Guaranty Association is responsible for his or her policy. However, when that is not the case, it may be necessary to determine whether the Pennsylvania Life and Health Insurance Guaranty Association (PLHIGA) may be required to provide such benefits because SHIP is domiciled in Pennsylvania. It is important to note that the conditions and limits of Guaranty Association protection typically apply to each policyholder, not to each policy. Thus, in a state in which such benefits are limited to \$300,000 (the majority of states), that limit will apply to all of a policyholder's policies issued by the same Company combined. The laws of each specific jurisdiction should be reviewed carefully to determine how these conditions and limits apply in particular cases.

It is important to note that the amount of statutorily promulgated Guaranty Association coverage limits is not directly comparable to a policy's GPR. GPR is the present value as of the valuation date of expected benefits unpaid, expected expenses unpaid, and unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect and including provision for moderately adverse developments. It measures the present value of benefits and expenses less the present value of premiums. The Guaranty Association coverage limits are stated nominally (that is the total to be paid over time, no matter how long that time) and not at present value. The GPR equivalent of stated Guaranty Association Limit depends on factors individual to each policyholder, mostly related to the expected timing and amount of benefit and premium payments. Thus, a \$300,000 Guaranty Association limit may equate to a GPR of \$270,000 or some other amount less than \$300,000 for a given policyholder.

Neither the Rehabilitator nor SHIP would be responsible for coverage decisions of the Guaranty Associations. Each Guaranty Association evaluates its own liability and makes its own coverage determinations in accordance with applicable law. Those laws vary to some degree among the states and benefits available in some states may differ from those available in others. For example, in some states the Guaranty Associations do not provide coverage for any portion of a policy or contract to the extent that the rate of interest on which it is based exceeds a specified rate, typically set by reference to Moody's Corporate Bond Yield Average over a specified time. These interest rate limitations often apply retrospectively (to interest earned pre-liquidation) and prospectively (to interest earned after liquidation), though perhaps in different ways. Other states have adopted legislation making such provisions inapplicable to LTCI.

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As noted above, Guaranty Association benefits are subject to statutory conditions and limits. For example, PLHIGA is not obligated to provide more than \$300,000 in benefits to a covered individual. In some states that limit can be significantly higher. However, the fact that applicable limits may be higher in another state does not entitle Pennsylvania residents to the higher protection afforded by the Guaranty Association of another state. In addition, the Guaranty Association statutes contain certain residency and other requirements that must be met in order to receive benefits. Some of SHIP's policyholders may have aggregate claims in excess of these limits or which do not qualify for Guaranty Association benefits for other reasons (Uncovered Benefits).

The methods by which Guaranty Associations discharge their statutory responsibilities vary from case to case but normally involve assumption by a Guaranty Association or an insurer of the contractual obligations created by the policies issued by the failed insurer, up to statutorily prescribed limits and subject to statutory conditions. Policyholders are required to continue paying their premiums without interruption in order to preserve their insurance coverage, unless those premiums have been suspended by Premium Waiver provisions in their policies. However, once benefits paid by the Guaranty Association reach the applicable statutory limit (and those benefits are therefore discontinued), the policyholder will no longer be required by the Guaranty Association to continue making premium payments.

As noted, SHIP has not been placed in liquidation and Guaranty Association coverage and associated limits are therefore not applicable to SHIP policies. While it is hoped that it will not be necessary to place SHIP in liquidation, and no specific plans exist to do so, past experience provides guidance about some likely aspects of such an eventuality. Specifically, it is probable that if the Guaranty Associations are "triggered" for a SHIP liquidation they would seek to raise rates to If Knew Premium levels. To the extent that the Plan does so now, it should reduce or eliminate the need for the Guaranty Associations to do so if that were to occur.

K. JURISDICTION OF COMMONWEALTH COURT

The Commonwealth Court has exclusive *in rem* jurisdiction over SHIP and all of its assets. That means it is the only court with jurisdiction over SHIP's assets and business. Note by way of distinction that other courts may have *in personam* jurisdiction over SHIP, its policyholders and claimants. The Commonwealth Court has authority to approve a rehabilitation plan for the company. 40 P.S. § 221.16 expressly authorizes the rehabilitator to "prepare a plan for the reorganization, consolidation, conversion, reinsurance, merger, or other transformation of" SHIP. Without going into detail, that statute gives the rehabilitator broad discretion to develop a plan to correct the conditions that led to the need to place SHIP's in rehabilitation, including changing the Company's policies (and rates) as part of the Plan. So long as all affected parties (including other state insurance departments) are provided an opportunity to object, they will be bound by the Court's approval of the Plan, and its modification of policies and premium rates as part of the Plan.

Some concern has been expressed by certain state regulators about the notion that premium

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rate modifications under the Plan will not require approval of the states in which the policies were issued. The concern is understandable given that there have not been many troubled companies for which the issue of rate increases in rehabilitation has arisen. Moreover, insurance rate regulation tends to be an area of intense public and political focus. In some states, Commissioners are constrained by statute in the magnitude of rate increases they can authorize for long-term care insurance policies. The Rehabilitator believes strongly that there is fundamental distinction between rate increases for companies in the market place and the extraordinary case of rate increases as part of a court supervised rehabilitation plan for a troubled company. While the matter is without an abundance of clear specific legal precedent, the Rehabilitator believes that the applicable legal authorities support the conclusion that it is properly within the purview of the Rehabilitator and the Commonwealth Court in an Article V rehabilitation proceeding. More importantly, the Plan would not be feasible, and would fail in a key goal, if rate modifications required approval from each of the states in which SHIP policies have been issued. First, that would prevent the plan from accomplishing its key goal of placing policyholders on “a level playing field” by having them pay substantially the same premium for the same coverage, thereby reducing or eliminating the much-criticized historical subsidies. Second, the need to obtain such approvals would insert a lengthy delay in the time-line that would be costly, if not fatal, to the Plan.

L. REINSURANCE

SHIP has assumed a number of LTC policies through co-insurance or reinsurance.

1. Transamerica

On October 11, 1994 JC Penney Insurance Company and JC Penney Life Insurance Company (collectively “JCP”) entered into a Reinsurance and Purchase Agreement and Administrative Services Agreement with American Travelers Life Insurance Company (“American Travellers”). The Reinsurance and Purchase Agreement was structured on an Indemnity Reinsurance basis and a trust account was later established pursuant to a Trust Agreement executed on December 31, 2002. American Travellers was purchased by Conseco in 1996 and subsequently changed its name to Conseco Senior Health Insurance Company and then to Senior Health Insurance Company of Pennsylvania (“SHIP”). JCP changed its name to Stonebridge Life Insurance Company in 2002 and, as a result of corporate transactions, is now Transamerica Life Insurance Company.

2. Primerica

On December 20, 1995 Primerica Life Insurance Company (“Primerica”) and Transport Life Insurance Company (“Transport Life”) entered into a Reinsurance and Administration Agreement whereby Transport Life, on an indemnity basis, accepted 100% of the policy liabilities of Primerica’s individual and group accident and health insurance policies. Transport Life merged with Conseco Senior Health Insurance Company in November 1997 and, with the separation from

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Conseco, Senior Health Insurance Company of Pennsylvania (“SHIP”) became the successor under the Reinsurance and Administration Agreement. Amendment #2 to the Reinsurance and Administration Agreement, dated November 11, 2008, limits the scope of SHIP’s reinsurance and administration to long term care policies only.

3. **American Health and Life**

Pursuant to a Reinsurance Agreement dated November 1, 1996, Transport Life entered into a Reinsurance Agreement whereby Transport Life agreed to administer and reinsure, on a coinsurance basis, 100% of the liability of American Health and Life Insurance Company’s long term care policies. As a result of certain corporate transactions, and later the separation of SHIP from Conseco, SHIP became the successor to Transport Life’s interests under the Reinsurance Agreement and continues to administer the policies.

4. **Washington National Insurance Company**

On June 30, 1998, American Travellers entered into a Coinsurance Agreement with Conseco Life whereby American Travellers ceded 100% of its net liability for certain Connecticut resident state policies to SHIP, including servicing and administration of these policies. On April 1, 2013, CNO assumed, through novation, all of the policies with the exception of certain Connecticut policies which opted out of the assumption. Washington National Insurance Company reinsured those Connecticut policies that opted out.

5. **Conseco Life Insurance Company**

Under an Assignment Agreement effective October 1, 2008 with Conseco Life Insurance Company (“CLIC”), all the assets and liabilities pertaining to SHIP’s non-long term care business were assigned to, and assumed by, CLIC, which, together with DXC Technology, administers all of the business. SHIP remains contingently liable for the assigned business in the event CLIC fails to perform its obligations under the Assignment Agreement. In recognition of this liability, CLIC is required to and does maintain assets in a trust account of which SHIP is beneficiary. That account appears to be adequately funded. The business they manage consists of

1. 7,106 Traditional Life,
2. 213 Universal Life,
3. 80 Deferred Annuity,
4. 223 Medicare Supplement,
5. 40,273 Specified Disease,
6. 756 Accident Only,
7. 667 Hospital Indemnity,
8. 521 Long term disability, and
9. 43 Other.

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6. **Teacher's Protective Mutual Life Insurance Company**

Teacher's Protective Mutual Life Insurance Company ("Teachers") and Senior Health Insurance Company of Pennsylvania ("SHIP") entered into an Indemnity and Assumption Reinsurance and Administrative Services Agreement on December 28, 2015 pursuant to which Teachers ceded to SHIP, on an indemnity reinsurance basis, 100% of liabilities and obligations paid or payable by Teacher's. These policies have been novated by SHIP so that they are treated as if they had been issued by SHIP in the first place.

All of these assumed LTCI policies have historically been treated administratively in material respects as if they had been issued directly by SHIP. That treatment will continue under the Plan unless the Court orders otherwise or a different agreement is reached with the cedents of those policies.

M. COMMISSIONS

The payment of commissions owed to Agents under agreements made prior to the inception of rehabilitation proceedings will be suspended under the Plan until policyholders have been made whole, that is, all their contractual claims have been paid in full and adequate provision made for reasonably anticipated future claims. Further, the Plan will suspend the accrual of commissions as of the Initial Plan Effective Date. Agents and brokers may assert claims for commissions earned prior to the Initial Plan Effective Date but, under the Plan, those claims will be subordinated to amounts owed to policyholders under SHIP insurance policies.

The Rehabilitator notes that Agents are not currently providing services at the request of and in support of the Rehabilitator. Since entering rehabilitation, SHIP has evaluated the ongoing role of Agents. It is the belief of the Rehabilitator that most policyholders do not have a close relationship with their Agents, often have not spoken with their Agents since their policies were purchased, and do not contact their Agents for questions about their policies or benefits. Most policyholders contact SHIP directly for policy information or questions, or a financial advisor or trusted professional (lawyer, banker, trustee or family member).

N. OPT OUT

The Company's LTC policies do not provide for any cash or surrender value and policyholders are not entitled to any cash payment upon cancellation either in the ordinary course of business or in liquidation. In short, upon liquidation, policyholders would not receive cash payments.

While the Plan does not propose a separately-identified cash opt-out option, certain features of the Plan satisfy an opt-out requirement. First, many policyholders will not be required by the Plan to make any changes in their policies. Second, every policyholder will have an option in every

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scenario to select a Non-forfeiture Option under which no more premium will be due and he or she will receive at least the coverage that can be provided at the current benefit level by the aggregate of all premiums paid by the policyholder to date less claims paid under the policy to date. In fact, elements of the Plan make the NFO option materially more valuable than this baseline. See section II.I, page 22. Finally, every policyholder will have at least one option under which he or she would receive at least as much in benefits as would be provided by his or her Guaranty Association coverage.

O. STATE DEPOSITS

SHIP has been required to place deposits with various states as a condition of its licensing in those states. These state deposits total approximately \$19.3 million. The Rehabilitator believes that once the Plan is approved (whether or not modified), she should pursue recovery of those deposits so that the funds can be used to support the Plan.

P. TAX MATTERS

The Plan is not intended to create net adverse tax consequences for policyholders or SHIP, and the Rehabilitator does not believe that it will do so if it is implemented as proposed. However, the tax effects of the Plan depend in part on events, circumstances and the conduct of other parties that are not within the control of, nor can be predicted by, the Rehabilitator.

While a number of federal income tax issues may arise under the Plan, two areas are of particular concern. First, will any modification of LTC policies under the Plan create adverse tax consequences for policyholders? Second, will the inability to fund fully policy obligations or provisions of the Plan create adverse tax consequences for SHIP?

1. Policy Modifications.

It does not appear that the Plan is likely to create adverse tax consequences for policyholders. However, if further analysis indicates that Policy Modifications or other provisions of the Plan, may raise such issues, it is likely that the Rehabilitator will seek from the Internal Revenue Service of the Department of the Treasury (the "IRS") a favorable private letter ruling ("PLR") to the effect that Policy Modifications under the Plan would not produce taxable deemed exchanges or other adverse tax consequences for policyholders.

2. Tax Issues for SHIP

It is possible that reductions in insurance reserves resulting from Policy Modifications or other elements of the Plan would be deemed taxable reserve releases creating taxable income. However, the Plan contemplates the restructuring of SHIP's policies, bifurcating the liabilities arising under them as between their IFRPV and their UBL, which will minimize this tax exposure.

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The Plan contemplates discharge of SHIP's UBL to the extent that SHIP cannot pay them.

SHIP is part of consolidated group for federal income tax compliance purposes, which also includes its affiliates, the Trust and Fuzion. The group files a consolidated tax return. SHIP and its affiliates currently possess substantial Deferred Tax Assets ("DTAs") such as net operating loss carry-forwards. These DTAs may serve to offset taxable income generated by operation of the Plan. It is possible that implementation of the Plan may give rise to tax liability, however, because of certain limitations on the use of such carry-forwards in the Internal Revenue Code. The ability of SHIP to realize the benefit of these DTAs may also depend in part on decisions made by other members of the consolidated group. While Fuzion is SHIP's wholly owned subsidiary, and under its control, the Trust is governed independently. Current tax law may affect the degree to which other parties may make decisions adverse to SHIP's interest and rehabilitation. Moreover, the discharge of indebtedness under the Plan may also result in reducing or eliminating SHIP's ability to take advantage of these DTAs.

As indicated above, to the extent that the Plan results in the reduction of policy obligations through the modification of policies to make them properly priced or Self-sustaining (thereby removing their UBL), it is possible that such reduction will be subject to federal income tax. It is possible that not all of such income may be excludable under an insolvency exception for discharge of indebtedness income, or be offset against net operating loss carry-forwards and other DTAs. It is also possible, as noted, that implementation of the Plan may give rise to tax liability. The Plan is designed, and the Rehabilitator intends to implement it, in a manner that will minimize or eliminate such potential adverse tax consequences. However, there can be no assurances that these measures will be effective.

Nothing in the Plan Document is intended to provide, nor shall be interpreted as providing tax or legal advice. Policyholders and other persons affected by the Plan should consult their own tax or legal and other advisors regarding the possible tax and other effects of the Plan. The Rehabilitator may seek guidance (such as a private letter ruling) from the U.S. Secretary of the Treasury regarding certain potential tax aspects or consequences of the Plan.

Q. PRINCIPLES AND FAIRNESS OF THE PLAN

The Plan is designed to comply with applicable statutory provisions. In addition, by reference to Pennsylvania statutes and judicial opinions governing other insurance rehabilitation and insolvency proceedings in this and other states, the Rehabilitator has adopted the following core principles that should guide implementation of the Plan:

1. To the extent reasonably possible under the circumstances, the Plan should correct the conditions which constituted the grounds for the order to rehabilitate the Company;

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2. The paramount goal of the Plan should be protection of policyholders;
3. The Plan should be fair and equitable;
4. The Plan should put policyholders and creditors as a group in a position not materially inferior to what liquidation of SHIP as of the Effective Date would produce; and
5. The Plan should include metrics to gauge progress.

The Rehabilitator believes that the Plan reasonably embodies these principles and that it is fair and equitable to policyholders, creditors and affected parties. It addresses historically discriminatory premium rates through asset allocations in determining Self-sustaining Policies and through the premium rate increase structure governing Policy Modifications. Within the means available, as regards policyholders the Plan is designed to reduce the Funding Gap which principally led to the inception of the rehabilitation proceeding. It does so through premium rate increases and benefit reductions to reduce or eliminate on a policy-by-policy basis the shortfall between assets and liabilities. The principal goal of the Plan is to protect the interests of policyholders by maximizing preservation of their insurance coverage. It treats similarly situated policyholders in the same way and devotes SHIP's assets to the fulfillment of its purposes in a non-discriminatory and non-arbitrary manner.

R. RISK FACTORS

There are substantial risks and uncertainties associated with the Plan and its implementation. Those described herein are not the only ones that could materially impact SHIP, the Plan, its implementation, and its impact on policyholders, creditors and the public.

1. The actuarial assumptions and projections used to develop the Plan, including investment income, default rates, lapse rates, expenses and claims may be materially different from actual results. Therefore, the benefits and claims that SHIP will be able to pay may be materially higher or lower than the amounts assumed in the Plan.
2. Although the Plan does not contemplate that SHIP will, as a result of the Plan, implement future premium rate increases not described in the Plan, there can be no assurances that such rate increases will not be sought by Guaranty Associations if SHIP is placed in liquidation.
3. Objections may be lodged against the Plan or its implementation which may not be able to be overcome without material changes in the Plan.
4. The Rehabilitator believes that the provisions of the Plan can be implemented with approval of the Commonwealth Court and without the need that insurance regulators in every state approve the Plan, including premium rate increases implemented under the Plan. However,

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regulators in other states may conclude that their approval is required. The Rehabilitator cannot provide any assurance that approval from other regulators will not ultimately be deemed necessary. Neither can the Rehabilitator provide assurances that if such other state approvals are necessary they can be obtained consistent with the timing and substance of the Plan.

5. Governmental authorities may change the laws and regulations that apply to SHIP, its business and state insurance receiverships in ways that impact policyholders, SHIP, the Plan, or its implementation negatively.
6. Adverse developments in the broader economy may affect adversely the performance of SHIP's invested assets, the costs of its operations or the development of its liabilities. As a result, financial assumptions made in the Plan may differ materially from actual events.
7. Certain changes in the general health of SHIP's insured population (such as developments prolonging the period that such persons remain on claim, the severity of such claims, or the frequency with which policyholders go on claim) may affect materially the development of SHIP's insurance liabilities. As a result, loss assumptions made in the Plan may differ materially from actual events.
8. The emergence of the Coronavirus disease known as "COVID-19" has created unprecedented and wide-ranging disruptions in virtually every facet of American society. Its economic implications, and the changes that will result in American healthcare and insurance are only now beginning to surface and will take a prolonged time to develop completely and be fully understood. The Rehabilitator cannot predict what effect COVID-19 will have on the Plan and its implementation. The Special Deputy Rehabilitator and rehabilitation team are making efforts to incorporate in the Plan expanded timelines and elements of flexibility that will facilitate responding to these recent and continuing developments.
9. The Plan depends on implementation of a complex restructure of SHIP's insurance business for which there is no close precedent and which depends in part on legal provisions that may be difficult to implement. Failure to implement these provisions may have a material adverse effect on the success of the Plan.
10. The success of the Plan will depend in part on policyholder elections which are difficult to predict. The actual results of those elections may have a material adverse effect on the Plan.

S. DISCLAIMERS AND SOURCES OF INFORMATION

The discussion of the Rehabilitation Plan in this document describes how it is proposed to be implemented if approved by the Court as proposed by the Rehabilitator. If the Plan is

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modified by the Court or pursuant to subsequent amendments proposed by the Rehabilitator, its implementation may differ materially from the description herein.

The Plan includes information concerning SHIP's history and current and projected financial condition. This information was prepared based on information available to SHIP and the Rehabilitator, including information provided by SHIP to the Rehabilitator or available in historical public filings, and on actuarial projections that inherently include a degree of uncertainty. The Rehabilitator has yet to conclude an investigation of all the reasons that led to the Company's distressed financial condition. Pursuant to her statutory ability to do so, the Rehabilitator has delegated broad responsibility to the SDR and in the Plan references to Rehabilitator should be interpreted as including the SDR unless specified otherwise. The Rehabilitator and SHIP do not make any warranty, express or implied, as to the accuracy or completeness of the information contained in the Plan. In particular, events and forces beyond the control of the Rehabilitator and SHIP may alter the assumptions upon which the disclosures in the Plan are based. The Plan Document includes certain projections, but they cannot forecast and reflect fully any events that may occur subsequent to the date hereof. Such events may have a material impact on the information contained in the Plan Document and any recovery or benefits that may be received by policyholders and other creditors of the Company. The Rehabilitator may or may not update the Plan (including the financial information and underlying assumptions) or may only update it in part or only after the passing of substantial amounts of time. Therefore, the financial information and projections set forth in this Plan document may become outdated with the passage of time.

THE REHABILITATOR AND SHIP ARE NOT OFFERING LEGAL, BUSINESS, FINANCIAL, TAX OR OTHER ADVICE TO ANY PERSON AND THE PLAN SHOULD NOT BE CONSIDERED TO CONTAIN ANY ADVICE OR INSTRUCTION CONCERNING SUCH MATTERS. THE READER SHOULD CONSULT WITH HIS OR HER LEGAL, BUSINESS, FINANCIAL, TAX AND OTHER ADVISORS AS TO ANY MATTERS CONCERNING THE PLAN.

The Plan document is not required to be prepared in accordance with federal or state securities laws. None of the Securities and Exchange Commission ("SEC"), any state securities commission, or any similar governmental body has approved the Plan Document or has opined on the accuracy or adequacy of the statements contained therein. None of the financial information in the Plan Document was prepared to comply with published guidelines of the SEC, the American Institute of Certified Public Accountants, U.S. Generally Accepted Accounting Principles or prescribed statutory accounting principles, except as specifically described therein.

The Plan Document may not be relied upon for any purpose (including to trade, buy or sell claims or securities) other than to obtain information about the details of the Plan and the related proceeding. Nothing contained herein is intended as or constitutes an admission of any fact or any party's liability with regard to any claim or litigation, including, but not limited to, any proceeding involving the Rehabilitator, SHIP, or any other party, or any proceeding with respect to the legal

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effect of the transactions contemplated by the Plan. Nothing contained in the Plan Document constitutes an admission, or can be deemed evidence, of the tax or other legal effects of the Plan on SHIP or on holders of claims against, or equity interests in, SHIP or its affiliates. Statements as to the rationale underlying the treatment of claims and other matters under the Plan are not intended to, and will not, waive, compromise or limit any of the Rehabilitator's or SHIP's rights or causes of action.

The Plan document contains statements that are, or may be deemed to be, "forward-looking statements" within the meaning of the Private Securities Litigation Reform Act of 1995. Any such forward-looking statements are based upon a variety of estimates and assumptions that, though considered reasonable by the Rehabilitator, may not be realized, and are inherently subject to significant business, economic and other uncertainties and contingencies. Some assumptions inevitably will not materialize and events and circumstances occurring subsequent to the date on which the statements were prepared may be significantly different from those assumed, or may be unanticipated, and thus may affect financial or other results in a material and possibly adverse manner. The statements, therefore, should not be relied upon as a guaranty or other assurance of the actual results that will occur.

To ensure compliance with Internal Revenue Service Circular 230, holders of claims and other interests are hereby notified that: (a) any discussion of United States federal tax issues contained or referred to in the Plan Document is not intended or written to be used, and cannot be used, by holders of claims and other interests for the purpose of avoiding penalties that may be imposed on them under the Internal Revenue Code; (b) such discussion is provided solely in connection with the transactions or matters addressed herein; and (c) holders of claims and other interests should seek advice based on their particular circumstances from an independent tax advisor.

All summaries of the Plan contained herein or in other materials prepared by the Rehabilitator or others, including other filings with the Court, are qualified in their entirety by reference to the Plan as set forth in its entirety herein. Summaries of the Plan herein are not complete and are subject to, and qualified in their entirety by, reference to the full text of the Plan.

VII. GLOSSARY

The following are terms used in, or helpful in understanding, the Plan.

- 1) **"Accumulated Premium"** means, for a policy or group of policies, the total Gross Premiums paid, and premium waived under Waiver of Premium provisions, from inception until the valuation date.
- 2) **"Accumulated Premium Method"** means allocation of assets in proportion to the Accumulated Premium of the relevant policies as is more fully explained in Section II.E.4.e, page 17.

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- 3) **“Active Allocable Assets”** is a notional determination applicable to policies not on claim and consisting of the Company’s Allocable Assets less the amount required to fund fully the Disabled Life Reserve.
- 4) **“Active Asset Premium Ratio”** means the ratio of Active Allocable Assets to the aggregate of Accumulated Premiums for all Active Lives.
- 5) **“Active Block”** means the LTC insurance policies issued or assumed by the Company that remain in force and are not on claim.
- 6) **“Active Life Reserve”** or **“Statutory Active Life Reserve”** means the excess of the present value of future benefits over the present value of future Net Premiums. Net Premiums do not include provisions for any expenses and are typically set at policy issue. The assumptions used in statutory active life reserve calculations are locked-in and several of the assumptions are prescribed by law.
- 7) **“Active Policies”** or **“Active Policyholders”** referred to also as Policies Not On claim and Policyholders Not On claim, means respectively policies or policyholders that have not been terminated due to non-payment of premiums, cancellation, or exhaustion of benefits and also are not listed in the Company’s records as having been approved for benefit payments and are not in the process of being approved for benefit payments as of the Determination Date.
- 8) **“Activities of Daily Living”** or **“ADL”** means eating, bathing, dressing, ambulating, transferring, toileting and continence.
- 9) **“Adult Day Care”** means a program for six or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly, or other disabled adults who can benefit from care in a group setting outside the home. It is generally administered as part of home health care benefits.
- 10) **“Adult Day Care Center”** means a facility which provides Adult Day Care programs and services and which is operated pursuant to the provisions of applicable state law relating to licensing and quality of care requirements.
- 11) **“Agent”** means any insurance agent, broker or producer that solicited, sold or placed insurance business issued or assumed by the Company or any of its predecessors.
- 12) **“Allocable Assets”** is a notional determination consisting of the total value of the Company’s liquid invested assets, after making provision for costs and expenses of administration, contingencies, and accrued but unpaid claim payments.

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- 13) **“Allocated Assets”** means, for a LTC policy or group of policies, the portion of the Allocable Assets notionally allocated to that policy or group of policies in accordance with the terms of, and solely for the purposes described in, the Plan. All asset allocations are notional and do not give any policyholder a right to any Allocated Assets or any particular sum of money.
- 14) **“Approval Order”** means an Order from the Commonwealth Court approving the Plan.
- 15) **“Article V”** means Article V of the Pennsylvania Insurance Department Act of 1921, P.L. 780, as amended, 40 P.S. § 221.1, et. seq.
- 16) **“Basic Policy Endorsements”** means certain endorsements that together constitute the policyholder Option Two under the Plan. They consist of specific Policy Modifications described fully in Section III.A.2.d, page 36, intended to provide reasonable benefits and premiums that will be immune from changes in Phase Two of the Plan. Policyholders making this election will not face additional modifications under the Plan except from paying full premium rather than Differential Premium if a Premium Waiver becomes inactive.
- 17) **“Benefit Triggers”** means the conditions that must be satisfied in order to be eligible for benefits under an LTC insurance policy.
- 18) **“Claim Reserve”** means the Disabled Life Reserve plus the reserve for pending and incurred but not reported claim payments as further defined herein.
- 19) **“Claim Waiver of Premium”** means a provision in a LTC insurance policy under which a policyholder who receives benefits under his or her policy for a specified period of time (such as 90 days) is no longer required to pay premiums for coverage after that time period as long as the policyholder remains eligible for benefits and/or receives a specified level of care.
- 20) **“Commonwealth Court”** or **“Court”** means the Commonwealth Court of Pennsylvania , which is the rehabilitation court for SHIP and has exclusive jurisdiction over SHIP’s rehabilitation.
- 21) **“Company”** means SHIP.
- 22) **“Cost of Insurance”** means the amount of premium expected to fund future policyholder benefits. It does not include amounts for future operating expenses and profits.
- 23) **“Court”** means for purposes of the Plan, and unless otherwise specified, the Commonwealth Court of Pennsylvania.

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- 24) **“Covered Benefits”** means the amount of policy benefits provided by SHIP’s insurance policies that, if SHIP were placed in liquidation, would be within the limits, conditions and scope of coverage of the responsible Guaranty Association taking into account the residence and other attributes of the policyholders as determined by the responsible Guaranty Association in accordance with applicable law.
- 25) **“Current Premium”** means the premium paid by or waived for a LTCI policy before the applicable Effective Date under the Plan. This is also the target premium for the Downgrade Process. See Section III.A.1.c, page 30.
- 26) **“Daily Benefit Amount”** or **“DBA”**, also called Maximum Daily Benefit (MDB), means a maximum daily dollar amount available on a covered day of care as specified in the policy.
- 27) **“Default Option”** means the Plan Option selected automatically for a policyholder who fails to make a valid election by the required date.
- 28) **“Determination Date”** means a date, which may vary among policyholders, after the Policyholder Election Date and before the Initial Plan Effective Date or Supplemental Plan Effective Date (whichever is applicable) to be selected by the Rehabilitator pursuant to the Plan as of which all the determinations and calculations required to construct the options available to each policyholder will be made by the Rehabilitator.
- 29) **“Differential Premium”** means the applicable premium (If Knew, Phase One, or Self-sustaining) less the Current Premium and is payable under the Plan in lieu of the applicable premium by policyholders on waiver. Under the terms of the Plan, differential premiums cannot be less than zero.
- 30) **“Disabled Allocable Assets”** is a notional allocation consisting of the portion of the Company’s assets allocable to policyholders on claim for purposes of determining whether they are Self-sustaining, and if not, their Shortfall Amounts. The method of determining the amount of such assets is described in Section II.E.4.d, page 16.
- 31) **“Disabled Life”** means a policyholder who is receiving, or has been approved to receive, policy benefits or a policy under which benefits are being provided, or have been approved, by the Company and is also referred to as a policyholder on claim.
- 32) **“Disabled Life Reserve”** or **“DLR”** means the present value of expected future benefits calculated for each policyholder listed in the Company’s records as a policyholder on claim.
- 33) **“Downgrade Process”** means the process for reducing the benefits of a policy pursuant to Option One so that the policyholder may retain the Current Premium but reduce the benefits

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provided by that policy to those that premium can fund on an If Knew basis in Phase One and a Self-sustaining Basis in Phase Two. It is described in detail at Section III.A.1.c, page 30.

- 34) **“Dual Waiver of Premium”** or **“Dual Waiver”** (DWOP), sometimes called Spousal Waiver of Premium, means a provision in a LTC insurance policy under which the premium of a spouse is also waived when the policyholder’s premium is waived upon going on claim.
- 35) **“Effective Date”** means the date as of which the provisions of the Plan, including modification of LTC policies and Policyholder Elections, will become effective following the approval of the Plan. For most policyholders the Effective Date will be the Initial Plan Effective Date. For policyholders who undergo specified changes in status during the Policyholder Transition Period as described in Section II.K.3.c, page 26 the Effective Date will be the Supplemental Plan Effective Date.
- 36) **“Elimination Period”** or **“EP”** means the time period during which a policyholder’s circumstances qualify for Long-term Care insurance benefits but for which no such benefits are yet payable by the Company. The Elimination Period is similar to a deductible or waiting period. The length of the elimination period varies by policy. The majority of the Company’s policies include elimination periods of zero days, 30 days, 60 days, 90 days, and 110 days, although the Company has some policies with elimination periods up to 365 days.
- 37) **“Expected Losses”** means the average future benefit payments and increases in reserves calculated for a given policy using original issue assumptions as adjusted from time to time by the Company, including its demographic characteristics, policy characteristics, assumed claim incidence rates, assumed claim termination rates, and assumed claim intensity.
- 38) **“Final Approval Date”** means the date upon which the Approval Order becomes final and non-appealable or upon which an appellate Order affirming the Approval Order has itself become final and no longer appealable.
- 39) **“Fully Covered”** means that the maximum liability projected for a particular policy (its MPV) is no greater than the limits of Guaranty Association coverage that would apply to that policy if SHIP were placed in liquidation. A Fully Covered policy has no Uncovered Benefits.
- 40) **“Funding Gap”** means the gap between: (a) the sum of: (1) the amount of SHIP’s assets, (2) projected future premiums, and (3) projected earnings on investments, and (b) the sum of: (1) SHIP’s future policy benefits, (2) related expense payment obligations, and (3) other expenses.
- 41) **“Fuzion”** means Fuzion Analytics, Inc., a subsidiary of SHIP that, among other things,

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provides management and administrative services to SHIP.

- 42) **“Gross Premium”** means the periodic payments that are required to keep the policy in force. The rates used to establish the Gross Premium are typically filed with, and subject to approval of, insurance regulators. Gross Premium includes provisions for expenses and profit margins.
- 43) **“Gross Premium Reserve” or “GPR”** means the present value as of the valuation date of expected benefits unpaid, expected expenses unpaid, and unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect and including provision for moderately adverse developments. Expected expenses include commissions and premium taxes (if applicable). GPR is the reserve amount that results from performing a GPV. For a Self-sustaining Policy GPR is no more than the assets allocated to that policy under the Plan for calculation purposes only.
- 44) **“Gross Premium Valuation” or “GPV”** is the determination of the present value of expected future benefits and related expenses less the present value of expected future premiums at current and anticipated rates where “expected” consists of best estimate assumptions including a provision for moderately adverse deviation. The gross premium valuation process is used in determining the GPR.
- 45) **“Guaranty Association”** means the life, health and accident insurance Guaranty Association or equivalent entity in a particular state responsible for providing benefits to the policyholders of an insolvent long-term care insurer.
- 46) **“HIPAA”** means the Health Insurance Portability and Accountability Act of 1996, which among other things establishes data privacy and security safeguards for patient health information and which also provides that premiums paid for “Tax Qualified policies” as defined in the Act, may be deductible from federal income tax.
- 47) **“IBNR” or “Incurred But Not Reported”** reserve means a reserve for claims or rights to benefits that have occurred but which are not yet known to the Company.
- 48) **“If Knew Differential Premium”** means the If Knew Premium less the Current Premium. It is the Differential Premium when the applicable premium is the If Knew Premium. Under the terms of the Plan differential premiums cannot be less than zero.
- 49) **“If Knew Premium”** means the premium that if charged from inception would have produced the greater of the initial target loss ratio or the minimum loss ratio applicable to the policy form. For the sake of simplicity, this will be assumed to be 60%. It is sometimes described as the premium the insurer would have charged from inception had it known then what it knows now.

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- 50) **“Impaired Policy”** means an LTCI policy: (1) for which the Current Premium is less than the If Knew Premium, and/or (2) that is Non-self-sustaining.
- 51) **“Inflation Protection”** means riders purchased by policyholders or policy features that provide for defined increases in benefits at regular intervals in order to protect against the effects of inflation on the cost of care.
- 52) **“Initial Funded Restructured Policy Value”** or **“IFRPV”** means a policy value equal to the portion of the liabilities arising under the policy that SHIP can reasonably be expected to meet based on future premiums and Allocated Assets. For a policy that is not an Impaired Policy, the IFRPV will be equal to the full amount of those liabilities.
- 53) **“Initial Plan Effective Date”** is the Effective Date for all policyholders other than those to whom the Supplemental Plan Effective Date applies. It will not be the same specific day for all policyholders. For each policyholder, the Initial Plan Effective Date will be the policy’s ***Monthiversary Date*** occurring during the ***Initial Plan Effective Month***. See definitions, pages 95 and 97. The Initial Plan Effective Month will be the same for all policyholders for whom the Effective Date is the Initial Plan Effective Date, that is, those who have not undergone certain specified changes in status during the Policyholder Transition Period as described in Section II.K.3.c, page 26.
- 54) **“Initial Plan Effective Month”** means the calendar month immediately following the Plan Preparation Period. The Initial Plan Effective Month will be the same for all policyholders for whom the Effective Date is the Initial Plan Effective Date, that is, those who have not undergone certain specified changes in status during the Policyholder Transition Period as described in Section II.K.3.c, page 26.
- 55) **“Instrumental Activities of Daily Living”** or **“IADL”** means such activities as meal preparation, shopping and travel, light housekeeping, laundry, telephoning, money handling, taking medications, and bill paying.
- 56) **“Insurance Regulatory Authority”** means with respect to any state or the District of Columbia, the jurisdiction’s applicable insurance department or equivalent regulatory agency or authority.
- 57) **“Lifetime Waiver of Premium”** or **“LWP”** means a provision in a LTC insurance policy under which the premium payments are permanently suspended upon the death of a covered spouse after a qualifying period (typically five, seven, or ten years).
- 58) **“Limited Benefit Period”** means any Maximum Benefit Period that is subject to a stated limit by the terms of the policy. It refers to a policy that is not a lifetime or unlimited benefit

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policy.

- 59) **“Liquidation Benefits”** means the benefits a policyholder would reasonably be expected to receive if SHIP were liquidated under the provisions of Article V, taking into account the Company’s history, the orders of the Court, the risks and uncertainties of the liquidation process, and the effect of Guaranty Association coverage.
- 60) **“Long-term Care”** or **“LTC”** insurance means defined benefit accident and health insurance policies covering long-term care services, including confinement to nursing facilities and assisted living facilities, as well as home health care and adult day care.
- 61) **“LTCI”** means long-term care insurance.
- 62) **“Maximum Benefit Amount”** means the dollar maximum in benefits available under a LTC policy.
- 63) **“Maximum Benefit Period”** or **“MBP”** means the maximum time (typically stated as number of days, either lapsed time or days of provided service) during which benefits will be available under a LTC policy. Benefits are usually defined in the contract to be a maximum amount payable per day or per month, for a maximum number of years. However, in some policies if the claimant uses less than the maximum amount permissible in a given period, the unused excess typically serves to lengthen the Maximum Benefit Period under what is known as the “pool of money” clause. Benefits commence after satisfaction of an Elimination Period (EP) and continue until the recovery or death of the claimant or until the pool of money has been exhausted. In these cases the Maximum Benefit Period is sometimes expressed as a dollar amount, the Maximum Benefit Amount. Under other policies (sometimes called “days of care” policies) reducing the daily benefit amount utilized does not extend the benefit period. For these policies the Maximum Benefit Period is expressed as the number of days, months or years during which coverage remains available under the policies. In either case, modifications by the policyholder under the Plan may have the effect of reducing the Maximum Benefit Period.
- 64) **“Maximum Daily Benefit”** or **“MDB”** also called Daily Benefit Amount (DBA), means a maximum daily dollar amount available on a covered day of care as specified in the policy.
- 65) **“Maximum Guaranty Association Benefits”** means the maximum amount of benefits to which a particular policyholder would be entitled from the applicable Guaranty Association (typically determined by state of residence at the time of liquidation) if the Company were to be liquidated.
- 66) **“Maximum Policy Value”** or **“MPV”** means the product of a policy’s Maximum Benefit Period times its Maximum Daily Benefit.

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- 67) **“Monthiversary Date”** means the day of the month upon which premium is due under a particular policy or would be due except for a Premium Waiver provision.
- 68) **“NAIC”** means the National Association of Insurance Commissioners.
- 69) **“Net Accumulated Premium”** means the total gross premiums paid under a policy from inception until the valuation date, less the Expected Losses for that policy.
- 70) **“Net Premium”** means the part of the Gross Premium that is intended to cover the cost of future claims, as opposed to future operating expenses and profit margin. The Net Premium is typically set at issue.
- 71) **“Non-core Policy Benefits”** means certain benefits provided by some SHIP LTC policies other than nursing home, facility, home health (which often includes hospice) or adult day care. They are enumerated in section II.G, page 21.
- 72) **“Non-forfeiture Option”** or **“NFO”** traditionally means an option to exchange an existing LTC policy for a reduced paid up contract on which no future premiums need be paid by the policyholder but under which benefits are limited to premiums previously paid less benefits previously received. NFO benefits are enhanced substantially under the Plan.
- 73) **“Non-Self-Sustaining Policy”** means a LTC policy the Projected Benefit Amount (PBA) of which exceeds its Projected Credit Amount (PCA). It is a policy for which Current Premium rates are inadequate given assets available to be allocated to it and its projected liability for benefits and expenses.
- 74) **“Non-Tax-Qualified”** or **“NTQ”** benefit triggers means LTC insurance policy provisions under which the conditions that must be satisfied to be eligible for benefits do not conform to the legal standards for Tax Qualified policies. Such provisions were formerly called “traditional” Long-term Care Insurance. They often include a benefit “trigger” called a “medical necessity” trigger under which the insurer is obligated to pay if the policyholder’s own doctor, or that doctor in conjunction with someone from the insurance company, determines that the policyholder needs covered care for any medical reason. The United States Department of the Treasury has not fully clarified the tax status of premiums paid for and benefits received under a NTQ Long-term Care Insurance policy as precisely as the status of benefits received under a tax qualified policy. Therefore, the federal taxation of benefits under a NTQ policy is not certain. **The Rehabilitator makes no representation and does not offer any opinion regarding tax matters.**
- 75) **“Partnership-Qualified”** (PQ), means LTC policies that are intended to satisfy the requirements under the Deficit Reduction Act of 2006 entitling the policyholder to a dollar

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of asset disregard or spend-down credit with respect to Medicaid eligibility for every dollar of benefit received under the LTC policy.

- 76) **“On claim”** refers to a policyholder who is receiving, or has been approved to receive, policy benefits or a policy under which benefits are being provided by the Company.
- 77) **“Paid-Up Policy”** means an in-force policy that is paid in full and no longer requires premium payments under its terms.
- 78) **“Phase One Differential Premium”** means the Phase One Premium less the Current Premium. It is the Differential Premium when the applicable premium is the Phase One Premium. Under the terms of the Plan, the Phase One Differential Premium cannot be less than zero.
- 79) **“Phase One Premium”** means the premium calculated for a specified policy (or group of policies) on the If Knew basis, but not less than the Current Premium.
- 80) **“Phase Two Policyholder Election Package”** means the Policyholder Election Package sent to certain policyholders to inform them of options available in Phase Two of the Plan and to enable them to elect from among those options.
- 81) **“PID”** means the Pennsylvania Insurance Department.
- 82) **“Plan”** means this Rehabilitation Plan.
- 83) **“Plan Document”** means this document describing the Plan.
- 84) **“Plan Limits”** means the minimum and maximum modifications permitted by the Plan for Option One in Phase One a policy’s Maximum Benefit Period (MBP) and Maximum Daily Benefit (MDB). A policy’s MBP cannot be reduced by the Plan below the lower of (a) the current MBP or (b) four years, and cannot be increased by the Plan above the greater of (a) the current MBP or (b) six years. A policy’s MDB cannot be reduced by the Plan below the lower of (a) the current MDB or (b) \$300, and cannot be increased by the Plan above the greater of (a) the current MDB or (b) \$600. As a practical matter, the minimum MPV under the Plan is \$438,000 except for policies the current MPV of which is below that or the applicable GA limits for which are above that. The maximum MPV is \$1,314,000 except for policies the current MPV of which, or the applicable GA limits for which, are above that.
- 85) **“Plan Operation Fund”** means an allocation of the Company’s assets reserved for funding policyholder liabilities as part of the rehabilitation in an amount determined by the Rehabilitator in consultation with her advisors.

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- 86) **“Plan Option”** means any of the options available to policyholders under the Plan, which are described on page 12.
- 87) **“Plan Premium”** means the premium that a policyholder must pay under the terms of the Plan. Depending on the policyholder’s circumstances, it could be the Phase One Premium, If Knew Premium, Self-Sustaining Premium, Phase One Differential Premium, If Knew Differential Premium, or Self-sustaining Differential Premium.
- 88) **“Plan Preparation Period”** means the time between the Final Approval Date and the Effective Date of the Plan, during which preparatory steps necessary to implement the Plan will be completed. It includes the period during which policyholders will make elections under the Plan.
- 89) **“Policies Not On claim”** or **“Policyholders Not On claim”**, also called Active Policies or Policyholders, means policies or policyholders that have not been terminated due to non-payment of premiums, cancellation, or exhaustion of benefits and also are not listed in the Company’s records as having been approved for benefit payments or in the process of being approved for benefit payments as of the Determination Date.
- 90) **“Policy Modifications”** means Premium Rate Increases or Benefit reductions selected by a policyholder, or made applicable, in accordance with the terms of the Plan.
- 91) **“Policyholder Election”** means the election by a policyholder to modify the premiums or benefits of a policy under the Plan.
- 92) **“Policyholder Election Date”** means the date by which the Rehabilitator must receive properly completed Policyholder Election Forms in order to give them effect.
- 93) **“Policyholder Election Form”** means the form on which a policyholder specifies whether, and if so how, he or she elects to modify his or her LTC policy in accordance with the terms of of the Plan.
- 94) **“Policyholder Election Package”** means the materials, including the Policyholder Election Form, to be sent to policyholders by the Rehabilitator so that they may make the elections available under the Plan.
- 95) **“Policyholders”** means holders of insurance policies and certificate holders under group insurance policies.
- 96) **“Policyholder Transition Period”** means the period between the Policyholder Election Date and the Initial Plan Effective Date during which policyholders may experience changes

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in circumstances (such as going on claim) as the result of which they may have to make new elections under the Plan.

- 97) **“Possible Active Benefit Reductions”** means the list of possible benefit reductions applicable to premium paying active policyholders who select a Downgrade option as described fully beginning on page 32.
- 98) **“Possible On Claim Benefit Reductions”** means the list of possible benefit reductions applicable to policyholders on claim who select a Downgrade option as described fully beginning on page 41.
- 99) **“Premium Waiver”** means a policy provision that allows a policyholder to discontinue paying premiums and maintain the policy in force during a period of covered care or under circumstances specified in the policy.
- 100) **“Projected Benefit Amount”** or **“PBA”** means the present value as of the valuation date of unpaid expected benefits and unpaid expected policy expenses. For purposes of this determination “expected” consists of best estimate assumptions including a provision for moderately adverse deviation.
- 101) **“Projected Credit Amount”** or **“PCA”** means, for a LTC insurance policy, the sum of (a) the present value as of the valuation date of expected premiums, adjusted for future premium increases reasonably expected to be put into effect and (b) the assets allocated to that policy using the Accumulated Premium Method. For purposes of this determination “expected” consists of best estimate assumptions including a provision for moderately adverse deviation.
- 102) **“Reduced Paid-up Policy”** or **“RPU”** means a policy offering reduced long-term care benefits but for which no more premium has to be paid and which will not lapse before the death of the policyholder. The Non-forfeiture Option offered under the Plan is a RPU.
- 103) **“Rehabilitation Plan”** means this Plan for the rehabilitation of SHIP’s Long-term Care insurance business.
- 104) **“Rehabilitator”** means Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, and her successors in office, in the capacity of Statutory Rehabilitator of the Company. Pursuant to her statutory authority to do so, the Rehabilitator has delegated broad responsibility to the Special Deputy Rehabilitator and in the Plan documents references to the Rehabilitator should be interpreted as including the SDR unless specified otherwise.
- 105) **“Restoration of Benefits”** means a LTC insurance policy feature under which the benefit period for a policyholder who has received benefits will be restored to the original Maximum

SHIP REHABILITATION PLAN

Benefit Period after receiving some or all claim benefits if the policyholder does not need or receive care during a specified period of time (such as 180 days).

- 106) **“Restructured Policy”** means a policy that has been restructured as described in Section VI.H, page 77, to reduce the liabilities arising under the policy to its IFRPV.
- 107) **“Return of Premium”** means a LTC insurance policy feature which provides for the return of a percentage of premium paid by the policyholder (such as 80%) if the policyholder does not make a claim (or has a limited expected amount of benefits paid) during a given period of time in which the policy was in force (such as ten years).
- 108) **“Self-sustaining”** means a policy for which its Projected Credit Amount (PCA) equals or exceeds its Projected Benefit Amount (PBA). It is a policy for which Current Premium rates are adequate given assets available to be allocated to it and its projected liability for benefits and claims expenses.
- 109) **“Self-sustaining Differential Premium”** means the Self-sustaining Premium less the Current Premium. It is the Differential Premium when the applicable premium is the Self-sustaining Premium. Under the terms of the Plan, differential premiums cannot be less than zero.
- 110) **“Self-sustaining Premium”** means the premium calculated by determining the amount of premium required to eliminate a policy’s Shortfall Amount.
- 111) **“Senior Health Care Oversight Trust”** means the Pennsylvania business trust governed by an independent Board of Trustees comprised of former insurance regulators and an independent actuary, who also served as members of the board of directors of SHIP, created in 2008 to be the sole owner of SHIP.
- 112) **“SHIP”** means the Senior Health Insurance Company of Pennsylvania, the subject of this Rehabilitation Plan.
- 113) **“Shortfall Amount”** for a LTC policy means the difference between its Projected Benefit Amount and its Projected Credit Amount where the difference is more than zero. The Shortfall Amount can also be expressed as a policy’s GPR less its Allocated Assets. If the difference is zero or less there is no shortfall and the policy is Self-sustaining.
- 114) **“Shortfall Percentage”** means for an LTC policy a fraction (expressed as a percentage) the numerator of which is the policy’s Shortfall Amount and the denominator of which is the policy’s Projected Benefit Amount. For a Self-sustaining Policy the Shortfall Percentage will be zero or less.

SHIP REHABILITATION PLAN

- 115) **“Special Deputy Rehabilitator”** or **“SDR”** means Patrick H. Cantilo or his successors, appointed by the Rehabilitator to serve as the Special Deputy Rehabilitator for SHIP.
- 116) **“Standard Rate Increases”** means those premium rate increases sought or obtained by the Company for groups of policies in the ordinary course of its business and unrelated to the Plan.
- 117) **“Statutory Reserve”** means the insurance reserve required by Pennsylvania insurance laws to be included in an insurer’s financial statement on account of its insurance business in force.
- 118) **“Supplemental Plan Effective Date”** is the Effective Date for policyholders who undergo certain changes in status during the Policyholder Transition Period as described in Section II.K.3.c, page 26. It will occur on the policy’s Monthiversary Date during the month specified by the Rehabilitator following the Policyholder Transition Period.
- 119) **“Tax Qualified”** or **“TQ”** benefit triggers means the conditions that must be satisfied to be eligible for benefits under a LTC insurance policy that is designed to conform to certain standards in federal law and may offer certain federal tax advantages. TQ policies were created as a result of HIPAA, which included provisions for favorable tax treatment of qualified Long Term Care Insurance contracts. To comply with those standards, TQ policies are required to cover services for a chronically ill individual, and do not have a “medical necessity” benefit trigger. A TQ benefit trigger requires that a person 1) be expected to require care for at least 90 days, and be unable to perform 2 or more Activities of Daily Living (eating, dressing, bathing, transferring, toileting, and continence) without substantial assistance (hands on or standby); or 2) for at least 90 days, need substantial assistance due to a severe cognitive impairment. In either case a licensed healthcare professional must certify a plan of care. Premiums paid for a TQ policy may be deductible from taxable income, and benefits from a TQ policy may not be subject to federal income tax. **The Rehabilitator makes no representation and does not offer any opinion regarding tax matters.**
- 120) **“Total Allocable Assets”** means the Company’s invested assets less reserves for costs of administration, contingencies, and certain debts of higher priority.
- 121) **“TQ Triggers”** means the requirements that must be met under a Tax Qualified LTC policy in order to receive benefits.
- 122) **“Trust”** means the Senior Health Care Oversight Trust, as defined above.
- 123) **“Uncovered Benefits”** means the portion of the LTC policy benefits to which policyholders are contractually entitled on the Effective Date that exceed Guaranty Association statutory

SHIP REHABILITATION PLAN

limits or otherwise are not covered by Guaranty Associations as determined by the responsible Guaranty Association in accordance with applicable law.

- 124) **“Waiver of Premium”** see Claim Waiver of Premium, Dual Waiver of Premium, and Lifetime Waiver of Premium.

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

IN RE: Senior Health Insurance : No. 1 SHP 2020
Company of Pennsylvania :
In Rehabilitation :

**ORDER APPROVING THE PLAN OF REHABILITATION FOR
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA**

AND NOW, this ____ day of _____, 2020 upon consideration of the Application of Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as statutory Rehabilitator of Senior Health Insurance Company of Pennsylvania (“SHIP”) for approval of the Plan of Rehabilitation for SHIP, and any objections filed thereto, and after hearing, it is hereby ORDERED as follows:

1. This Court has original jurisdiction over proceedings to rehabilitate SHIP and over SHIP’s insurance business pursuant to Article V of the Insurance Department Act of 1921, 40 P.S. §§ 221.1-221.63. Under 40 P.S. § 221.16(d), this Court has the power to approve or disapprove a plan of rehabilitation or modify such plan and approve it as modified.

2. SHIP was placed into rehabilitation by Order of this Court dated January 29, 2020.
3. The Rehabilitator filed a Plan of Rehabilitation for SHIP (the “Plan”) on April 22, 2020.
4. By Order dated _____, 2020 (the “Notice Order”), this Court directed the Rehabilitator to provide notice of the filing of the Plan in the form approved thereby (the “Plan Notice”) to the persons and by the means set forth in the Notice Order.
5. The Notice Order required, among other things, that objections to the Plan to be filed no later than _____, 2020 and fixed _____, 2020 as the date for the commencement of a hearing on the Plan.
6. At the hearing on the Plan, all persons having interests affected by the Plan and who complied with the Notice Order were afforded an opportunity to be heard regarding support for or objections to the Plan.
7. The Court therefore finds that it has jurisdiction over the persons and entities identified in the Notice Order or who otherwise intervened, submitted comments, or participated in the hearing on the Plan.
8. Having heard the Rehabilitator’s evidence in support of the Plan, having heard argument on the Plan, and having considered the support for and objections

to the Plan, this Court hereby approves the terms, conditions, and provisions of the Plan and the attachments thereto and finds the Plan to be fair and equitable and free of any abuse of the Rehabilitator's discretion. The Rehabilitator is authorized to implement the Plan and carry out any transactions contemplated by the Plan without further order of this Court.

9. All objections to the Plan are overruled.

10. All other orders, injunctions, and stays issued by this Court in this matter shall continue in full force and effect except as modified hereby.

BY THE COURT:

MARY HANNAH LEAVITT
President Judge

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

In Re: Senior Health Insurance : No. 1 SHP 2020
Company of Pennsylvania in :
Rehabilitation :

CERTIFICATE OF SERVICE

I, Michael J. Broadbent, hereby certify that a Notice of Filing of the foregoing Application is being served on all parties listed on the Master Service List, if any, by electronic mail or facsimile, or by First Class Mail where no electronic mail address or facsimile number was available, and that an electronic copy of the foregoing Application has been posted on SHIP's website at <https://www.shipltc.com/court-documents>.

/s/ Michael J. Broadbent
Michael J. Broadbent

Dated: April 22, 2020

EXHIBIT K

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

In Re: Senior Health Insurance :
Company of Pennsylvania :
(in Rehabilitation) : **No. 1 SHP 2020**

**FORMAL COMMENTS OF THE MAINE SUPERINTENDENT
OF INSURANCE, THE MASSACHUSETTS COMMISSIONER
OF INSURANCE, AND THE WASHINGTON INSURANCE
COMMISSIONER**

Pursuant to the Court’s Case Management Order for Comments and Hearing on the Proposed Plan of Rehabilitation, dated June 12, 2020 (“Case Management Order”), the Superintendent of Insurance of the State of Maine, the Commissioner of Insurance of the Commonwealth of Massachusetts, and the Insurance Commissioner of the State of Washington (collectively, the “State Insurance Regulators”), submit these Formal Comments in objection to the Proposed Plan of Rehabilitation (“Proposed Plan”) for Senior Health Insurance Company of Pennsylvania (“SHIP”) submitted by the Rehabilitator with her Application for Approval of the Plan of Rehabilitation for Senior Health Insurance Company of Pennsylvania (“Plan Application”). The State Insurance Regulators have applied to intervene in this proceeding with respect to the Proposed Plan. The State Insurance Regulators intend to participate in the hearing on the Proposed Plan.

The Rehabilitator has not shown that the Proposed Plan satisfies the standards for approval. The Plan Application does not provide the analysis and

information necessary to show that the Proposed Plan is equitable, has a reasonable likelihood of success, and satisfies other applicable legal and constitutional standards. The Rehabilitator should be required to provide analysis and information to the State Insurance Regulators so that they may evaluate the Proposed Plan, consider its effects, and provide substantive comments concerning whether it complies with applicable standards. In any event, the Court should reject the Proposed Plan's attempt to override the laws of the other States providing for review by their insurance regulators of the premium rates to be charged to their residents. The Pennsylvania insurer rehabilitation statute does not authorize displacement of other States' regulatory laws, and the Full Faith and Credit Clause forbids it. These and other more particular comments and objections are set forth below.

Background

SHIP is an insurance company that specialized in long-term care coverage. Prior to rehabilitation, SHIP was licensed and transacted business in 46 States (all but Connecticut, New York, Rhode Island and Vermont), the District of Columbia, and the U.S. Virgin Islands. *See* Proposed Plan at 67. It operated subject to the laws of those jurisdictions and the regulatory authority of each jurisdiction's insurance commissioner or comparable state official.

SHIP's business consists entirely of long-term care insurance, with no policies issued later than 2003. Fewer than 50,000 policies currently remain in force. Proposed Plan at 68. The average long-term care policyholder age is 86, and the average claimant is 89 years old. *Id.* at 69. SHIP also wrote some assumed reinsurance. *Id.*

SHIP is insolvent, as its reported liabilities greatly exceed its assets and it has acknowledged it will not be able to continue to meet its obligations in the ordinary course. Proposed Plan at 72, 79. For 2019, SHIP reported assets of \$1,907,181,137 and liabilities of \$2,823,279,366 with a deficit (negative capital and surplus) of \$915,731,212. *Id.* at 72. The Rehabilitator acknowledges that "SHIP's Funding Gap is between \$500 million and \$1 billion." *Id.*

The purpose of the Proposed Plan is "to narrow or eliminate that Funding Gap by a combination of an increase in revenue through rate increases and a reduction in liabilities through benefit modifications." *Id.* at 74. The Proposed Plan thus proposes to address the deficit or Funding Gap exclusively on the backs of current policyholders, both by increasing their premiums and cutting their benefits. As the scale of the deficit suggests (a deficit of \$915 million on liabilities of \$2.8 billion is a shortfall of 32%), the revenue increases or benefit cuts that need to be made are large, and the consequences for policyholders are likely to be severe. *See, e.g.*, Proposed Plan at 10 (noting that under Option Four policyholders

would face “very large rate increases . . . sometimes as much or more than ten-fold”); *id.* at 35 (Table 5) (“downgrade” example with “target benefit reduction” of 37.5%). The State Insurance Regulators are accordingly greatly concerned over the ramifications of the Proposed Plan in their States and more generally. The State Insurance Regulators have a regulatory interest in seeing that contract rights of Maine, Massachusetts, and Washington policyholders are respected and that the standards and protections of the statutory rate-setting processes are honored.

I. THE REHABILITATOR SHOULD BE DIRECTED TO PROVIDE ACCESS TO THE ANALYSIS AND INFORMATION UNDERLYING THE PROPOSED PLAN.

A. The Rehabilitator Has Not Provided Factual Support For The Proposed Plan Nor Demonstrated That It Satisfies Statutory and Constitutional Standards.

The Rehabilitator should be directed to provide the State Insurance Regulators with the analysis and information that underlies the Proposed Plan. The Rehabilitator has submitted the Proposed Plan pursuant to 40 P.S. § 221.16(d), which provides that

The rehabilitator may prepare a plan for the reorganization, consolidation, conversion, reinsurance, merger or other transformation of the insurer. Upon application of the rehabilitator for approval of the plan, . . . the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. If it is approved, the rehabilitator shall carry out the plan.

40 P.S. § 221.16(d). As the proponent seeking approval of the Proposed Plan, the Rehabilitator has the burden of showing that the plan complies with statutory and

constitutional standards. In particular, the Rehabilitator must show that the plan is feasible, and that the effects of the plan upon policyholders and others are fair and equitable. The Rehabilitator effectively acknowledges this burden by asking the Court to find that the Proposed Plan is “fair and equitable and free of any abuse of the Rehabilitator’s discretion.” Proposed Order at ¶ 8. However, the Rehabilitator’s Application for Approval of the Proposed Plan provides no factual support. It merely states that “[t]he attached Plan provides the facts that demonstrate the need for the corrective action recommended by the Plan.” Plan Application ¶ 5.

The key assertion upon which the Rehabilitator’s request for approval of the Proposed Plan rests is found at page 11 of the Proposed Plan: “The Rehabilitator believes that the Plan structure, which is the product of extended analysis by industry experts, offers a reasonable prospect of success based on sound principles.” Proposed Plan at 11. However, the Proposed Plan offers no further information about the “extended analysis of industry experts” concerning the Plan’s structure, and it provides no information about why the Rehabilitator thinks it has a “reasonable prospect of success.” All one can conclude from the Proposed Plan document is that the Plan is complex and that – based on the size of the deficit

or the “Funding Gap” – it will greatly increase premiums and cut benefits.¹ *See also* Proposed Plan at 77 (noting that the Rehabilitator “will request that, in due course, the Court’s Order approving the Plan discharge SHIP’s liability for any unpaid [Unfunded Benefit Liability].”).

It is critical that the State Insurance Regulators – and the Court – be presented with the analysis showing how the Proposed Plan will affect various types of policyholders and whether the Proposed Plan has a reasonable chance of success. If the effects of the Proposed Plan on policyholders are inequitable or do not comport with statutory and constitutional standards (in particular, the *Neblett* standard discussed below; *see also* the Full Faith and Credit Clause), the Plan should not be approved. If the Proposed Plan is unlikely to succeed, then it should not be approved.

The implication of the Proposed Plan is that the impacts on policyholders and prospects for success may not be known until at least after Phase One is complete. *See* Proposed Plan at 6. However, delay in consideration of these points operates to prefer policyholders who are presently on claim and disadvantage those

¹ The Proposed Plan is complex and provides so many potential options for policyholders, *see* Proposed Plan at 7-8, 29-66, that the actual consequences for individual policyholders are difficult to discern. Indeed, because of the complexity of calculations required, the Rehabilitator requests that the Court approve the Proposed Plan before individual policyholders are presented with their “Policyholder Election Package” identifying their actual options. *See* Proposed Plan at 26 (Package will include “the premium amount and/or benefit reductions that will apply to the policyholder’s specific policy under each applicable option of Phase One.”).

who may have a claim later. As the Rehabilitator acknowledges, absent a feasible plan, “the continuation of full benefit payments to current claimants virtually assures that policyholders who go on claim in the future will not be able to receive full, or in some cases any, benefits from SHIP.” *Id.* at 79.

The Proposed Plan acknowledges that it needs “to place policyholders in no worse a position than they would face in a liquidation of SHIP.” Proposed Plan at 8. This reflects the well-established constitutional requirement of *Neblett v. Carpenter*, 305 U.S. 297 (1938). *See Foster v. Mutual Fire, Marine and Inland Ins. Co.*, 531 Pa. 598, 614 A.2d 1086, 1093-94 (1992) (“Under *Neblett*, creditors must fare at least as well under a rehabilitation plan as they would under a liquidation . . .”). In the absence of analysis showing how policyholders will be affected by the Proposed Plan and how they would fare in a liquidation, and then comparing the two, it is not possible to assess whether the Proposed Plan comports with *Neblett*. Such information is particularly necessary if the *Neblett* standard involves further consideration concerning whether benefit cuts are substantial, made for a legitimate public purpose, and reasonable and appropriate. *See Consedine v. Penn Treaty Network America Ins. Co.*, 63 A.3d 368, 451-52 (Pa. Commw. Ct. 2012), *aff’d*, *In re Penn Treaty Network America Ins. Co.*, 632 Pa. 272, 119 A.3d 313 (2015). The State Insurance Regulators request information to understand how the Plan can comport with this standard in light of the significant

benefit cuts proposed, in particular where those cuts will vary across States. *See* Proposed Plan at 11, 22, 72, and 74.

Based on the limited information included in the Proposed Plan, it appears to the State Insurance Regulators that the Proposed Plan may be inequitable and inconsistent with the *Neblett* standard. The Proposed Plan seeks to impose greater burdens on policyholders in some States and lesser burdens on policyholders in other States. The Proposed Plan makes clear that the Rehabilitator is of the view that differences in historical rates across the States warrants imposing different burdens on policyholders in the different States. *See* Proposed Plan at 77, 81, 86. Such differing burdens do not appear fair or equitable. Policyholders are not responsible for any differences in rates they may have paid in the past. They have paid the rates that are provided in their contracts and approved by the insurance regulators in their States, and they are entitled to the benefits provided by their contracts. To differentiate among the policyholders in the Proposed Plan penalizes those in some States and benefits those in others without justification.

These differences may also be inconsistent with the Pennsylvania liquidation statutes and violate the *Neblett* standard. The Pennsylvania liquidation priority statute – like those in other States – requires uniform treatment of all claims within a priority class. In a liquidation, policyholders in all States would file claims in the

domiciliary liquidation proceeding. *See* 40 P.S. § 221.37.² Policyholders – whose policy-related claims fall in priority class (b) – would receive equivalent percentage distributions on their allowed claims in that proceeding. *See* 40 P.S. § 221.44 (“No subclasses shall be established within any class.”). Under the Proposed Plan, however, it appears that some policyholders in some States would receive more (suffering small benefit cuts) while those in others would get less (suffering greater benefit cuts). This would appear to violate the equal treatment mandate of the priority statute. It also means that some policyholders will receive less under the Proposed Plan than they would receive in a liquidation, which violates the “no worse than in liquidation” requirement of *Neblett*. While it is possible that the involvement of guaranty associations may bear on this issue, the Proposed Plan does not provide sufficient information to assess their involvement, and many SHIP policies provide coverage with a material likelihood of exceeding guaranty association limits. *See* Proposed Plan at 12, 45-46.

Finally, the Proposed Plan may not be in the best interests of policyholders because it may require such large increases in premiums that policyholders will be

² The statutory scheme in Pennsylvania and all other States centralizes claims in the domiciliary liquidation. It is possible that there might be ancillary receiverships in certain States, in particular States that hold special deposits. If so, policyholders in those States could also file claims in the ancillary receiverships. *See, e.g.*, 40 P.S. § 221.58. However, the SHIP special deposits total only \$19.3 million, Proposed Plan at 84, and do not appear material. The domiciliary liquidator would hold essentially all SHIP assets, so policyholders would have every incentive to file claims in the domiciliary proceeding.

compelled to drop the coverage for which they have paid for years, as the time when they most need it approaches.

The necessary showing that the Proposed Plan is equitable, legal, and feasible requires disclosure of the financial analysis upon which the Proposed Plan rests. The Rehabilitator's Application for Approval of the Proposed Plan and the Proposed Plan do not contain any information that would allow the Court, the State Insurance Regulators, or anyone else to assess the actual effects or feasibility of the Proposed Plan. It is important to know types, percentages and amounts of benefits the Rehabilitator expects to cut, the percentages and amounts of premiums that the Rehabilitator expects to increase, whether the policyholders of different types or in different States will bear different burdens or be treated differently, and how the effects on policyholders compare with what would happen in a liquidation. The Court should order the Rehabilitator to provide the analysis and information that would permit the State Insurance Regulators and the Court to assess the impacts and feasibility of the Proposed Plan.

There is precedent for requiring such disclosure. *See Foster v. Mutual Fire, Marine and Inland Ins. Co.*, 531 Pa. 598, 614 A.2d 1086, 1089-90 (1992). In *Mutual Fire*, the rehabilitator submitted a proposed plan of rehabilitation to the court. As described by the Supreme Court:

The Policyholders Committee and numerous other parties strenuously objected to the proposed plan on the grounds, *inter alia*, that the

Rehabilitator had released no financial information or documentation to substantiate the projections of 100% payment to policyholders contained therein. Hence, the court ordered the Rehabilitator to allow the Policyholders Committee and all interested persons access to Mutual Fire's books and records.

Id. (emphasis added). So here, the Court should direct the Rehabilitator to make available to the State Insurance Regulators the analysis and information upon which the Rehabilitator relies in advocating the Proposed Plan.

B. Request For Disclosure Of Information.

In order to assess the fairness, feasibility and legality of the Proposed Plan, the State Insurance Regulators request that the Court direct the Rehabilitator to produce:

1. The “extended analysis by industry experts” on which the structure of the Proposed Plan is based (*see* Proposed Plan at 11);
2. All analyses or reports prepared by or for the Rehabilitator or SHIP, including reports by consultants such as Milliman, concerning the benefit reductions underlying or contemplated by the Proposed Plan, including all reports concerning the magnitude of the reductions and their application or effects in different States;
3. All analyses or reports prepared by or for the Rehabilitator or SHIP, including reports by consultants such as Milliman, concerning the premium increases underlying or contemplated by the Proposed Plan,

including all reports concerning the magnitude of the increases and their application or effects in different States;

4. All analyses or reports prepared by or for the Rehabilitator or SHIP, including reports by consultants such as Milliman, concerning insurance guaranty association coverage of SHIP policies, including all reports concerning SHIP's liabilities in excess of liabilities covered by insurance guaranty associations;
5. All analyses or reports prepared by or for the Rehabilitator or SHIP, including reports by consultants such as Milliman, comparing the effects of the Proposed Plan with the effects of a liquidation of SHIP;
6. All analyses or reports prepared by or for the Rehabilitator or SHIP, including reports by consultants such as Milliman, concerning the "prospect of success" of the Proposed Plan (*see* Proposed Plan at 11); and
7. All other analyses or reports on which the Rehabilitator relies to support the Proposed Plan.

C. Policyholders On Waiver-of-Premium Status Should Not Be Deprived Of That Benefit.

The State Insurance Regulators need to receive the analysis and information underlying the Proposed Plan in order to offer comments on particular policy benefit downgrades and premium increases. However, the Proposed Plan's

treatment of policyholders on waiver-of-premium status is inequitable and warrants comment now. SHIP policies provided for waiver of premium in certain circumstances. *See* Proposed Plan at 19. The waiver-of-premium benefit is one of the basic protections provided by long-term care insurance. Typically, once a patient has been in a long-term care facility for the waiting period specified in the policy, the patient stops paying the insurer and the insurer begins reimbursing the patient – without diminishing the policy benefit by deducting further premiums. Numerous SHIP policyholders residing in Maine, Massachusetts and Washington are presently entitled to “on-claim waiver” of premium, meaning they are not paying premium because they are currently receiving long-term care, or to “active waiver” of premium, either because the policyholder’s spouse is currently on claim or because the policyholder’s spouse has already died and the terms of the policy entitle the surviving spouse to a lifetime waiver of premium. *See* Joint Application to Intervene of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance ¶¶ 9, 14 (July 31, 2020); Joinder of the Washington Insurance Commissioner in the Joint Application ¶ 9 (September 15, 2020).

The Proposed Plan would take this benefit away from policyholders who are already receiving it, turning their premium waiver into a premium discount. Under the Proposed Plan, a premium waiver will continue in effect only as to the current (pre-Plan) premium. Proposed Plan at 20. If the policyholders want to maintain

their benefits as provided in their policy (Option Four) or even at reduced levels (Option Two) (*see* descriptions, Proposed Plan at 7), they will be required to start paying a differential premium – which could be substantial – while on waiver. *Id.* at 20-21. This requirement applies even to policyholders on so-called “lifetime” waiver of premium. *Id.* at 21. Otherwise, on-waiver policyholders will automatically have their benefits downgraded. *See id.* at 38, 43 (describing Option One); *id.* at 34, 53 (identifying Downgrade as the default option for both active waiver and on-claim waiver policyholders). The State Insurance Regulators view this treatment of policyholders who are already in the difficult circumstances necessary for waiver as unfair and inappropriate.

**II. THE PROPOSED PLAN IMPROPERLY SEEKS TO
OVERRIDE INDIVIDUAL STATES’ REGULATORY
AUTHORITY OVER PREMIUM RATES TO BE
CHARGED TO THEIR RESIDENTS.**

The Proposed Plan expressly sets out to override the insurance laws of other States that vest regulatory authority over the rates for policyholders resident in a State in the insurance regulatory official of that State. *See* Proposed Plan at 22 (“Premium increases and Policy Modifications will not be submitted to individual insurance departments for approval.”); *id.* at 80-81. This exceeds the authority granted to the Rehabilitator by the Pennsylvania statutes, violates the insurance statutes of the various States, is unconstitutional, and is inconsistent with the comity to be accorded other States.

A. Regulation of Premium Rates Is A Matter Committed To The Individual States.

Rate regulation is a matter for the individual States. “A state may constitutionally regulate or require approval of rates and charges of insurance companies doing business within its borders.” S. Plitt, D. Maldonado, J. Rogers, 1 *Couch on Insurance 3d* § 2:31 at 2-129 (2019). See *German Alliance Ins. Co. v. Lewis*, 233 U.S. 389 (1914); *Insurance Dept. v. City of Philadelphia*, 196 Pa. Super. 221, 173 A.2d 811, 813 (1961) (“It has long been settled that the insurance business is charged with a public interest, and that its regulation is constitutional.”). “The intended purpose of the regulation of rates is to promote the general welfare by preventing rates which are excessive, inadequate or unfairly discriminatory.” *Couch on Insurance 3d* § 2:31 at 2-134. “[B]y June 30, 1948, all of the states had passed rate regulating legislation.” *City of Philadelphia*, 173 A.2d at 813. The state statutes generally commit review and approval of rates to the insurance regulator, subject to judicial review under the state statutes. See *Couch on Insurance 3d* § 2:34.

As pertinent here, rates for long-term care insurance are regulated by the individual States under statutes that provide for review by the insurance regulator of the policyholder’s State of residence and judicial review in the courts of that State. The Rehabilitator’s proposal to increase rates – potentially by an order of

magnitude – without seeking approval from the insurance regulators of the States in which the affected policyholders live violates these statutes. For example:

- The Maine statutes provide that “[e]very insurer shall file for approval by the superintendent every rate, rating formula, classification of risks and every modification” of long-term care rates for use in Maine so that the Maine Superintendent of Insurance can determine that the filing complies with “requirements that rates not be excessive, inadequate or unfairly discriminatory.” 24-A Me. Rev. Stat. § 2736. *See also* 02-031 Code Me. Rules, ch. 420, § (6)(A)(9) (“The filing must include sufficient supporting information to demonstrate [to the Superintendent] that the rates are not excessive, inadequate, or unfairly discriminatory.”).
- The Massachusetts statutes provide that long-term care insurance rates must be submitted for review by the Massachusetts Commissioner of Insurance, and increases may not be implemented unless the Commissioner determines that they comply with applicable legal standards. *See* Mass. Gen. Laws ch. 175, § 108, 211 Code Mass. Reg. 42.00 and 211 Code Mass. Reg. 65. A long-term care insurance policy may be disapproved by the Commissioner “if the benefits provided therein are unreasonable in relation to the premium charged, or if it contains any provision which is unjust, unfair, inequitable, misleading or deceptive, or which encourages misrepresentation as to such

policy.” Mass. Gen. Laws ch. 175, § 108(8)A. *See Genworth Life Ins. Co. v. Comm’r of Ins.*, 95 Mass. App. Ct. 392, 126 N.E.3d 1019, 1023 (2019) (affirming the disapproval of requested long-term care insurance rate increases).

- The Washington statutes require that all long-term care insurance rates and rate increase requests must be filed with and approved by the Washington Insurance Commissioner prior to use. Wash. Rev. Code § 48.19.010(2). The Commissioner’s review includes an actuarial analysis, and increases may not be implemented unless the Commissioner determines that they comply with applicable legal standards. *See* Wash. Rev. Code §§ 48.83, 48.84; Wash. Admin. Code 284-54 & 284-60; Wash. Rev. Code § 48.18.110; Wash. Rev. Code § 48.18.480; Wash. Admin. Code §§ 284-83, 284-84. Long-term care insurance rate increases are not permitted if “the benefits provided therein are unreasonable in relation to the premium charged.” Wash. Rev. Code § 48.18.110; *see* Wash. Admin. Code § 284-54-600. In addition, rate increases will be denied if the Commissioner finds the rates constitute “unfair discrimination between insureds or subjects of insurance having substantially like insuring, risk, and exposure factors, and expense elements, in the terms or conditions of any insurance contract, or in the rate or amount of premium charged therefor, or in the benefits payable

or in any other rights or privileges accruing thereunder.” Wash. Rev. Code § 48.18.480.³

The States provide for judicial review of rate decisions by state insurance regulators, and the courts of each State review the decisions of its regulator in accordance with applicable statutory and constitutional standards. *See, e.g., Anthem Health Plan of Maine, Inc. v. Superintendent of Ins.*, 40 A.3d 380 (Me. 2012); *Automobile Insurers Bureau of Massachusetts v. Comm’r of Ins.*, 420 Mass. 599, 650 N.E.2d 1234 (1995); *Genworth, supra*.

B. The Proposed Plan May Not Properly Displace The Regulatory Authority Of The States Over Rates.

The Proposed Plan seeks to disregard the long-standing state-based system for regulation and approval of insurance rates and instead impose rates set by the Rehabilitator and the Rehabilitation Court. *See* Proposed Plan at 22. Such

³ Forty-three States (including Maine, Massachusetts, Pennsylvania and Washington) and the District of Columbia and Puerto Rico have entered the Interstate Insurance Product Regulation Compact (“IIPRC”) by enacting statutes. *E.g.*, 24-A Me. Rev. Stat. ch. 28; Mass. G.L. ch. 175K; 40 P.S. ch. 41; Wash. Rev. Code ch. 48.130. One of the powers of the Commission created by the IIPRC is to review rate filings for disability income and long-term care insurance and approve rate filings that satisfy the applicable uniform standard. It has prepared uniform standards for long-term care insurance, https://www.insurancecompact.org/documents/standards_ltc_i_3_core.pdf, which have been adopted by nearly all members. *See* https://www.insurancecompact.org/documents/ltc_state_participation.pdf. In general, the rate filing standards provide that the IIPRC will review rate filings for individual long-term care insurance policies. Standards at pp. 2-3. A rate schedule increase that does not exceed 15% is subject to the review and approval or disapproval of the Commission. *Id.* at p. 11. A rate increase that exceeds 15% is subject to the review and approval of each Compacting State. *Id.* at pp. 11-12.

displacement of regulation by other States concerning rates in those States is beyond the authority of the Rehabilitator or the Court. The Pennsylvania insurer rehabilitation statute – like those in other States – does not provide for displacement of regulatory authority over an insurer in rehabilitation. It provides for the Rehabilitator to take over control of the insurer, which continues to operate subject to the laws that apply to insurers.

“The best indication of the legislature’s intent is the plain language of the statute.” *City of Erie v. Pennsylvania Labor Relations Bd.*, 612 Pa. 661, 32 A.3d 625, 634 (2011). *See* 1 Pa.C.S.A. § 1921(b). “Every statute shall be construed, if possible, to give effect to all its provisions.” 1 Pa.C.S.A. § 1921(a). Further, a statute should not be construed to produce an absurd result, as the legislature “does not intend a result that is absurd, impossible of execution or unreasonable.” *Mercury Trucking, Inc. v. Pennsylvania Public Utility Com’n*, 618 Pa. 175, 55 A.3d 1056, 1068 (2012). *See* 1 Pa.C.S.A. § 1922(1). The Pennsylvania insurer rehabilitation statute does not provide authority to displace rate regulation in other States, even if such authority could be constitutional (*see* Part II.C below).

An order to rehabilitate the business of an insurer “shall appoint the commissioner . . . rehabilitator and shall direct the rehabilitator to take possession of the assets of the insurer and to administer them under the orders of the court.” 40 P.S. § 221.15(c). Subject to court approval, a rehabilitator “may take such

action as he deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate the insurer.” 40 P.S. § 221.16(b). This provision establishes the rehabilitator’s authority over the insurer, not outsiders, and much less state regulators. This is apparent from the sentences that follow, which specify that the rehabilitator “shall have all the powers of the directors, officers and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator. He shall have full power to direct and manage, to hire and discharge employees subject to any contract rights they may have, and to deal with the property and business of the insurer.” *Id.* (emphasis added). A rehabilitator may also prepare a plan for the reorganization, consolidation, conversion, reinsurance, merger or other transformation of the insurer. *Id.* § 221.16(d).

This statute does not displace otherwise applicable regulatory authority over the business of the insurer in rehabilitation. Indeed, the Pennsylvania Act avoids any ambiguity on this point by specifying that it must not be interpreted to limit the Pennsylvania Commissioner’s authority under other law. It provides: “This article shall not be interpreted to limit the powers granted to the commissioner by other provisions of the law.” 40 P.S. § 221.1(a). Where the Act expressly does not limit the Pennsylvania Commissioner’s other statutory authority, it cannot be interpreted to somehow limit the authority of other state regulators under their own States’

laws. That would be an absurd result. Further, the Act generally notes that it is private powers (*i.e.*, the powers previously vested in the insurer’s officers and directors) that are displaced by specifying that the “[t]he purpose of this article is the protection of the interests of insureds, creditors, and the public generally, with minimum interference with the normal prerogatives of the owners and managers of the insurers” *Id.* § 221.1(c) (emphasis added). Nothing in the statute allows a rehabilitation plan to avoid state regulation.⁴ An insurer in rehabilitation is subject to rate regulation like any other insurer. *See* National Association of Insurance Commissioners, *Receiver’s Handbook for Insurance Company Insolvencies* at 12 (2019) (receiver should consider “Rate increases needed on business and insurer’s ability to secure those increases from regulatory authorities”) (emphasis added).

The commonly accepted practice for insurers in rehabilitation that wish to increase rates is to continue to file requests for rate increases with the insurance regulator in the affected states. Indeed, even in liquidations, when an insurance guaranty association takes over ongoing policies and seeks to increase rates, the guaranty associations may be required to make rate filings with the regulators of

⁴ The statute expressly contemplates that a rehabilitator continues to be subject to courts in other jurisdictions. *See* 40 P.S. § 221.17(a) (“The rehabilitator shall immediately consider all litigation pending outside this Commonwealth and shall petition the courts having jurisdiction over that litigation for stays whenever necessary to protect the estate of the insurer.”); 40 P.S. § 221.5(b) (“The receiver may apply to any court outside of the Commonwealth for the relief described in subsection (a) or suspension of any insurance licenses issued by the commissioner.”)

the various states as required by their States' laws. *See, e.g.*, 24-A Me. Rev. Stat. §§ 4608(3-A)(B)(4) & (5), 4608(11)(J-1) (requiring approval of guaranty association rates by the Superintendent). While some guaranty associations may have the ability to set premium rates for policies that they issue without approval of a state insurance regulator, *e.g.*, Mass. Gen. Laws §§ 146B(8)(C)(3)(b), 146B(8)(C); Wash. Rev. Code § 48.32A.075(2)(b)(v), that represents an express choice by the applicable State legislature to exempt the guaranty association. Such exemptions provide no support for allowing a rehabilitator to set rates. They show that when the legislature intends to allow an entity to set rates without regulatory approval, it will explicitly say so.

The State Insurance Regulators are not aware of any plan of rehabilitation, either in Pennsylvania or in any other jurisdiction, that has purported to displace state rate regulation and set rates payable by policyholders in other States without review and approval by the insurance regulators of those States as required by their statutes. The Proposed Plan acknowledges that “there have not been many troubled companies for which the issue of rate increases in rehabilitation has arisen.” Proposed Plan at 81. This is because insurers in rehabilitation routinely continue to make rate filings, as do guaranty associations in liquidations. Thus, it is an understatement to say, as the Rehabilitator does, that “the matter is without an abundance of clear specific legal precedent.” *Id.* The State Insurance Regulators

are not aware of any precedent supporting the Rehabilitator's attempt to displace state regulation and set nationwide rates for an insurer in rehabilitation through a rehabilitation plan, most likely because no rehabilitator has so deliberately sought to disregard state law.

C. The Pennsylvania Rehabilitator's Proposal To Set Rates In Other States In Disregard Of Those States' Statutes Violates The Constitution.

The Proposed Plan's disregard of the statutes of other States governing the rates charged to their residents violates the mandate of the Full Faith and Credit Clause of the United States Constitution. "Full Faith and Credit shall be given in each State to the public Acts, Records, and judicial Proceedings of every other State." U.S. Const., Art. IV, § 1. The purpose of the full faith and credit command "was to alter the status of the several states as independent foreign sovereignties, each free to ignore obligations created under the laws or by the judicial proceedings of the others." *Baker v. General Motors Corp.*, 522 U.S. 222, 232 (1998) (quoting *Milwaukee County v. M.E. White Co.*, 296 U.S. 268, 277 (1935)). "A statute is a 'public Act' within the meaning of the Full Faith and Credit Clause." *Franchise Tax Bd. Of Cal. v. Hyatt*, 136 S.Ct. 1277, 1281 (2016).

The Rehabilitator's view that Pennsylvania law authorizes control over rates in other States is erroneous as set forth in Part II.B above, but even if it were

correct it would violate the Constitution.⁵ Insurance rates are a matter of particularly local concern and regulation. *See* Part II.A above. One State cannot dictate to another State what rates are to be applied to that State’s own residents. It has long been established that an insurer domiciled in one State writing insurance in another is subject to the second State’s laws concerning that business. *American Fire Ins. Co. v. King Lumber & Mfg. Co.*, 250 U.S. 2, 10 (1919) (Pennsylvania insurer writing insurance in Florida had to do so “in accordance with the laws of Florida”). *See Pink v. A.A.A. Highway Exp., Inc.*, 314 U.S. 201, 209 (1941) (“Every state has the authority under the Constitution to establish laws through both its judicial and its legislative arms, which are controlling upon its inhabitants and domestic affairs.”); *Clark v. Williard*, 294 U.S. 211, 213 (1935) (“Every State has jurisdiction to determine for itself the liability of property within its territorial limits to seizure and sale under the processes of its own courts.”).⁶ This principle applies to state review and approval of rates. Pennsylvania cannot unilaterally

⁵ That the Rehabilitator’s unexplained interpretation of the rehabilitation statute would work an unconstitutional intrusion into the affairs of other States is an additional reason not to adopt that construction. *See Bricklayers of Western Pa. Combined Funds, Inc. v. Scott’s Dev. Co.*, 625 Pa. 26, 90 A.3d 682, 692 (2014) (“[C]ourts give statutes a constitutional interpretation if that is reasonably possible.”).

⁶ The relations between the States concerning assets and claims in insurer liquidations have since been addressed through the adoption by the States of model acts promulgated by the National Association of Insurance Commissioners. *See* III National Association of Insurance Commissioners, *Model Laws, Regulations, and Guidelines* at ST-555-3 (2019) (Chart of States adopting model acts). Such statutes allocate responsibilities for assets and claims through common statutory provisions for domiciliary and ancillary receiverships. *See, e.g.*, 40 P.S. §§ 221.53-221.62. They say nothing about rates, which continue to be governed by other law.

substitute its own laws for the laws governing relations between a corporation doing business in another State and the residents of that State. *See Phillips Petroleum Co. v. Shutts*, 472 U.S. 797, 822 (1985) (law of Kansas, the forum State in a nationwide class action, does not govern rights of residents in other States: Kansas “may not abrogate the rights of parties beyond its borders having no relation to anything done or to be done within them.”) (quoting *Home Ins. Co. v. Dick*, 281 U.S. 397, 342 (1930)).

The Rehabilitator cannot use the Full Faith and Credit Clause to “require a State to substitute for its own statute, applicable to persons and events within it, the statute of another State reflecting a conflicting and opposed policy.” *Hyatt*, 136 S.Ct. at 1281 (quoting *Carroll v. Lanza*, 349 U.S. 408, 412 (1955)). *See Ferrelli v. Com.*, 783 A.2d 891, 894 (Pa. Commw. Ct. 2001) (Full Faith and Credit Clause “does not require a state to subordinate public policy within its borders to the laws of another state”). This is particularly the case where the Proposed Plan reflects hostility to the rates and regulatory actions of the other States. *See Proposed Plan* at 11, 22, 73, 81, 86. *Cf. Hyatt*, 136 S.Ct. at 1281. To the extent that the Proposed Plan attempts to supersede other States’ regulation of rates charged their residents, it is unconstitutional.

D. The Court Should Accord Comity To The Laws Of The Other States And Decline To Approve The Proposed Plan's Attempt To Disregard Those Laws.

The Proposed Plan's displacement of the rate setting authority of the individual States, if adopted, would be a blatant interference and intrusion by Pennsylvania on the sovereignty of its sister States. Even if it were permitted by the Pennsylvania rehabilitation statute, which it is not, or were constitutional, which it is not, the Court should refrain from adopting the Proposed Plan on this point out of comity. "'Comity' is the principle that courts of one state or jurisdiction will give effect to laws and judicial decisions of another state out of deference and mutual respect, rather than out of duty." *Smith v. Firemens Ins. Co. of Newark, New Jersey*, 404 Pa. Super. 93, 590 A.2d 24, 27 (1991).

The Proposed Plan is unprecedented and ignores the long-standing authority of each State to approve or set rates in that State. When a Maine, Massachusetts, or Washington insurer does business in Pennsylvania, Pennsylvania residents are protected by having the fairness and reasonableness of the rates they pay determined under Pennsylvania law by the Pennsylvania Commissioner, subject to review by Pennsylvania's courts. The residents of Maine, Massachusetts, Washington, and other States are entitled to the same protection when they buy coverage from a Pennsylvania insurer.

Each State has enacted statutes providing for review by its insurance regulator of the premium rates charged its residents, in accordance with the State's own statutory procedures and standards. The Proposed Plan seeks to displace those statutes and usurp the regulatory authority of the other States. The Court should decline to do so out of respect for the laws of the other States.

III. THE PLAN SHOULD BE MODIFIED TO PROVIDE THAT PAYMENTS ON ASSUMED REINSURANCE CONTRACTS CEASE.

The Proposed Plan identifies contracts with six insurance companies under which SHIP assumed LTC policies through co-insurance or reinsurance. Proposed Plan at 81-83. The policies subject to these reinsurance agreements have apparently been treated as if they had been issued by SHIP, and the Rehabilitator has proposed to continue that treatment under the Proposed Plan. *Id.* at 83. The Rehabilitator has informed state insurance regulators that the Rehabilitator will modify the Proposed Plan so that assumed reinsurance obligations will not be paid.

At this time, the Rehabilitator has not yet filed this necessary modification with the Court. It was not proper to propose that policies reinsured by SHIP should be treated as if they were issued by SHIP. Reinsurance obligations do not fall within the policy-related priority class (b); instead, they are other contractual obligations within priority class (e) for general creditors. *See* 40 P.S. § 221.44. Since SHIP is insolvent, its continued payment of these obligations is inconsistent

with the priority statute. That statute requires that all obligations in higher priority classes be paid in full (or reserved for in full) before a lower priority claim may be paid anything. *Id.* It is evident that SHIP is not able to pay all of its policy obligations. The Proposed Plan should accordingly provide that SHIP will stop paying the lower priority reinsurance obligations so that the assets may be used to pay policyholders. The reinsured policies remain the obligation of their issuing insurers, and the policy benefits should not be diminished on account of SHIP's insolvency.

Conclusion

For all of the above reasons, the Maine Superintendent of Insurance, the Massachusetts Commissioner of Insurance, and the Washington Insurance Commissioner request that the Court:

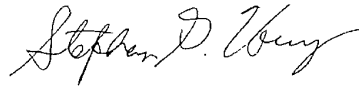
1. Direct the Rehabilitator to provide the analyses and information requested in Part I.B above to the State Insurance Regulators so they may
 - (a) review the material to assess the impacts of the Proposed Plan and whether it comports with the applicable legal standards, (b) seek discovery on these issues as needed and permitted by the Court, and
 - (c) make further submissions to the Court concerning the Proposed Plan;

2. Direct that the Proposed Plan be modified to protect policyholders on waiver-of-premium status from having to pay premium or being forced to accept benefit modifications;
3. Direct that the Proposed Plan be modified to provide that the Rehabilitator must seek approval of rate changes in each State from the insurance regulator of the State in accordance with the States' laws; and
4. Direct that the Proposed Plan be modified to provide that SHIP shall cease paying assumed reinsurance obligations in light of its financial condition and their lower priority.

September 15, 2020

Respectfully submitted,

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and Massachusetts Special Assistant Attorneys General and
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PROOF OF SERVICE

I, Stephen G. Harvey, hereby certify that on September 15, 2020, I served the foregoing FORMAL COMMENTS OF THE MAINE SUPERINTENDENT OF INSURANCE, THE MASSACHUSETTS COMMISSIONER OF INSURANCE, AND THE WASHINGTON INSURANCE COMMISSIONER via PACFile system as well as via email upon the following:

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Dated: September 15, 2020

STATE OF SOUTH CAROLINA
RICHLAND COUNTY

IN THE COURT OF COMMON PLEAS
FOR THE FIFTH JUDICIAL CIRCUIT
2020-CP-4005802

Raymond G. Farmer, as Director of the South
Carolina Department of Insurance, and the South
Carolina Department of Insurance,

Plaintiffs,

vs.

Jessica K. Altman, as Rehabilitator of Senior
Health Insurance Company of Pennsylvania,
Patrick H. Cantilo, as Special Deputy
Rehabilitator of Senior Health Insurance
Company of Pennsylvania, and Senior Health
Insurance Company of Pennsylvania in
Rehabilitation,

Defendants.

**DEFENDANTS' MOTION TO
SUPPLEMENT AND
SUPPLEMENTAL
MEMORANDUM OF LAW**

Defendants Jessica K. Altman, as Rehabilitator (the “Rehabilitator”) of Senior Health Insurance Company of Pennsylvania (“SHIP”), Patrick H. Cantilo, as Special Deputy Rehabilitator (the “Special Deputy Rehabilitator”) of SHIP, and SHIP (collectively “Defendants”) move for leave to supplement their Motion to Dismiss and thereby advise the Court on the status of the rehabilitation proceedings in the Commonwealth Court of Pennsylvania.

On August 25, 2021, the Honorable Judge Mary Hannah Leavitt of the Commonwealth Court of Pennsylvania approved the Second Amended Plan of Rehabilitation its entirety but for one section related to agent commissions. (A copy of the August 25, 2021, Memorandum Opinion and Order approving the Second Amended Plan of Rehabilitation is attached hereto as Exhibit L; a copy of the Second Amended Plan was attached to Defendants’ Motion as Exhibit B.) Among other findings, Judge Leavitt approved of the rate setting mechanism in the Second Amended Plan and the issue-rate

rate approval option by which Plaintiffs can opt-out of the Plan. On September 13, 2021, Judge Leavitt approved a settlement agreement resolving the agent commissions issue and directed the Rehabilitator to file her final plan for implementation, which the Rehabilitator will do promptly. (A copy of the September 13, 2021, Memorandum Opinion and Order approving the settlement agreement is attached hereto as Exhibit M.)

WHEREFORE, Defendants respectfully pray, based on the foregoing and the previously filed Memorandum of Law in Support of Defendants' Motion and accompanying exhibits, that the Court accept this supplement, grant Defendants' Motion to Dismiss the Complaint, and dismiss Plaintiffs' claims with prejudice.

Respectfully submitted,

September 14, 2021

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Pennsylvania, Patrick H. Cantilo, as Special
Deputy Rehabilitator of Senior Health Insurance
Company of Pennsylvania, and Senior Health
Insurance Company of Pennsylvania*

STATE OF SOUTH CAROLINA
RICHLAND COUNTY

IN THE COURT OF COMMON PLEAS
FOR THE FIFTH JUDICIAL CIRCUIT
2020-CP-4005802

Raymond G. Farmer, as Director of the South
Carolina Department of Insurance, and the
South Carolina Department of Insurance,

Plaintiffs,

vs.

Jessica K. Altman, as Rehabilitator of Senior
Health Insurance Company of Pennsylvania,
Patrick H. Cantilo, as Special Deputy
Rehabilitator of Senior Health Insurance
Company of Pennsylvania, and Senior Health
Insurance Company of Pennsylvania in
Rehabilitation,

Defendants.

CERTIFICATE OF SERVICE

I hereby certify that on September 14, 2021, I served the foregoing DEFENDANTS'
MOTION TO SUPPLEMENT AND SUPPLEMENTAL MEMORANDUM OF LAW via
electronic mail and U.S. Mail:

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COZEN O'CONNOR

September 14, 2021
Charlotte, North Carolina

By: s/ Tracy L. Eggleston
Tracy L. Eggleston

EXHIBIT L

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

IN RE: Senior Health Insurance :
Company of Pennsylvania :
In Rehabilitation : No. 1 SHP 2020

RE: Application for Approval of the Plan of Rehabilitation for Senior Health
Insurance Company of Pennsylvania

BEFORE: HONORABLE MARY HANNAH LEAVITT, Judge

OPINION NOT REPORTED

FILED: August 24, 2021

MEMORANDUM OPINION AND ORDER

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I. Introduction

Before the Court is the application of Jessica K. Altman, Pennsylvania Insurance Commissioner, which she filed in her capacity as Statutory Rehabilitator of Senior Health Insurance Company of Pennsylvania (SHIP). By this application, the Rehabilitator seeks approval of her Second Amended Plan of Rehabilitation (Second Amended Plan or Plan) for SHIP pursuant to Section 516(d) of Article V of The Insurance Department Act of 1921 (Article V), Act of May 17, 1921, P.L. 789, *added by* the Act of December 14, 1977, P.L. 280, 40 P.S. §221.16(d). The Rehabilitator has the statutory responsibility to develop a plan to correct the conditions that caused SHIP's hazardous financial condition. Giving deference to the Rehabilitator's discretion in formulating this Plan, this Court must decide whether to approve the Plan, approve the Plan with modifications, or disapprove the Plan.

At present, SHIP has approximately \$1.4 billion in assets and \$2.6 billion in liabilities, producing a deficit of approximately \$1.2 billion (also referred to as the Funding Gap). The Second Amended Plan's ultimate goal is to eliminate the Funding Gap by increasing premium revenue and modifying the existing terms of most of the approximately 39,000 policies in force. The Plan is structured to maximize policyholder choice in several ways. Depending on his circumstances and preferences, a policyholder may choose to continue his policy with all benefits and terms unchanged by paying the actuarially justified annual premium for that policy. Alternatively, the policyholder may choose to reduce some policy coverages as more suitable to the policyholder's current circumstances in order to avoid or temper a premium increase. A policyholder who is 95, for example, may decide to reduce the

maximum coverage period from 10 to 5 years in lieu of paying the premium required for a policy with a 10-year period of coverage.

The Second Amended Plan also seeks to correct SHIP's discriminatory premium rate structure. At present, SHIP policyholders pay substantially different premiums for the same coverages. The difference in premiums is attributed to the decisions of different state regulators on SHIP's proposed rate increases. The state where the policy is issued retains authority for all rate increases, even after the policyholder moves to another state. Policyholders whose state of issue has approved the requested rate increase pay more for the same coverages than policyholders whose state of issue has disapproved the requested rate increase. As a result, the former group of policyholders pays more than its fair share of the costs of providing the coverages and the latter group pays less than its fair share. The Second Amended Plan seeks to eliminate these inequities.

The Court conducted a hearing on the Second Amended Plan from May 17, 2021, through May 21, 2021. The parties submitted post-hearing briefs on June 21, 2021, and June 28, 2021. On July 21, 2021, the Rehabilitator and Intervening Agents and Brokers filed an application for the Court's approval of a settlement agreement, which will amend Part VI.N of the Plan. The Rehabilitator's application for approval of the Second Amended Plan is ready for disposition, with the exception of Part VI.N, on which a decision will be deferred for 30 days to allow a hearing on the Rehabilitator's settlement agreement with the Intervening Agents and Brokers.

II. Findings of Fact

A. Business and History of SHIP

SHIP is a Pennsylvania life and health insurance company. Its origins date to 1887, when its corporate predecessor, the Home Beneficial Society,

commenced business. By the 1980s, the company was known as American Travelers Insurance Company and was primarily writing long-term care insurance. In 1996, the company was acquired by, and merged into, CIHC, Inc., a wholly-owned subsidiary of Consecro, Inc., and renamed Consecro Senior Health Insurance Company. In 2002, Consecro, Inc. filed a petition for reorganization under Chapter 11 of the United States Bankruptcy Code.¹ In 2003, Consecro, Inc. emerged from bankruptcy as CNO Financial Group. In 2003, Consecro Senior Health Insurance Company ceased writing long-term care insurance and limited its operations to the administration and servicing of existing policies. In October 2008, Consecro Senior Health Insurance Company changed its name to Senior Health Insurance Company of Pennsylvania (SHIP), and its ownership was transferred from CNO Financial Group to the newly-formed nonprofit Senior Health Care Oversight Trust, which has managed the run-off of SHIP's long-term care insurance business since 2008.

SHIP was licensed in 46 states (excluding Connecticut, New York, Rhode Island, and Vermont), the District of Columbia, and the U.S. Virgin Islands. Through its predecessors, SHIP issued approximately 645,000 long-term care policies; as of December 31, 2020, 39,148 policies remained in force. Exhibit (Ex.) RP-33 at 3.² SHIP's policies cover long-term care services provided in congregant settings, such as nursing homes and assisted living facilities, as well as home-based health care services and adult day care. The states with the greatest number of SHIP

¹ 11 U.S.C. §§101-1532.

² As of the date of the hearing on the Plan, SHIP had approximately 45,000 policies in force that are not long-term care policies. These policies are not material to the Second Amended Plan or the proposed rehabilitation of SHIP; they do not consume SHIP resources, either because they are reinsured or because claims under those policies are paid through a trust which is adequately funded.

long-term care policies in force as of December 31, 2020, are Texas with 4,960 policies; Florida with 4,040 policies; Pennsylvania with 3,862 policies; California with 3,183 policies; and Illinois with 1,753 policies. Ex. RP-22 at 2. By contrast, the three states represented by the intervening state regulators in this matter have comparatively fewer policies in force; as of year-end 2020, there were 316 policies in force in Maine, 296 in Massachusetts, and 1,287 in Washington. *Id.*

The average age of a SHIP long-term care policyholder is 86, and the average age of a policyholder on claim is 89. Only 53% of SHIP long-term care policyholders pay premium. This is because the remaining 47% of policyholders either are on premium waiver³ or have previously taken a non-forfeiture option, which allows the policyholder to discontinue paying premiums in exchange for a period of coverage equal to the premiums previously paid to the company less any benefits previously received. Approximately 13% of SHIP's long-term care policyholders are on claim, and the Rehabilitator expects that number to rise to 32% of all policyholders by 2050. Ex. RP-56 at 21. The Rehabilitator also expects the volume of SHIP's claims to continue outpacing its premium collections. Specifically, in the absence of the Rehabilitator's plan, SHIP will pay another \$3 billion in claims but collect only \$230 million in premiums. *Id.* at 20.

B. SHIP's Financial Condition

SHIP has approximately \$1.4 billion in assets and \$2.6 billion in liabilities, *i.e.*, a Funding Gap of \$1.2 billion. Ex. RP-31 at 1-2. The major causes

³ Approximately 99% of SHIP's long-term care policies provide that a policyholder who receives benefits under his policy for a specified period of time (such as 90 days) is no longer required to pay premiums for coverage after that time period as long as the policyholder remains eligible for benefits or receives a specified level of care. "Once the policyholder's eligibility for benefits ends, the policyholder is required to resume paying premiums." Ex. RP-55 at 86 (Second Amended Plan).

of SHIP's insolvency were the use of erroneous actuarial assumptions to develop initial premium rates, poor investment returns, high operating costs, and the inability to obtain the approval of actuarially justified rate increases from state insurance regulators. Two significant adverse events exacerbated SHIP's financial situation. In 2018, following the appointment of a Special Deputy Rehabilitator and a revision of SHIP's key actuarial assumptions, SHIP recorded a \$374 million premium deficiency reserve; a \$44 million increase in claim reserves; and a \$176 million investment loss from the so-called Beechwood investment program. These accounting entries increased SHIP's 2018 deficit by \$500 million. *See* Ex. RP-56 at 23. In 2019, revised actuarial assumptions required an increase in reserves, thereby adding another \$400 million to SHIP's deficit. *Id.* SHIP's annual premium revenue as of December 31, 2020, is \$58 million. *Id.* at 14.

C. Rehabilitation Plan

Given SHIP's negative capital and surplus, the Insurance Department applied to this Court for an order placing SHIP in rehabilitation, with the consent of the Senior Health Care Oversight Trust and SHIP's directors. On January 29, 2020, the Court granted the application and appointed the Pennsylvania Insurance Commissioner to serve as Rehabilitator of SHIP; to take steps to address SHIP's financial challenges; and to protect its policyholders and other creditors.

The Rehabilitator engaged a Special Deputy Rehabilitator, Patrick Cantilo, and actuarial consultants, including Oliver Wyman, to study SHIP's financial condition and to manage the company while they developed corrective measures. On April 22, 2020, the Rehabilitator filed a plan for the rehabilitation of SHIP. The Court issued a case management order which, *inter alia*, solicited formal

and informal comments from any interested person. Several intervened to offer comments on the rehabilitation plan and participate in any proceedings, including:⁴

- 1) The Maine Superintendent of Insurance, the Massachusetts Commissioner of Insurance, and the Washington Insurance Commissioner (Intervening Regulators);
- 2) The National Organization of Life and Health Guaranty Associations (NOLHGA);
- 3) ACSIA Long Term Care, Inc.; Global Commission Funding LLC; LifeCare Health Insurance Plans, Inc.; Senior Commission Funding LLC; Senior Health Care Insurance Services, Ltd., LLP; and United Insurance Group Agency, Inc. (Intervening Agents and Brokers);
- 4) Anthem, Inc.; Health Care Service Corporation; Horizon Health Care Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey; and UnitedHealthcare Insurance Company (Intervening Health Insurers); and
- 5) James Lapinski, a policyholder and agent, and Georgianna Parisi, a policyholder.

After reviewing the formal and informal comments, the Rehabilitator filed an amended rehabilitation plan on October 21, 2020. Following a second comment period and a pre-hearing conference, the Rehabilitator filed the Second Amended Plan on May 3, 2021.

The Second Amended Plan is designed to be implemented in three phases. Phase One, beginning immediately upon Court approval, is the principal phase and seeks to reduce substantially or eliminate the Funding Gap. This phase identifies the SHIP policies that require modification because their current premium

⁴ The original intervening persons also included Transamerica Life Insurance Company and Primerica Life Insurance Company, both of which issued policies reinsured and administered by SHIP. These parties are no longer actively participating in the proceeding.

falls below the “If Knew Premium” for the benefits provided by the policies. Ex. RP-55 at 10. The If Knew Premium rate is the rate that, if charged from inception, would have produced an underwriting loss ratio of 60% for each policy form. *Id.* at 27. If Knew Premium rates are intended to price policies adequately on a lifetime basis, but not to recoup losses due to inadequate pricing in the past. Further, the policyholder’s age and current medical condition are not taken into account when setting the If Knew Premium rate. The If Knew Premium is an accepted methodology for setting premiums for long-term care insurance policies.

Policyholders whose current premium (including the premium they would be paying but for a premium waiver) falls below the If Knew Premium for the policy’s benefits will be required to elect one of four options:

Option 1: continue paying the current premium or maintain the premium waiver if one is in effect, but if the current or waived premium is less than the If Knew Premium, have the policy benefits reduced in accordance with Plan provisions so that the premium for the reduced benefits (including waived premium) is equal on an If Knew Premium basis to the current premium. The benefit reductions will be selected automatically by the Plan.

Option 2: select certain policy endorsements that provide essential benefits (sometimes greater than the benefits provided by Option 1) for an actuarially justified premium. The maximum benefit period is capped at four years, the maximum daily benefit is capped at \$300 and inflation protection is capped at 1.5%.

Option 2A: an enhanced alternative with a five-year benefit period and 2% inflation rider. Options 2 and 2A will not be subject to further rate increases or benefit reductions in Phase Two of the Plan. Options 2 and 2A are designed to provide reasonable coverage at reasonable premium rates.

Option 3: Non-forfeiture Option (NFO) through which the policyholder will receive a Reduced Paid-up (RPU) policy providing limited benefits but for which no future premiums will

be charged. Under the Plan, this option will include more generous benefits than the typical industry non-forfeiture option or reduced paid-up policy, most notably in that it will offer as much as a 30-month benefit period unless the current policy has a shorter benefit period. Moreover, policyholders who select this option will never have to pay additional premiums and this policy will never lapse.

Option 4: retain the current policy benefits and pay the corresponding If Knew Premium (unless equal to or lower than the policyholder's current premium). For many policyholders this may require a substantial increase in premium.

See Ex. RP-55 at 11-12. Policyholders who presently pay a premium at or above the If Knew Premium may elect Option 2 or Option 3 if preferable, given their present circumstances. Otherwise, these policyholders will not have their policies modified in any respect.

Before making an election, each policyholder will receive information detailing the premiums and benefits associated with each option. Special elections will apply to policyholders who are not currently paying premium due to a premium waiver provision in their or their spouses' policies. Most of these policyholders have a current premium (what they would be paying but for the waiver) that is lower than the If Knew Premium. These policyholders will be required to pay a differential premium, which represents the difference between (1) the premium they would be paying but for the premium waiver in effect (the current premium), and (2) the If Knew Premium appropriate for their policy coverages. Ex. RP-55 at 12. Should the premium waiver terminate, these policyholders will then be required to pay the full applicable If Knew Premium. Similar options will be offered to policyholders on claim.

For every policyholder there will be a default option that applies automatically if no election is made. For the policyholder whose current premium falls at or above the If Knew Premium, the default option leaves the policy unchanged. For the policyholder whose current premium falls below the If Knew Premium, the default option will be identified in the election materials. For policyholders on premium waiver, the default option will be Option 1 (the benefit downgrade). Where the nonforfeiture option would provide these policyholders better benefits than the downgrade, Option 3 will be the default option. For policyholders paying premium, Option 2 (basic policy endorsements) will be the default option.

In Phase Two of the Second Amended Plan, the results of Phase One will be evaluated to determine whether additional policy modifications may be necessary for certain policies that are still underpriced. It is expected that modifications in Phase Two will largely be based on achieving a self-sustaining premium for every policy. The goal of Phase Two will be to eliminate any Funding Gap not eliminated in Phase One. In Phase Three, the Rehabilitator will complete the run-off of SHIP's long-term care insurance business remaining in force.

The Second Amended Plan corrects the condition that caused SHIP's insolvency: the underpricing of policies. The Plan will address the Funding Gap by increasing premiums or modifying policy coverages. The Rehabilitator has concluded that a modification of coverages will do more to reduce the Funding Gap than premium increases. Further, many policyholders are paying for more coverage than they are likely to use.

The Rehabilitator designed the Plan around the core principle of policyholder choice. All policyholders will have at least one option for preserving

their current coverage (by paying an increased premium) and at least one option for preserving their current premium (by reducing policy benefits). The Plan's premium rate structure takes rate increase history and product differences into account, and it will develop premium rate increases based solely on the characteristics of each policy and not on the policyholder's state of residence or the state where the policy was issued.

The payment of commissions owed to agents under agreements made prior to the inception of rehabilitation proceedings will be suspended under the Second Amended Plan until policyholders' claims have been paid in full and adequate provision made for reasonably anticipated future claims. Accrual of commissions will also be suspended as of the effective date of the Plan, *i.e.*, the date the policyholder elections become effective. Claims for commissions owed to agents and brokers will be subordinated to policyholder claims. The Plan's treatment of agent and broker commissions reflects the Rehabilitator's belief that most policyholders do not maintain a close relationship with their agent after purchasing their policy. They typically contact SHIP or another trusted professional when they have questions about their policy.

D. Hearing on Second Amended Plan

At the hearing on the Second Amended Plan, the Rehabilitator offered testimony from the following witnesses: Special Deputy Rehabilitator Patrick Cantilo, who was admitted as an expert in insurer insolvency matters, specifically as to long-term care insurers; Marc Lambright, an actuarial consultant to the Rehabilitator, who testified as a fact witness; and Vincent Bodnar, an actuarial consultant to the Rehabilitator, who was admitted as an actuarial expert and as an expert on long-term care insurance, including product development and sales

practices, the rate setting and approval process for insurers, and the liquidation of financially troubled insurers.

i. Rehabilitator's Evidence

a. Patrick Cantilo

Special Deputy Rehabilitator Patrick Cantilo provided the history of the business of SHIP, summarized above, and his involvement in the rehabilitation since 2018.

He first discussed the effects of the COVID-19 pandemic on SHIP's business and financial condition. Cantilo testified that since the beginning of the pandemic in 2020, SHIP has experienced a moderate increase in mortality, *i.e.*, more of its insureds died than would normally be expected, which generated a moderate increase in policy lapses. There was a small increase in morbidity, *i.e.*, the expected incidence of disease. The pandemic adversely affected SHIP's expected yield on invested assets. Cantilo opined that the aggregate effects of the pandemic had a relatively moderate impact on SHIP's financial condition and are not material to the Second Amended Plan.

Cantilo focused his testimony on the approximately 39,000 long-term care policies of SHIP. Approximately 53% of SHIP's current policyholders are paying premium, generating \$58 million in revenue as of year-end 2020. The remaining 47% of policyholders are on claim, have previously selected a non-forfeiture option or are on premium waiver. *See* Ex. RP-56 at 14. Many policyholders have been paying less premium than is necessary to fund their coverages, and this premium deficiency has existed for years. SHIP policies that create the greatest liability have a 5% compounded inflation rider; unlimited lifetime benefits; and are non-tax qualified, meaning that they have lower benefit triggers

and shorter elimination periods. The effect of the inflation rider has been to increase the maximum daily benefit up to \$650, without regard to actual inflation levels or the actual cost of the policyholder's care. Cantilo testified that the inflation rider is a "big contributor" to SHIP's overall deficit. Notes of Testimony (N.T.), 5/17/2021, at 34.

Cantilo testified that the majority of policyholders pay an annual premium of less than \$2,500 per year. N.T., 5/17/2021, at 37-38. *See* Ex. RP-56 at 14. The group is 71% female, and the majority are in their 80s and 90s. Approximately 70% of the policies in force provide comprehensive coverage for both home health care and facility care in either an assisted living facility or nursing home. Inflation protection is a feature of 47% of these policies. The majority of policies, 54%, provide between one and four years of benefits; and 27% provide lifetime benefits. Ex. RP-56 at 17.

Cantilo opined that SHIP's claims, when compared to premiums, do not present "a good picture." N.T., 5/17/2021, at 41. The number of policies in force has declined since SHIP began operating in 2009, and at present, the cost of claims outpace the premium revenue. Of the total premium revenue that SHIP is expected to collect prior to the expiration of the policies in force, approximately \$7.4 billion, it has already collected \$7.1 billion. Stated otherwise, SHIP expects to collect only about \$300 million in additional premium. On the other hand, SHIP's expected claims during that same period total approximately \$11 billion; it has paid only \$7.7 billion so far. In short, SHIP can expect to pay another \$3 billion in claims but to collect only \$300 million in premium, unless its business is restructured in a rehabilitation.

Cantilo testified that SHIP is not atypical in the industry. Long-term care insurers collect more premium than needed in the early years of writing policies. They invest the excess, put it aside, and then tap into those invested assets to pay claims. When a company stops writing new business, as SHIP did 18 years ago, the premium curve begins to flatten and the claim curve begins to rise. Cantilo testified that the assets set aside for the purpose of paying claims did not earn the expected income that was needed to meet liabilities.

Cantilo discussed the reasons for SHIP's insolvency, beginning with the erroneous actuarial assumptions made when the policies were first issued. SHIP underestimated the number of people who would become ill and qualify for benefits. At the same time, SHIP overestimated how quickly people would recover and stop needing care, referred to in the industry as morbidity improvement. SHIP overstated mortality by assuming more people would die before submitting claims than actually did. Relatedly, SHIP overestimated the number of policies that would lapse by reason of death or non-payment of premium. Cantilo estimated that through 2040, when most of the block of business will have terminated, the aggregate effect of the erroneous actuarial assumptions approximately equals the total deficit of \$1.2 billion. *See* Ex. RP-56 at 29.

Another factor in SHIP's insolvency is its investment history. SHIP experienced lower market yields than it anticipated while it was selling and pricing its long-term care policies. To counter the effects of economic conditions, in 2009, SHIP invested in two programs, the Beechwood program and Roebing Re. Instead, these programs produced investment losses between \$150 million and \$300 million (as reported in 2018).

Cantilo testified that a significant cause of SHIP's insolvency is its discriminatory premium rate structure. As SHIP management realized its premium rates were inadequate, it began seeking premium rate increases from state regulators across the country from 2009 to 2021. SHIP received wildly different rate approvals. *See* Ex. RP-56 at 45. Cantilo testified that from 2009 to 2019, SHIP lost \$312 million in cumulative premium due to rejected rate increase filings, or \$371 million using an assumed 3.5% interest rate of return on investments. N.T., 5/17/2021, at 63-64; Ex. RP-56 at 50-51. The different responses of state regulators to SHIP's requested rate increases have created a discriminatory rate structure, which has been the focus of criticism in the regulatory community. Policyholders whose state of issue has approved rate increases are effectively subsidizing policyholders whose state of issue has not approved rate increases. Similarly situated policyholders are paying vastly different premiums for the same coverage. Cantilo opined that this has created an unfortunate side effect: states inclined to approve actuarially justified rate requests become hesitant to do so because of the failure of other states to act in kind.

The Rehabilitator's team had to decide whether to pursue a rehabilitation or liquidation of SHIP. Cantilo testified that the team chose rehabilitation because SHIP is financially able to provide a reasonable package of coverages to the remaining 39,000 policyholders. The Rehabilitator also considered that, in a liquidation, guaranty association coverage will be triggered, resulting in taxpayers contributing hundreds of millions of dollars to pay claims of policyholders who have not paid an appropriate premium. Rather than shifting the burden of the inadequate premium to taxpayers, the team concluded that the better course was to right-size the existing policies to an actuarially justified premium. Acknowledging that no rehabilitation plan will magically restore SHIP to solvency, Cantilo testified

the Second Amended Plan will, at a minimum, substantially reduce the Funding Gap and correct SHIP's inequitable premium rate structure. He explained that the Plan must be implemented quickly because of the advanced age of the policyholders.

In preparing the Second Amended Plan, the Rehabilitator relied on the combined expertise of Cantilo; Vincent Bodnar and other actuarial analysts at Oliver Wyman; Robert Robinson, who was appointed Chief Rehabilitation Officer of SHIP and who served as Chief Rehabilitation Officer and Chief Liquidation Officer for Penn Treaty;⁵ Pennsylvania Insurance Department legal counsel and staff; and SHIP technical staff. The Rehabilitator also sought and considered the input of state insurance regulators, staff of the National Association of Insurance Commissioners, policyholders and other formal and informal commenters. The Rehabilitator's team prepared extensive analyses of SHIP's finances, its policyholders, the long-term care insurance market, and other matters relevant to SHIP's condition and prospects for rehabilitation. Key data and information have been made available to interested persons through a data site, which included actuarial files relating to assumptions and analyses, a seriatim actuarial file for every policy at issue, and tailored reports related to the Second Amended Plan.

Cantilo explained how the Second Amended Plan will operate. He described it as "completely scaleable," meaning that the elements of the Plan can respond to changes in the amount of the Funding Gap as SHIP moves through Phase

⁵ Penn Treaty Network America Insurance Company, a Pennsylvania insurer, and its subsidiary, American Network Insurance Company (collectively, Penn Treaty), provided long-term care insurance to over 126,000 policyholders in all 50 states and the District of Columbia. Penn Treaty became insolvent for many of the same reasons that SHIP is insolvent, *i.e.*, benefit-rich policies were underpriced at inception and the company's active live reserves became understated. Penn Treaty was placed into rehabilitation by the Pennsylvania Insurance Commissioner on January 6, 2009. Rehabilitation ultimately proved unsuccessful, and on March 1, 2017, this Court ordered the liquidation of Penn Treaty.

One and into Phase Two and Phase Three. N.T., 5/17/2021, at 97. In Phase One, the policyholder's options are based on the If Knew Premium, and in Phase Two the options will be developed to establish a self-sustaining premium structure.⁶ Cantilo testified that it was important to give each policyholder at least two options: (i) retain his current coverages by paying the actuarially justified premium (Option 4) or (ii) retain his current premium by adjusting coverages to match that premium (Option 1). Between those two options there is a non-forfeiture option (Option 3) that is more generous than a non-forfeiture option in liquidation and basic policy options (Options 2 and 2A), which provide a reasonable package of long-term care coverage at an affordable price.

Cantilo testified that the If Knew Premium was selected as the target premium in Phase One because it is generally accepted by regulators across the country; it was the methodology used by guaranty associations to increase premium rates for policyholders in the Penn Treaty liquidation; it is an easy rate methodology to explain to policyholders; and it achieves the goal of putting policyholders on a level playing field when it is calculated on a seriatim basis.

Cantilo explained in detail each Phase One option in the Second Amended Plan. Option 1 is the downgrade option. It allows the policyholder to keep his current premium but reduces benefits until the premium is adequate, on an If Knew basis. The policyholder will not choose which benefits to downgrade, which was discovered to be too complicated in the Penn Treaty liquidation. The methodology for reducing benefits under Option 1 will proceed in the following sequence: elimination of benefit restoration provisions; elimination of benefit

⁶ The scope of Phase Two can only be determined after the completion of Phase One and an assessment of the remaining Funding Gap. Cantilo anticipates that the Rehabilitator will return to the Court at that point in the rehabilitation process.

extension provisions; adoption of tax-qualified benefit triggers; discontinuation of return of premium provisions; removal of inflation protection and locking of maximum daily benefit at current levels; conversion from indemnity to reimbursement of actual expenses up to the maximum daily benefit amount; reduction in the maximum daily benefit; extension of any elimination period to 90 days and applying it to each period of care; reduction in the policy's maximum benefit period; elimination of all premium waiver provisions; and conversion of the policy to a pool of money with a reduction of the maximum benefit period to the amount required to match the current premium. Ex. RP-55 at 45-46; Ex. RP-56 at 69. If the first revision is sufficient to match the policy's coverages to the existing premium, no further coverage modifications will be made.

Under Option 2, the policyholder selects basic policy coverages and a corresponding If Knew Premium. After extensive policyholder outreach, the Rehabilitator selected the key components of long-term care that most policyholders desire if they cannot afford the most expensive package of coverages. These include a maximum benefit period equal to the lesser of the current benefit period or four years; a maximum daily benefit equal to the lesser of 80% of the current daily benefit or \$300 for nursing facility care;⁷ and an annual inflation adjustment capped at 1.5%. Option 2A, which is an enhanced version of Option 2, provides a maximum benefit period of five years and an annual inflation adjustment of 2% for a higher premium. Policyholders who elect Option 2 or 2A will not be expected to participate in Phase Two of the Second Amended Plan.

Option 3 is the non-forfeiture option, which offers the policyholder a maximum benefit period of 2.5 years and a maximum daily benefit equal to the lesser

⁷ The maximum daily benefit for facility care other than nursing home care is \$225. The maximum daily benefit for home health care is \$150.

of 80% of the current daily benefit or \$300 for nursing facility care.⁸ Cantilo contrasted Option 3 with the standard non-forfeiture option in the industry, which offers the policyholder the equivalent of accumulated premium less claims. Typically, this results in only several months of coverage, particularly where the policy is rich in benefits. By contrast, Option 3 provides a reasonable alternative to a “luxurious” policy. Policyholders who election Option 3 will not be required to participate in Phase Two of the Plan.

Option 4 allows the policyholder to keep his current coverages by paying the If Knew Premium. Cantilo testified that this option is the least favored by the Rehabilitator because if the majority of policyholders choose this option the Funding Gap will only be reduced by half. N.T., 5/17/2021, at 191. This is because the If Knew Premium does not cover the prior years of premium inadequacy.

Cantilo explained that the options will vary depending on whether the policyholder is on claim or paying premium. A policyholder on premium waiver may choose to pay a differential premium, *i.e.*, the difference between the waived premium and the If Knew premium. The policyholder may choose not to pay the differential premium, but the benefits of his policy will be reduced in a commensurate amount. Cantilo testified that the rationale behind the differential premium is to apportion the burden of rehabilitation among all policyholders, not just the subset still paying premium. It would be unfair for the 13% of policyholders on premium waiver to be immunized from a premium adjustment at the expense of the other 87%.

Cantilo described the option election process, which will begin with the Rehabilitator sending every policyholder a packet of information containing three

⁸ The maximum daily benefit for facility care other than nursing home care is \$225. The maximum daily benefit for home health care is \$150.

sections. The first section describes the policyholder's current policy, including the monthly premium, available benefits, maximum policy value and the applicable statutory guaranty association limit were SHIP to be liquidated. The second section provides information on each option and how it changes the key provisions of his policy, *e.g.*, duration of benefit period and maximum daily benefit amount. The amount of the maximum policy value not covered by the applicable guaranty association is also provided. The third section contains two key pieces of information: the policyholder's estimated annual premium should a liquidation be ordered and the policyholder's estimated self-sustaining premium in Phase Two of the rehabilitation. Cantilo explained that these two numbers will enable policyholders to better choose among the options, especially since Options 1 and 4 will subject them to Phase Two.

To create user-friendly policyholder election materials, the Rehabilitator has engaged consultants who specialize in preparing Medicare supplement materials. The election forms will use graphics and be intuitively easy to follow. The Rehabilitator also plans to post a video tutorial online to guide the policyholder through the election forms. Cantilo testified that the Rehabilitator's goal is 100% policyholder participation. If a policyholder whose current premium is below the If Knew Premium does not make an election by the deadline, there are default options. For policyholders on premium waiver, the default option is Option 1, the downgrade option, unless Option 3 will provide better coverage, in which case it will be the default. For policyholders paying premium, the default option is Option 2, the basic policy endorsements.

The Rehabilitator conducted considerable outreach about the rehabilitation of SHIP beginning in the early stages of the rehabilitation. The

Rehabilitator participated in regular meetings of the National Association of Insurance Commissioners and organized numerous meetings and conference calls with state regulators. The goal was to design a rehabilitation plan to address all concerns, particularly those expressed about state-of-issue responsibility for premium rate review. The Rehabilitator set up a secure data site for interested persons that contains all of the exhibits to this proceeding, including the seriatim actuarial files for every policy. Individual reports were generated for each state explaining how resident policyholders of that state would fare under the plan.

To date, the Rehabilitator has received comments from approximately 100 policyholders. Cantilo testified that this was far fewer than the number of comments in Penn Treaty. As expected, most policyholder concerns related to reduction of benefits and rate increases. Cantilo was surprised how many policyholders were supportive of a rehabilitation and the plans submitted by the Rehabilitator.

The principal concerns raised by state insurance regulators related to the following areas: (1) treatment of reinsurance assumed; (2) setting of premium rates by the Rehabilitator and this Court rather than by state-of-issue regulators; (3) desirability of liquidation instead of rehabilitation; and (4) feasibility of the Second Amended Plan. Cantilo discussed each of these areas in turn.

On the first concern, Cantilo explained that SHIP's assumed reinsurance involved approximately 2,000 long-term care policies originally issued by American Health and Life, Primerica and TransAmerica, or the predecessors of those companies. SHIP's predecessors entered into agreements to reinsure 100% of these policies and administer claims. In the case of TransAmerica, on December 29, 2020, this Court approved an agreement by which TransAmerica recaptured its

policies from SHIP. Cantilo opined that the recapture was consistent with industry norms.

With regard to premium rates, Cantilo acknowledged the objections of the Intervening Regulators. They contend that the state where the policyholder resided when the policy was issued is solely responsible for the regulation of the policy's premium rate. Cantilo opined that this makes sense for solvent insurers, but when an insurer enters rehabilitation, the domiciliary state has sole responsibility for the insolvent insurer and the restructuring of its business. This responsibility includes the adjustment of premiums and policy coverages where necessary to correct the insurer's financial condition.

Cantilo testified that the Intervening Regulators' legal assertion that they have the right to review and approve premium rates for policies issued by SHIP in their states creates "some ironic consequences." N.T., 5/17/2021, at 157. For example, 34 policies issued in Maine, 84 policies issued in Massachusetts and 89 policies issued in Washington are held by policyholders who now reside in other states. Thus, the Intervening Regulators assert the right to set the rates for 207 policyholders who live outside of their states. Ex. RP-56 at 97. Further, 21 policyholders who reside in Maine, 83 policyholders who reside in Massachusetts and 87 policyholders who reside in Washington had their policies issued in other states. Under the Intervening Regulators' legal assertion, other state regulators would set the rates for 191 policyholders residing in the states represented by Intervening Regulators. *Id.* at 98. In short, their inflexible view of rate regulation results in approximately 400 policyholders residing in Maine, Massachusetts and Washington having their rates set by states in which they do not reside. The better approach, in Cantilo's view, is for the domiciliary regulator of an insurer in

rehabilitation to manage rate and contract modifications as part of a comprehensive rehabilitation plan.

Nevertheless, the Second Amended Plan contains an Issue State Rate Approval Option. As Cantilo explained, every state will be given the option of opting out of the rate approval section of the Second Amended Plan. If a state opts out, the Rehabilitator will file an application to increase premium rates for policies issued in that state to the If Knew Premium level. No rate increase will be sought for policies on premium waiver or which are already at or above the If Knew Premium. The Rehabilitator will file the application on a seriatim basis to eliminate subsidies and restore a level playing field. The regulator for the opt-out state will then render a decision on the application; if it is only partially approved, the Rehabilitator will downgrade the benefits for the affected policies.⁹ Cantilo testified that this is essential to eliminate the subsidies that exist between policyholders across states by virtue of uneven rate increase approvals over the years. Each opt-out state policyholder will still have four options, which are not exactly the same as those offered in the Second Amended Plan. They are: (1) pay the approved premium and have benefits reduced to match; (2) accept a downgrade of benefits to match the current premium; (3) accept an issue-state non-forfeiture option; or (4) keep the current benefits and pay the If Knew Premium. Cantilo pointed out that the non-forfeiture option available to opt-out policyholders will not be as generous as the enhanced non-forfeiture option in Option 3 of the Second Amended Plan. There will also be no “basic policy benefits” option, *i.e.*, Option 2 in the Plan.

Cantilo next addressed the Intervening Regulators’ argument that immediate liquidation of SHIP is preferable to rehabilitation. In this regard, the

⁹ If the state takes no action on the rate application within 60 days, it will be deemed denied.

Intervening Regulators focus on the present value of future benefits less the present value of future premiums, also referred to as the “Carpenter value,” to support their view that policyholders would fare better in a liquidation. N.T., 5/17/2021, at 175.¹⁰ Cantilo criticized this measure because it does not give an accurate picture of a policyholder’s situation. He offered the example of an actual 92-year-old SHIP policyholder currently paying \$2,761 for a policy with unlimited benefits. Ex. RP-56 at 102. Using the Intervening Regulators’ preferred methodology, the “Carpenter value” of that policy is \$33,890, which is higher than the “Carpenter value” produced under any of the four Plan options. However, to receive this value of \$33,890, the policyholder would have to pay \$11,520 in annual premium. By contrast, this policyholder could choose Option 3, a paid-up policy with a slightly lower “Carpenter value” of \$33,550. With a paid-up policy, however, this policyholder would receive 2.5 years of coverage and never pay another premium. Cantilo offered other examples where Option 3 would be the best option for a policyholder, given the annual premium the policyholder would be required to pay to the guaranty association in a liquidation. *See, e.g.*, Ex. RP-56 at 103. Cantilo opined that these are not exceptions; “[t]here are many cases where the raw projection of future benefits less future premium doesn’t really tell you what the real value of the policy is.” N.T., 5/17/2021, at 177.

Cantilo discussed several different ways to compare the value of the Plan options to what would be available in a liquidation. Using the Intervening Regulators’ standard of present value of future benefits less present value of future premiums, 85% of policyholders will have at least one option as favorable in

¹⁰ “Carpenter value” refers to the United States Supreme Court’s decision in *Neblett v. Carpenter*, 305 U.S. 297 (1938), which is often cited for the proposition that, in order for a rehabilitation plan to be constitutional, policyholders must fare as well in rehabilitation as they would in a liquidation.

liquidation and 15% will not. Ex. RP-56 at 105. Using the present value of future benefits divided by annual premiums, those numbers are 79% and 21%. *Id.* at 106. Using the maximum policy value divided by annual premium, those numbers are 89% and 11%. *Id.* at 107. Using the maximum policy value less present value of future premiums, those numbers are 96% and 4%. *Id.* at 108. Finally, using the Rehabilitator's preferred standard of maximum policy value, also referred to as the "benefit account value" or "lifetime maximum benefit" in some policies, *id.* at 104, 100% of policyholders will have at least one option in the Plan that offers the same or a better value than in a liquidation. *Id.* at 109.

Cantilo acknowledged that these are actuarial techniques that rely on the exercise of professional judgment. He opined that the maximum policy value is what policyholders use when they purchase an insurance policy, *i.e.*, the maximum daily benefit and the maximum benefit period.

Cantilo offered additional reasons to explain why rehabilitation is preferable to liquidation. First and foremost is the value of policyholder choice. Second, the Second Amended Plan contains features that would not be available to policyholders in liquidation, such as an option to retain their current policy level of coverage, which may exceed the applicable guaranty association cap, by paying the If Knew Premium. Third, there is the enhanced non-forfeiture option that provides reasonable coverage for no additional premium. In a liquidation, the non-forfeiture option would be locked into the policy's present coverages and terms, which may result in a very short period of coverage. Fourth, the Plan reduces or eliminates the subsidies in the current rate structure, which cannot be done in a liquidation.

Finally, Cantilo testified about the likelihood of success of the Second Amended Plan. He opined that the Plan is designed to eliminate the Funding Gap

over three phases. This is not likely to happen in Phase One, but Phase One will materially reduce the Funding Gap.

Cantilo offered an exhibit illustrating the amount of the Funding Gap reduction under 11 hypothetical policyholder election scenarios. In general, the more that policyholders elect to pay the If Knew Premium for their current benefits (Option 4), the worse the outcome for the Funding Gap. For example, in Scenario 1, where 7% elect Option 1, 8% elect Option 2 or 2A, 4% elect Option 3 and 81% elect Option 4, the Funding Gap is reduced by \$525 million. Ex. RP-56 at 113. At the other extreme, in Scenario 11, where a very small number of policyholders elect Option 4 and the rest split evenly among Options 1, 2, 2A and 3, the Funding Gap is completely eliminated. *Id.* This underscores how the policyholders will be the masters of the fate of SHIP. No matter how much of the Funding Gap is eliminated in Phase One, SHIP will be in better shape if it eventually has to be liquidated because the discriminatory subsidies in the premium rate structure will be eliminated and the policies will be right-sized.

On examination by the Intervening Health Insurers, Cantilo testified that the SHIP policies contain provisions that allow SHIP to modify the premium rate. Some policies provide that rate increases will require the approval of state regulators, while others specify that rate increases may be sought only where an increase is warranted given the claims experience of the cohort of policyholders covered by the same policy form. Cantilo stated that these provisions are standard in long-term care insurance policies. The Rehabilitator designed the If Knew Premium methodology in the Second Amended Plan to be consistent with the standards for setting long-term care insurance premium rates, which are substantially the same in every state.

b. Marc Lambright

Marc Lambright, an accident and health insurance actuary with Oliver Wyman, testified for the Rehabilitator. Lambright testified that the Pennsylvania Insurance Department engaged Oliver Wyman in early 2017 to conduct a targeted examination of SHIP's reserves and the assumptions used by its actuarial firm, Milliman, to set the reserves. Following its examination, Oliver Wyman submitted a report making several observations: Milliman's cash flow testing assumptions were too optimistic; claim reserves for the past several years were inadequate; and the Beechwood investment program was riskier than assumed in the 2016 cash flow test report. Ex. RP-56 at 53. Oliver Wyman made several recommendations for the ongoing financial monitoring of SHIP. They included using more recent experience to develop morbidity, lapse and termination assumptions. *Id.* Milliman largely rejected Oliver Wyman's recommendations.

In 2018, after SHIP was placed under the supervision of the Insurance Department, Cantilo asked SHIP to devise a corrective action plan.¹¹ Cantilo also asked Oliver Wyman to continue analyzing SHIP's financial condition. Lambright testified that much of 2018 was spent pressing SHIP to substantiate some of its actuarial assumptions. Lambright testified that the Beechwood investment losses (\$176 million) and the premium deficiency reserve booked in 2018 (\$347 million) had a significant impact on SHIP's financial picture. N.T., 5/18/2021, at 374. In 2019, Lambright assisted Vincent Bodnar as he built the corrective action plan that would become the rehabilitation plan.

¹¹ Section 510(a) of Article V authorizes the Insurance Commissioner to "make and serve upon the insurer and any other persons involved, such orders ... as are reasonably necessary to correct, eliminate or remedy" the insurer's condition that required the supervision. 40 P.S. §221.10(a).

c. Vincent Bodnar

Vincent Bodnar, an actuary at Oliver Wyman with a specialty in long-term care insurance, testified as an expert witness. Bodnar performed actuarial work for the Rehabilitator and was involved in developing the Second Amended Plan, including the Phase One options to be offered to the policyholders.

Bodnar described the seriatim model as the core of the Second Amended Plan. A seriatim model, which produces actuarial projections for each policy individually, has become the industry standard in the past five years. The input to the seriatim model consists of individual policyholder characteristics such as age, gender, issue age, benefit features of the policy, and the premium charged. Applied to the input file are actuarial assumptions, including morbidity and mortality rates, lapse rates, and exhaustion rates, which Oliver Wyman has developed using SHIP's historical experience. The seriatim model projects future premiums and future claims for each policy on a month-by-month basis. N.T., 5/18/2021, at 397.

Bodnar explained that the If Knew Premium methodology employed in Phase One determines the premium an insurer would charge had it known when the policy was issued what it knows today, *i.e.*, that it would experience lower returns on investments, lower mortality rates, lower lapse rates, and higher claim incidence rates. The If Knew Premium assumes a 60% lifetime loss ratio from inception of a policy, *i.e.*, the use of 60% of expected premium to pay benefits to policyholders. The other 40% of expected premium is used to pay salaries, administrative overhead, premium taxes, federal taxes and profit for the insurer. The goal of the lifetime loss ratio is to establish a premium level that is reasonable in relation to the benefits paid. The 60% lifetime loss ratio is the benchmark required for a premium rate increase in most states. The If Knew Premium methodology employed in Phase One will be

actuarially justified and will not recoup past underpricing losses, although several states allow such recoupment. In the Penn Treaty liquidation, guaranty associations sought premium rate increases from the states based on an If Knew Premium methodology similar to the one employed in Phase One.

Because the Second Amended Plan intends to set premium rates on a seriatim basis, each policyholder will receive an individual premium increase calculated on the benefit features of his policy and the policyholder's characteristics. The model does not consider individual claim experience but, rather, "all the various variants that make up a given assumption" for a risk class. N.T., 5/18/2021, at 412. By contrast, in a traditional rate application process, insurers request state approval of an aggregate premium rate increase, although their models might be developed on a seriatim basis.

Bodnar testified that it is common for an insurer to receive mixed responses to a premium rate increase request from state regulators because each state has its own approach to reviewing rates. Additionally, the rate review process typically takes between 90 days and 2 years. Protracted rate reviews with drastically different outcomes has resulted in some SHIP policyholders paying a premium rate that subsidizes the inadequate premium rates of other SHIP policyholders. The Second Amended Plan seeks to eliminate this inequitable discrimination in premium payments.

Based on his experience with insurance product development and consumer choices, Bodnar testified that, generally, policyholders look at maximum policy value, *i.e.*, the maximum daily benefits, elimination period, and premium rate in choosing an insurance policy. Bodnar considered all these factors in developing the options in the Second Amended Plan. Option 1 allows policyholders to retain

their current premium rates with reduced benefits. Options 2 and 2A provide policyholders with basic policy coverages at corresponding If Knew Premium rates. The basic policy retains the key components of long-term care and reduces or eliminates some features, such as a 4.5% inflation rider, that are not so important to policyholders. The maximum daily benefit, although reduced, would continue to provide meaningful coverage to most policyholders. The policyholders who elect Option 2 or 2A would not be subject to a rate increase in Phase Two, which is an appealing feature. In the Penn Treaty liquidation, policyholders were offered a benefit reduction option similar, but not identical to, Options 1 and 2 or 2A, but Bodnar did not recall how that affected their premium level. N.T., 5/19/2021, at 517, 520. By contrast, the Second Amended Plan proposes to offer policyholders three options by which to reduce their coverages and save premiums.

Option 3 of the Second Amended Plan offers a non-forfeiture option, which allows policyholders to receive up to 2.5 years of coverage and stop paying any additional premium. This is more generous than the standard non-forfeiture option, which caps coverage to the amount of premiums the policyholder has paid from inception. Policyholders in the Penn Treaty liquidation who chose the standard non-forfeiture option received continued coverage for a shorter period of time, sometimes only months. *Id.* at 435.

Option 4 of the Second Amended Plan allows policyholders to keep their current policy benefits and pay the If Knew Premium rate to retain those benefits. The guaranty associations in the Penn Treaty liquidation did not offer an equivalent option to policyholders whose coverages exceeded the statutory limits. Instead, they offered a rate increase option that retained the policy's coverages up to the statutory maximum amount allowed for each resident.

Bodnar explained how the different Phase One options relate to Phase Two of the Plan. Policyholders who elect Options 1 and 4 and have a policy providing coverage in excess of the guaranty association limits will be subject to a rate increase in Phase Two. Phase Two seeks to deploy a self-sustaining premium rate methodology, which will keep the lifetime loss ratio at 60% and thus be actuarially justified. Phase Two is not absolutely necessary under the Second Amended Plan because Phase One could close the Funding Gap, or the assumptions deployed in Phase One could play out differently than projected. Bodnar opined that any meaningful reduction in the Funding Gap during the rehabilitation would be a success.

Bodnar opined that a rehabilitation as proposed in the Second Amended Plan, as opposed to an immediate liquidation, presents policyholders with better options; sets the premium rates to equitable levels; and reduces SHIP's Funding Gap. There is no formulaic method to determine whether policyholders are better off in a rehabilitation or in a liquidation; the so-called "Carpenter test" is not an actuarial test. Policyholders who choose Option 4 will have a policy with a net present value greater than or equal to what they would have in liquidation because it will not be capped at the level set forth in the applicable guaranty association statute. However, Option 4 has the least effect on reducing the Funding Gap. N.T., 5/19/2021, at 512-513.

Bodnar opined that policyholders are likely to consider the maximum policy value/premiums analysis or the maximum policy value analysis in making determinations. The present value analysis, or "Carpenter test," is appropriate for evaluating the impact of the Phase One options on SHIP's liabilities. However, he explained that policyholders do not use a present value analysis when they choose

their long-term care insurance coverage. Nor would they rely solely on the present value analysis to select one of the options offered under the Second Amended Plan.

Upon approval of the Second Amended Plan, Bodnar and the actuarial team at Oliver Wyman will prepare an actuarial memorandum in support of the If Knew Premium rates, similar to what would be submitted to state regulators in a rate increase filing. In developing the Second Amended Plan, Oliver Wyman has prepared an actuarial report describing the If Knew Premium rating methodology and an assumption report, Ex. RP-16 and Ex. RP-17, and has gathered all the information needed for the actuarial memorandum. N.T., 5/19/2021, at 460.

ii. Intervening Regulators' Evidence

a. Frank Edwards

Frank Edwards, the vice president and chief life health actuary of INS Consultants, testified as a fact witness on behalf of the Intervening Regulators. Edwards testified that under the Second Amended Plan, policyholders bear the responsibility for the \$1.2 billion Funding Gap through benefit reductions and premium increases. By contrast, in liquidation, policyholders would bear a burden of approximately \$397 million, and the guaranty associations would bear a burden of approximately \$837 million. This represents the difference between the net amount the guaranty associations would pay to policyholders and the distributions they would receive from the SHIP estate. Because a rehabilitation does not trigger the guaranty associations, these funds will not be available to benefit policyholders under the Second Amended Plan.

Edwards observed that among the four options in the Second Amended Plan for Phase One, Option 4 provides a net present value for approximately 83% of policyholders that is greater than they would receive in a liquidation. The other

options provide policyholders with a net present value that is lower than they would receive in liquidation.

Oliver Wyman presented 10 scenarios to illustrate the potential results of the Second Amended Plan for SHIP's liabilities, each leaving a deficit that ranged from \$699 million to \$186 million. Ex. RP-16 at 11. Only Scenario 11, later added, eliminates the Funding Gap. Based on the information provided by Oliver Wyman, Edwards calculated a "Best Interest" scenario, which assumed that each policyholder will choose the option that provides the greatest net present value, or "Carpenter value." Ex. SIR 5-4. Option 4 would give 67.13% of the policyholders the greatest net present value, which would reduce SHIP's Funding Gap by \$184 million. *Id.*

Edwards addressed a comparison of rehabilitation to liquidation under Phase Two. Edwards calculated the effects of hypothetical Phase Two premium increases on policyholders who selected Option 4 in Phase One. Assuming a premium increase of 50% in Phase Two, the percentage of policyholders receiving a net present value greater than in a liquidation under Option 4 drops to 33.89%. The percentage of policyholders in a rehabilitation, in the aggregate, that would receive a net present value greater than liquidation is 54.57%. Assuming a premium increase of 100% in Phase Two, the percentage of policyholders for whom Option 4 provides a net present value greater than in a liquidation drops to 22.92%. The percentage of all policyholders in a rehabilitation, in the aggregate, that would receive a net present value greater than in a liquidation is 47.21%. Even so, these hypothetical premium increases of 50% and 100% would leave remaining a Funding Gap of approximately \$858 million and \$676 million, respectively. Ex. SIR 5-5.

Edwards observed that the information presented by Oliver Wyman indicated that the net present value of Option 2 for policies with benefits in excess

of guaranty association limits is typically less than the net present value of the guaranty association limits. Ex. SIR 5-6.

Edwards did not evaluate Oliver Wyman's work. He compared the Second Amended Plan to liquidation using hypotheticals in which policyholders made elections based solely on maximizing the present value of future policy benefits minus the present value of future premiums, or the "Carpenter value."

iii. Intervenor NOLHGA's Evidence

a. Peter Gallanis

Peter Gallanis, the president of NOLHGA, testified as a fact witness. NOLHGA intervened in this proceeding to offer its suggestions on the Second Amended Plan; provide background information on the guaranty association system; and identify and request certain information material to its guaranty association members.

NOLHGA's members are life and health guaranty associations, one for each state and the District of Columbia, which are nonprofit entities created by state statutes to protect policyholders when a life or health insurance company is liquidated. In multi-state insurance insolvencies, the guaranty associations collaborate and coordinate through NOLHGA to fulfill their statutory obligations. NOLHGA has been involved in approximately 100 multi-state insurance receiverships, nine of which involved long-term care insurance. If SHIP goes into liquidation, most NOLHGA member guaranty associations would be activated to provide coverage to SHIP policyholders, subject to the statutory limit on coverage in the member's state, which is generally \$300,000 per resident.

Gallanis testified that the Second Amended Plan should emphasize that the options that policyholders select in Phase One will be permanent. The Second

Amended Plan's discussion of SHIP's unfunded liability needs clarification, or it should be eliminated. The subject need not be addressed until a liquidation may occur.

He testified that the Rehabilitator's sample Illustrative Policyholder Guidance Pages on guaranty association coverage and premium rates in liquidation could be misleading. In response, NOLHGA prepared a sample Summary of Policyholder Protection by Guaranty Associations in Liquidations that it believes should be sent to policyholders during Phase One. Ex. N-1. Gallanis believes NOLHGA should review all policyholder communications that refer to liquidation or guaranty associations and be allowed to comment on these communications before they are sent to policyholders.

Gallanis testified that NOLHGA wants more information on SHIP's reinsurance agreements with Transamerica, American Health and Life Insurance Company, and Primerica Life Insurance Company. NOLGHA also seeks more information on SHIP's in-force policies that are not long-term care policies.

Gallanis explained that members of a guaranty association are licensed life and health insurers. If SHIP is placed under an order of liquidation, the guaranty associations will provide resident policyholders with coverage up to the lesser of the maximum benefit level provided in the policy or the statutory limit for guaranty association coverage, which is \$300,000 per resident in most states.¹² The guaranty associations may continue coverage under the policy; work with the receiver to transfer the business to a financially solvent insurer; or issue alternative policies. The guaranty associations may seek premium rate increases or offer policyholders

¹² The guaranty association limits range between \$100,000 in Puerto Rico, \$300,000 in 42 states and the District of Columbia, \$500,000 in 6 states, \$615,525 in California, and no limit in New Jersey.

modified benefits based on current premium rates, as was recently done in the Penn Treaty liquidation. The guaranty associations generally do not charge premiums to policyholders who have been on premium waiver. The options offered by the guaranty associations in the Penn Treaty liquidation are illustrative of what could be offered in a potential SHIP liquidation.

In a liquidation, the guaranty associations will assess their member insurers, using the methodology set forth in their governing statutes to determine each member insurer's assessment. The member insurers pay the assessments from their general accounts. In some states, the member insurers can offset a portion of the assessment against state premium taxes that the insurers would otherwise owe. Member insurers can also impose surcharges on their policyholders to fund assessments. The guaranty associations are not funded by state revenues.

Gallanis explained that NOLHGA does not endorse or oppose the Second Amended Plan. NOLHGA intends to monitor the rehabilitation if this Court approves the Second Amended Plan, so that the guaranty associations will be prepared if SHIP ultimately is liquidated.

b. Matthew Morton

Matthew Morton, an actuary with the Long Term Care Group and an advisor to NOLHGA, testified as a fact witness about guaranty association coverage and premium rate increases in liquidation. Morton assisted NOLHGA in several long-term care insurer insolvencies, including the Penn Treaty liquidation.

In a liquidation, a policyholder receives a continuation of coverage from a guaranty association. The policy's benefits are paid in full until the policyholder exhausts the maximum benefit amount or maximum coverage period set forth in the policy, or until the payments reach the statutory coverage limit. Many

long-term care policyholders are not affected by the statutory coverage limit because: (1) the policy's maximum benefit amount is less than the statutory coverage limit; (2) the policyholder never goes on claim; or (3) the policyholder does not stay on claim long enough to reach the statutory coverage limit.

In the Penn Treaty liquidation, the guaranty associations implemented a nationwide rate increase program, which resulted in 34 states approving 100% of the requested rate increases; 11 states approving between 80% and 100% of the requested rate increases; and 3 states approving less than 60% of the requested rate increases. No state denied a rate increase request. The majority, 44 states, approved the initial rate increase filing within 15 months. The guaranty associations spent 6 to 12 months preparing and filing the rate increase applications.

The guaranty associations' methodology for calculating premium rate increases in the Penn Treaty liquidation was similar to the If Knew Premium methodology proposed in the Second Amended Plan, with two exceptions. First, the Second Amended Plan proposes to calculate rate increases seriatim, or individually, while Penn Treaty's rate increase applications were developed on a cohort basis, by which policyholders were grouped together by policy form. The cohort basis is the industry standard for an insurer that is a going concern. Second, the Second Amended Plan proposes to calculate rate increases based on the total maximum value of the policy. In Penn Treaty's liquidation, the premium rates were calculated based on benefits being capped at the guaranty association statutory limits.

Morton testified that the premium rate increase methodology used by the guaranty associations in the Penn Treaty liquidation "largely" addressed the inequities in premium rates and the cross-state rate subsidization issue. N.T., 5/20/2021, at 806. When asked on cross-examination to expound on his

understanding of “largely,” Morton acknowledged that using a cohort method to adjust premium rates results in some policyholders paying more than the If Knew Premium. *Id.* at 817-18. If a seriatim method is used, all policyholders will pay the If Knew Premium and no more.

In the Penn Treaty liquidation, the default option for policyholders who failed to make elections was to accept the rate increase. Policyholders were offered policy modifications, including lowering daily benefits or the inflation rider; a reduced paid-up policy; or a cash-out option in exchange for termination of the policy. Only one state approved the cash-out option. Approximately 76% of the Penn Treaty policyholders accepted the rate increase, among which “a little bit less than a half” took the option by default; 13% of the policyholders reduced their benefits; 8% of the policyholders elected to cash out; and 3% of the policyholders elected a reduced paid-up policy. *Id.* at 812. The guaranty associations treated Penn Treaty policyholders on premium waiver the same before and after the liquidation by continuing the waiver.

iv. Intervening Agents and Brokers’ Evidence

a. Daniel Schmedlen

Daniel Schmedlen, Chief Executive Officer of LTC Global, testified on behalf of the Intervening Agents and Brokers. These agents and brokers are all employed by LTC Global and are paid commissions by SHIP. The commission is set forth in the agency agreement and based on a percentage of premium. The policyholder pays a premium to the insurer, which deducts a certain percentage of the premium and remits it to the agent as a commission. The agent is not obligated to contact the insured after issuance of the policy, although the agent might accept the initial premium payment on behalf of the insurer.

A sample agent agreement was introduced into evidence by the Rehabilitator. It provided that the agent and successors “shall have the vested right to receive all commissions payable under this [a]greement.” Ex. RP-10 at 3. Schmedlen understood this language as creating the agent’s vested property interest in that part of any premium collected by SHIP that it owed to the agent as a commission. LTC Global expects that its agents will continue to receive commissions during SHIP’s rehabilitation, as they did during Penn Treaty’s rehabilitation.

The insurer determines the amount of commission payable to the agents. Once a policy is issued and delivered, the agent is paid a commission in accordance with the commission schedule set forth in the agency agreement. The first-year commission is higher than the renewal commission, and the amount of renewal commission changes with time. The commission schedule in the sample agent agreement showed that the first-year commission ranged from 45% to 70% of the first-year premium, depending on the age of the policyholder. After 10 years, the commission is typically reduced to a percentage of premium in the “middle single digits.” N.T., 5/20/2021, at 850. If the insurer has to refund any portion of the premium to the insured, the agent returns his commission to the insurer in proportion to the refunded premium. Where there is no premium paid, there is no commission owed to the agent.

v. Intervening Health Insurers’ Evidence

Intervening Health Insurers introduced into evidence six sample insurance policies issued by SHIP’s predecessors and assumed by SHIP. The policies provided that SHIP may increase premium rates over time without

specifying the methodology to be used in calculating the rate increases. The policies are silent on agent and broker commissions.

vi. Intervening Policyholders' Evidence

a. James Lapinski

Intervenor James Lapinski, a policyholder of SHIP as well as a broker, testified on his own behalf. He expressed concern about the Second Amended Plan's discussion of the impact of the COVID-19 pandemic on the long-term care insurance industry. He requested that the Rehabilitator update the discussion with more recent data. Lapinski presented a three-page excerpt from the Society of Actuaries report, dated September 30, 2020, which indicated that COVID-19 has had an impact on emerging long-term care insurance experience through higher mortality and lower claim incidence. An excerpt of a newsletter produced by Fairfax County, Virginia, suggested that more than 80% of COVID-19 deaths have been adults over 65 years old. Further, 34% of COVID-19 deaths in the United States have been seniors living in long-term care facilities, which accounts for less than 1% of the U.S. population. Lapinski opined that a combination of a decline in claim utilization and increase in lapse or cancellation of policies suggests that SHIP has experienced a major decrease in claims experience due to the pandemic.

Lapinski presented a balance sheet of SHIP showing that the value of SHIP's bond holdings as of December 31, 2020, declined by approximately \$500 million from the previous year. SHIP's reported cash on hand and short-term investment income also declined from the previous year by approximately \$500,000. This does not correlate with the decrease in the value of the bonds. Lapinski questioned the changes in reserves shown in the balance sheet. Specifically, he requested the Rehabilitator to explain the decline in SHIP's capital and surplus from

approximately \$12 million in 2017 to a deficit of \$916 million in 2019, as well as the decline in the number of policies in force from 151,000 in 2009 to approximately 39,000 as of the filing of the Second Amended Plan. Observing that the Second Amended Plan contains excerpts from SHIP's unfiled 2019 statutory financial statement and the internal 2020 financial information (*see* Appendix B of the Second Amended Plan), Lapinski requested that SHIP file its 2019 and 2020 statutory financial statements before this Court rules on the Second Amended Plan.

Lapinski and his wife pay annual premiums totaling \$9,000 for their three policies. Over the past 25 years, they have paid over \$200,000 in premiums. He estimated that skilled nursing facilities cost \$500 per day, which they cannot afford without insurance coverage. Lapinski raised concerns with the timing of the rehabilitation and stated his desire for SHIP to avoid the lengthy process that Penn Treaty had gone through prior to liquidation.

b. Rose Marie Knight

Rose Marie Knight, a policyholder, also testified. She agreed with Lapinski's testimony. She has been a policyholder for 22 years and currently pays an annual premium of \$1,200. She questioned why SHIP has not raised her premium for the last four or five years. Knight's policy has a lifetime benefit period. She will have to pay a higher premium to retain this maximum coverage period under the Second Amended Plan. Knight expressed concern about her ability to pay a higher premium and becoming a burden on her children. N.T., 5/21/2021, at 935. She noted that the government has recently incurred great debts, which will cause inflation that "is starting to hit." *Id.* at 933-34.

Both Lapinski and Knight expressed concern and confusion as to the Second Amended Plan's proposed policy restructuring, which they interpreted as removing benefits or cancelling guaranty association coverage.

III. Standard of Review

Section 516(b) of Article V authorizes the Rehabilitator to “take such action as [she] deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate the insurer. ... [She] shall have full power ... to deal with the property and business of the insurer.” 40 P.S. §221.16(b). The legislatively stated purpose of Article V, to which the Court must give effect, is “the protection of the interests of insureds, creditors, and the public generally....” and the “equitable apportionment of any unavoidable loss” through, *inter alia*, “improved methods for rehabilitating insurers....” *Grode v. Mutual Fire, Marine and Inland Insurance Co.*, 572 A.2d 798, 803 (Pa. Cmwlth. 1990) (*Mutual Fire I*) (single-judge opinion) (quoting Section 501 of Article V, 40 P.S. §221.1).

The Pennsylvania Supreme Court has explained this Court's role in a rehabilitation as follows:

In overseeing the course of rehabilitation to check any abuse of discretion by the Commissioner, the Commonwealth Court is authorized to “approve or disapprove the plan [of rehabilitation] proposed, or may modify it and approve it as modified. If it is approved, the rehabilitator shall carry out the plan.” 40 P.S. § 221.16(d). Therefore, in order for the Plan to warrant the Commonwealth Court's imprimatur it must be found to be free from any abuse of the Rehabilitator's discretion.

Foster v. Mutual Fire, Marine and Inland Insurance Co., 614 A.2d 1086, 1091 (Pa. 1992) (“*Mutual Fire II*”). Further, “it is not the function of the courts to reassess the

determinations of fact and public policy made by the Rehabilitator.” *Id.* Our Supreme Court has explained:

‘It has been established as an elementary principle of law that courts will not review the actions of governmental bodies or administrative tribunals involving acts of discretion *in the absence of bad faith, fraud, capricious action or abuse of power* That the court might have a different opinion or judgment in regard to the action of the agency is not a sufficient ground for interference; *judicial* discretion may not be substituted for *administrative* discretion.’

Id. at 1092 (quoting *Norfolk and Western Railway Co. v. Pennsylvania Public Utility Commission*, 413 A.2d 1037, 1047 (Pa. 1980) (emphasis in original)).

With the above principles in mind, the Court considers whether the Rehabilitator abused her discretion in formulating the Second Amended Plan. The Court is also mindful that “the Rehabilitator is constrained by constitutional mandate[s].” *Mutual Fire I*, 572 A.2d at 804.

IV. Legal Analysis

A. The Second Amended Plan Serves a Rehabilitative Purpose and is within the Discretion of the Rehabilitator

1. Goals of the Plan

There is no fixed goal that every rehabilitation plan must satisfy to obtain this Court’s approval. Specifically, the Pennsylvania Supreme Court has stated that a

rehabilitation, in order to be legitimate, does not have to restore the company to its exact original condition. 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.

Mutual Fire II, 614 A.2d at 1094 (quoting 2A COUCH ON INSURANCE 2d §22.10).

The unrefuted testimony of the Rehabilitator's witnesses established two overarching goals of the Second Amended Plan: (i) to reduce or eliminate the Funding Gap and (ii) to eliminate SHIP's inequitable and discriminatory premium rate structure, which is marked by cross-policyholder subsidies. The Plan will meet these goals by setting premium rates for all policyholders pursuant to an actuarially sound methodology, the If Knew Premium rate, which is widely accepted by regulators across the country, and by offering policyholders meaningful options. Instead of being forced to accept rate increases commensurate with their current coverages, policyholders will have the option to reduce coverages, thereby reducing their premiums.

In pursuing these goals, the Second Amended Plan addresses one of the major causes of SHIP's financial distress: policy underpricing. The Plan will address underpricing by (i) resetting premiums, on a prospective basis, to what they would have been without the erroneous actuarial assumptions and (ii) doing so on a seriatim basis, thereby ensuring that the premiums going forward are consistent across the entire pool of policyholders so that similarly situated policyholders will not be paying different premiums. The Plan will give policyholders meaningful choices for coverage in lieu of rate increases, without placing the cost of SHIP's historical policy underpricing upon the public through the guaranty association system. These goals serve the public good. *See Mutual Fire II*, 614 A.2d at 1094, n.4 (determining that the state's interest in "regulat[ing] the fiscal affairs of its insurers for the welfare of the public" is a legitimate and significant public purpose).

2. No Contrary Evidence

The Intervening Regulators, who object to the Second Amended Plan in its totality, did not introduce an expert witness to dispute any of the Rehabilitator's

actuarial projections, including the impact of the various options on policyholders and the Funding Gap, or the Plan's proposed premium rate methodologies. The Intervening Regulators' actuary, Frank Edwards, testified as a fact witness, and he acknowledged that he was not asked to evaluate the Rehabilitator's work.

Edwards' testimony consisted of "mathematical exercises," N.T., 5/19/2021, at 564, that compared the Plan to a liquidation. He assumed that policyholders are "better off" with the "maximum present value" of their policies. *Id.* at 568. Known as the "Carpenter value," maximum present value is future benefits minus future premiums, adjusted to their present value. Edwards acknowledged that he could not opine on policyholder preferences. Cantilo and Bodnar, both qualified experts, testified persuasively that policyholders do not make choices based on the maximum present value of their policies. Rather, policyholders will rely on other metrics, most notably the maximum policy value, such as maximum daily benefit and maximum benefit period, to make choices. Using those metrics provides a better outcome for policyholders than they would experience in liquidation.

B. The Goals of the Plan Could Not Be Achieved in Liquidation

The Rehabilitator's evidence demonstrated that immediate liquidation of SHIP would be improvident for several reasons. First, a liquidation of SHIP will not address the Funding Gap. Second, a liquidation will not address the existing inequitable premium rate structure and cross-policyholder subsidies. Instead, it will perpetuate those problems. Third, a liquidation of SHIP will unnecessarily delay any resolution of SHIP's financial condition. Fourth, the options available to policyholders under the Second Amended Plan are better than what would be offered by guaranty associations in a liquidation.

1. Liquidation Will Not Address the Funding Gap

As noted, the Funding Gap is largely attributable to significant historical underpricing of SHIP's policies. In a liquidation, the entire cost of this shortfall will be shifted to the guaranty association system and, ultimately, to the public. As NOLHGA's Peter Gallanis acknowledged, the guaranty associations will fund the cost of the underpricing by assessing their member companies, which, in turn, fund the assessments from their policyholder generated funds. These insurers will then recoup some portion of the loss through premium tax offsets or by raising rates they charge to their own policyholders. The Rehabilitator concluded that shifting the burden to taxpayers and policyholders of other life and health insurers will not serve the "public good." *Mutual Fire II*, 614 A.2d at 1094. That determination is within her discretion and is entitled to deference. *Id.* at 1091 ("[T]he involvement of the judicial process is limited to the safeguarding of the plan from any potential abuse of the Rehabilitator's discretion.").

2. Liquidation Will Perpetuate the Inequitable Premium Rate Structure

In a liquidation of SHIP, assuming the guaranty associations would seek rate increases as they did in the Penn Treaty liquidation, similarly situated policyholders will continue to pay different rates. NOLHGA's actuary, Matthew Morton, acknowledged that this is attributable to the guaranty associations' practice of seeking rate increases for cohorts of policyholders. Using a cohort method results in some policyholders paying more than the If Knew Premium in liquidation. The Second Amended Plan will adjust premium rates on a seriatim basis, which eliminates the possibility of any policyholder paying more than the If Knew Premium.

Further, the guaranty associations must request rate increases from the state of issue, not the state where the policyholder resides. The experience from the Penn Treaty liquidation showed that states do not act uniformly. For example, Florida (one of Penn Treaty's largest states by premium) granted only 50% of the guaranty associations requested, and actuarially justified, rate increases for policies written in that state. Florida similarly has refused to grant SHIP's requested rate increases, and there is no reason to believe the result would be any different in a liquidation. *See* Ex. RP-53 (showing that since 2009, SHIP has requested approximately \$62.6 million in premium rate increases from the Florida Insurance Department, but only \$7.6 million has been approved).

The Intervening Regulators' States of Maine, Massachusetts and Washington are illustrative of the problem. Since 2009, only Massachusetts has approved a significant percentage of the rate increases sought by SHIP. *See* Ex. RP-53 (showing a 90% approval ratio in Massachusetts but an 11% approval ratio in Maine and a 63% approval ratio in Washington). The Rehabilitator's evidence demonstrated that a liquidation will not alleviate SHIP's premium rate inequities and cross-policyholder subsidization issues.

3. Liquidation Involves Inherent Delays

At a minimum, a liquidation would cause a material delay in addressing the policy underpricing which lies at the root of SHIP's insolvency. NOLHGA's actuary testified that in the Penn Treaty liquidation it took six months to a year to prepare and file the rate applications on behalf of the guaranty associations. It took an additional 15 months to receive decisions from most of the state insurance regulators, with the final state's approval taking more than 4 years. Bodnar testified that the rate approval process can take anywhere from 90 days to 2 years or more.

Thus, at best, in a liquidation of SHIP it would take nearly two years to prepare, file and receive approvals on rate increase requests, and there would be no certainty that the rates would be approved at the requested actuarially justified level.

By contrast, the Second Amended Plan can be implemented quickly, thereby addressing the causes of SHIP's financial distress, preserving assets, and reserving flexibility for Phase Two and beyond. Cantilo testified that it would take approximately six months to prepare and transmit election packages to policyholders and gather any Issue State Opt-out elections. Upon implementation of the Plan, the Rehabilitator will know within approximately eight months how much of the Funding Gap will be eliminated. The outcome of Phase One will determine whether Phase Two will be necessary and, if so, its scope. While the Self-Sustaining Premium methodology proposed for Phase Two is actuarially justified according to Bodnar's undisputed expert testimony, the Rehabilitator may consider alternatives as necessary depending on the outcome of Phase One. The Rehabilitator will also provide reports to the Court at the appropriate times with her recommendations regarding Phase Two. A liquidation does not offer this kind of flexibility. *See Mutual Fire I*, 572 A.2d at 803 ("[T]he benefits of rehabilitation – its flexibility and avoidance of inherent delays – are preferable to the static and cumbersome procedures of statutory liquidation.").

4. Policyholders Will Have Fewer Choices in Liquidation

In a liquidation of SHIP, policyholders will not be offered the choices provided under the Second Amended Plan. NOLHGA's witnesses acknowledged that the benefit modification offers made by the guaranty associations in the Penn Treaty liquidation, which were the first of their kind in a long-term care insurance liquidation, do not match the options offered under the Plan. Specifically, there was

no equivalent to the basic policy coverages provided in Option 2/2a. There was no enhanced non-forfeiture option similar to Option 3. There was no option similar to Option 4 that could provide coverage above the applicable guaranty association cap. The Plan provides greater flexibility for policyholders than they would have in liquidation by offering meaningful policy modification alternatives that will also alleviate the Funding Gap and inequitable rate structure.

C. The Plan Meets the Legal Standards for Confirmation

1. The Plan's Rate Approval Mechanism and Issue-State Rate Approval Alternative are Permissible Under Pennsylvania Law and the United States Constitution

The Intervening Regulators object to the Second Amended Plan for the stated reason that the Plan proposes to have premium rates set by the Rehabilitator and this Court rather than by state-of-issue regulators. Intervening Regulators' Memorandum of Law, 6/14/2021, at 41. The Intervening Regulators assert that the Rehabilitator's statutory powers under Article V to "direct and manage" the "property and business of the insurer," Section 516(b) of Article V, 40 P.S. §221.16(b), does not include authority to change "SHIP's policies and rates without required regulatory approvals." Intervening Regulators' Memorandum of Law at 44. They also assert that the Plan's deviation from the ordinary state-by-state rate review process violates the Full Faith and Credit Clause of the United States Constitution¹³ and is inconsistent with the principle of comity. The Plan's Issue

¹³ It states:

Full Faith and Credit shall be given in each State to the public Acts, Records, and judicial Proceedings of every other State. And the Congress may by general Laws prescribe the Manner in which such Acts, Records and Proceedings shall be proved, and the Effect thereof.

State Rate Approval Option does not cure these infirmities because it is coercive and offers, at most, a “nominal deference” to the state of issue’s authority to regulate the premium rates for policies issued in that state. Intervening Regulators’ Memorandum of Law at 50, 52.

We begin with a review of Section 516 of Article V, which sets forth the powers and duties of the Rehabilitator. It states, in pertinent part, as follows:

(b) The rehabilitator may take such action as he deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate the insurer. He shall have all the powers of the directors, officers and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator. He shall have full power to direct and manage, to hire and discharge employees subject to any contract rights they may have, and to deal with the property and business of the insurer.

* * *

(d) The rehabilitator may prepare a plan for the reorganization, consolidation, conversion, reinsurance, merger or other transformation of the insurer. Upon application of the rehabilitator for approval of the plan, and after such notice and hearing as the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. If it is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens upon the equities of policyholders of the company, provided that all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for such period and to such an extent as may be necessary.

U.S. CONST. art. IV, §1. A statute is a “public Act” within the meaning of the Full Faith and Credit Clause. *Franchise Tax Board of California v. Hyatt*, 136 S.Ct. 1277, 1281 (2016) (*Hyatt II*) (citing *Carroll v. Lanza*, 349 U.S. 411, 412 (1955)).

40 P.S. §221.16(b)(d) (emphasis added).

The Rehabilitator may “take such action as [she] deems necessary or expedient to correct the condition” that caused the need for rehabilitation, 40 P.S. §221.16(b), and in doing so, she may prepare a rehabilitation plan to “*impair the contractual rights of some policyholders* in order to minimize the potential harm to all of the affected parties.” *Consedine v. Penn Treaty Network American Insurance Co.*, 63 A.3d 368, 452 (Pa. Cmwlth. 2012) (*Penn Treaty*) (citing *Mutual Fire II*, 614 A.2d at 1094) (emphasis added). This authority includes a reduction of coverage to match the policyholder’s existing premium. It has long been understood that the legislature has vested the Rehabilitator with broad discretion in proposing a rehabilitation plan. *Mutual Fire I*, 572 A.2d at 804, *affirmed*, *Mutual Fire II*, 614 A.2d at 1086 (observing that the insurance commissioner, as statutory rehabilitator of an insurer, is given broader discretion to structure a rehabilitation plan than is given to a statutory liquidator).

In the *Mutual Fire* rehabilitation, the plan amended the policyholders’ contractual right to full payment on covered claims by reducing all claim payments by an equal percentage. Here, the Rehabilitator could have done something similar by reducing the coverage of each policy to match the premium being paid. This would equitably address the Funding Gap. However, this would not give policyholders a choice. Further, policyholders whose premium is very inadequate might find themselves with a policy with very limited coverage.

Mutual Fire was a different receivership. There, the policies lapsed during the rehabilitation, and the sole object of the rehabilitation was to pay outstanding claims to the fullest extent possible. By contrast, here, the SHIP policies

are still in force and will remain in force until SHIP emerges from rehabilitation. In this respect, SHIP's rehabilitation is more complex.

A core cause of SHIP's insolvency is policy underpricing, and the Rehabilitator proposes to "correct the condition" through a combination of benefit modifications and premium rate increases. Section 516(b) of Article V, 40 P.S. §221.16(b). Policyholders will be able to decide which of the four options offered under the Second Amended Plan best fits their individual circumstances. The Plan follows the principles of *Mutual Fire I* and *II* and extends them to a different context, as appropriate for a long-term care insurer. The Plan falls within the Rehabilitator's "broad powers ... to effectuate equitably the intent of the Rehabilitation statutes." *Mutual Fire II*, 614 A.2d at 1094. The Plan's mechanism for setting actuarially justified rates also falls within the Rehabilitator's broad powers, and they will be reviewed by the Court as part of the rehabilitation proceeding.

Arguably, the only contract "right" given up by the SHIP policyholder is the expectation that the state where the policy was issued will approve the premium rate for each of the four options in Phase One. No policyholder commented on this "right" to state-by-state rate regulation. Policyholder Rose Marie Knight expressed concern about the fact that her premium had not been increased for years. N.T., 5/21/2021, at 933.

The Intervening Regulators assert that the Plan's rate approval provisions "override the insurance laws of other [s]tates" and, thus, violate the Full Faith and Credit Clause of the United States Constitution. Intervening Regulators' Memorandum of Law at 38. Alternatively, the Intervening Regulators contend that this Court should refrain from approving the Plan under the principle of comity because the Plan's "displacement of the rate setting authority of the individual

[s]tates” is a “blatant intrusion” on the sovereignty of other states. Intervening Regulators’ Memorandum of Law at 49. The Court finds no merit to these arguments.

Article V empowers this Court to rehabilitate the business of “a domestic insurer or an alien insurer domiciled in this Commonwealth.” Section 515(a) of Article V, 40 P.S. §221.15(a). As a general rule, the insolvent insurer’s state of domicile “has an overriding interest in assuring that the rehabilitation, if possible, is effectuated.” *Matter of Mutual Benefit Life Insurance Co.*, 609 A.2d 768, 777 (N.J. Super. 1992). The court’s “decree approving the rehabilitation plan for an insolvent insurer domiciled in its state has a *res judicata* effect upon out-of-state policyholders so as to preclude a subsequent attack upon the plan in another state.” 1 COUCH ON INSURANCE 3d §5:31.

Maine, Massachusetts, and Washington have adopted, in substantial part, the Uniform Insurers Liquidation Act (UILA),¹⁴ which was approved by the National Conference of Commissioners on Uniform State Laws in 1939. The UILA addressed the difficulties that arise in the receivership of an insolvent insurer with assets and liabilities located in several states; the UILA provides a “uniform system for the orderly and equitable administration of the assets and liabilities of defunct multistate insurers.” *Altman v. Kyler*, 221 A.3d 687, 692 n.6 (Pa. Cmwlth. 2019) (quotations omitted). Pennsylvania, on the other hand, adopted the Insurer’s Supervision, Rehabilitation and Liquidation Model Act (Model Act) approved by the National Association of Insurance Commissioners. *See Koken v. Reliance*

¹⁴ See 24-A Me. Stat. Ann. §4363; *In re Liquidation of American Mutual Liberty Insurance Company*, 747 N.E.2d 1215, 1225 n.13 (Mass. 2001); and *American Star Insurance Co. v. Grice*, 865 P.2d 507, 509 (Wash. 1994).

Insurance Co., 893 A.2d 70, 76 (Pa. 2006). Following the Model Act, Article V addresses “the problems of interstate rehabilitation and liquidation by facilitating cooperation between states in the liquidation process, and by extending the scope of personal jurisdiction over debtors of the insurer outside this Commonwealth.” Section 501(c) of Article V, 40 P.S. §221.1(c).

Given Maine, Massachusetts, and Washington’s adoption of the UILA and Pennsylvania’s adoption of the similar Model Act, a single, cohesive, uniform handling of SHIP’s rehabilitation through a single state is consistent with the underlying policies sought to be served by those laws. Notably, the laws of Maine, Massachusetts and Washington also designate the domiciliary insurance commissioner as the receiver of an insurer undergoing liquidation or rehabilitation.¹⁵ The Intervening Regulators have presented no reason to set aside Pennsylvania’s primacy in SHIP’s receivership.

Nor does the Full Faith and Credit Clause require this Court to apply the insurance rate regulatory laws of Maine, Massachusetts, and Washington with respect to the establishment of the If Knew Premium rate in the Second Amended Plan. The purpose of the full faith and credit command

was to alter the status of the several states as independent foreign sovereignties, each free to ignore obligations created under the laws or by the judicial proceedings of the others, and to make them integral parts of a single nation throughout which a remedy upon a just obligation might be demanded as of right, irrespective of the state of its origin.

¹⁵ See 24-A Me. Stat. Ann. §4364; Mass. Gen. Laws Ann. 175 §180B; Wash. Rev. Code §48.99.020.

Baker by Thomas v. General Motors Corporation, 522 U.S. 222, 232 (1998) (citation omitted). Congress' Full Faith and Credit Act¹⁶ requires that "all courts ... treat a state court judgment with the same respect that it would receive in the courts of the rendering state." *Standard Chartered Bank v. Ahmad Hamad Al Gosaibi and Brothers Co.*, 99 A.3d 936, 941 (Pa. Super. 2014) (citing *Matsushita Electric Industrial Co. v. Epstein*, 516 U.S. 367, 373 (1996)).

The relevant precedent differentiates between the credit owed to *laws* and the credit owed to *judgments* under the Full Faith and Credit Clause. *Baker*, 522 U.S. at 232. The Full Faith and Credit Clause "does not compel a state to substitute the statutes of other states for its own statutes dealing with a subject matter [] which it is competent to legislate." *Id.* (citation omitted). Instead, "it is frequently the case under the Full Faith and Credit Clause that a court can lawfully apply either the law of one State or the contrary law of another." *Franchise Tax Board of California v. Hyatt*, 538 U.S. 488, 496 (2003) (*Hyatt I*). By contrast, "[a] final judgment in one State, if rendered by a court with adjudicatory authority over the subject matter and persons governed by the judgment, qualifies for recognition throughout the land." *Baker*, 522 U.S. at 233. A court may be guided by the forum state's public policy in determining the law applicable to a controversy,

¹⁶ It provides:

Such Acts, records and judicial proceedings or copies thereof, so authenticated, shall have the same full faith and credit in every court within the United States and its Territories and Possessions as they have by law or usage in the courts of such State, Territory or Possession from which they are taken.

28 U.S.C. §1738.

Likewise, the Pennsylvania legislature has enacted the Uniform Enforcement of Foreign Judgments Act, which defines "foreign judgment" as "any judgment, decree, or order of a court of the United States or of any other court requiring the payment of money which is entitled to full faith and credit in this Commonwealth." 42 Pa. C.S. §4306.

but there is no “public policy exception” to the full faith and credit due a court’s judgment. *Id.* at 233.

At issue here is whether the Second Amended Plan, if approved by this Court, would give full faith and credit to the insurance laws of Maine, Massachusetts, and Washington. The Court concludes that it would.

In *Carroll v. Lanza*, 349 U.S. 411 (1955), the United States Supreme Court considered a negligence action brought by a Missouri worker against a general contractor in Arkansas, where he sustained injuries. Both Missouri and Arkansas had enacted a workers’ compensation law that provided the exclusive remedy of the employee for a work-related injury. The Arkansas law, however, also allowed the injured employee to pursue common-law tort claims against a third party. The Supreme Court held that the Full Faith and Credit Clause did not make Missouri’s statute a bar to enforcement of Arkansas’ law. Arkansas had sufficient grounds to apply its own law because of its interest in protecting persons injured within its borders and, thus, “opened its courts to negligence suits against prime contractors, refusing to make relief by way of workmen’s compensation the exclusive remedy.” *Id.* at 412-13. In sum, Missouri law (compared with Arkansas Law) embodied “a conflicting and opposed policy,” and Arkansas law did not embody “any policy of hostility to the public Acts of Missouri.” *Id.* at 413.

Likewise, in *Hyatt I*, 538 U.S. 488, a former California resident who had moved to Nevada brought tort actions in Nevada state court against the California franchise tax board, alleging negligent misrepresentation, invasion of privacy, fraud, and other torts in connection with the board’s assessments and penalties for taxes he allegedly owed. The Nevada Supreme Court applied Nevada law, which gave state agencies immunity for negligence but not for intentional torts.

Accordingly, the Nevada Supreme Court ordered the trial court to dismiss the negligence claim for lack of jurisdiction but allowed the intentional tort claims to proceed to trial. The tax board appealed.

The United States Supreme Court upheld the Nevada Supreme Court's decision. The Court emphasized that the Full Faith and Credit Clause does not require one state to apply another state's law that violates its "own legitimate public policy." *Id.* at 497 (internal quotations omitted). Nevada's choice of law in that case did not "exhibi[t] a policy of hostility to the public Acts of a sister State." *Id.* at 499 (citing *Carroll*, 349 U.S. at 413). Further, Nevada had "sensitively applied principles of comity with a healthy regard for California's sovereign status" by "relying on the contours of Nevada's own sovereign immunity from suit as a benchmark for its analysis." *Id.* at 499.

Following remand, a jury found in the taxpayer's favor and awarded him almost \$500 million in damages and fees. The tax board again appealed to the Nevada Supreme Court, arguing that the Full Faith and Credit Clause required Nevada to limit damages to \$50,000, the maximum that Nevada law would permit in a similar suit against its own agencies. The Nevada Supreme Court affirmed \$1 million of the award. Instead of applying the Nevada statute applicable to suits against Nevada's own agencies, the Nevada Supreme Court applied a special rule for one case. On further appeal, the United States Supreme Court held that this decision of the Nevada Supreme Court violated the Full Faith and Credit Clause because it lacked the "healthy regard for California's sovereign status" and "reflect[ed] a constitutionally impermissible policy of hostility to the public Acts of a sister State." *Franchise Tax Board of California v. Hyatt*, 136 S.Ct. 1277, 1282-83 (2016) (*Hyatt II*) (citation omitted).

In the case *sub judice*, the evidence demonstrated that the Rehabilitator will use the If Knew Premium methodology in the implementation of the Plan. This methodology will assume a 60% lifetime loss ratio, which is the benchmark for a premium rate increase in Pennsylvania and most other states. The If Knew Premium methodology is used by insurance regulators nationwide to set long-term care insurance premium rates. The self-sustaining premium to be implemented in Phase Two of the Plan will likewise use a 60% lifetime loss ratio. *See* 31 Pa. Code §89a.117 (“Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least 60%[.]”).

A review of the insurance statutes of Maine, Massachusetts, and Washington shows that these sister states share Pennsylvania’s interest in ensuring that long-term care insurance premium rates are not excessive, unfairly discriminatory, or unreasonable in relation to the benefits provided under the policy.¹⁷ This commonly-shared interest will be advanced, rather than impaired, by the Second Amended Plan, which seeks to correct SHIP’s discriminatory premium rate structure; sets the premium rates to appropriate levels; and employs the If Knew

¹⁷ The Maine Insurance Code requires that the state insurance regulator determine that the rate filings on health insurance policies comply with “the requirements that rates not be excessive, inadequate or unfairly discriminatory.” 24-A Me. Stat. Ann. §2736. The insurance statute in Massachusetts provides that the insurance commissioner may “disapprove such form of policy if the benefits provided therein are unreasonable in relation to the premium charged, or if it contains any provision which is unjust, unfair, inequitable, misleading or deceptive, or which encourages misrepresentation as to such policy[.]” Mass. Gen. Laws Ann. Ch. 175 §108(8)(A). Likewise, the insurance statute in Washington provides that long-term care insurance rate increases are not permitted “if the benefits provided therein are unreasonable in relation to the premium charged.” Wash. Rev. Code §48.18.110. These standards are similar to the Pennsylvania standard for adjusting long-term care insurance premium rates. *See* Section 353 of The Insurance Company Law of 1921, Act of May 17, 1921, P.L. 682, *as amended, added by* the Act of June 23, 1931, P.L. 904, 40 P.S. §477a.

Premium methodology to establish a premium level that is reasonable in relation to the benefits paid.

Alternatively, under an Issue-State Rate Approval Option, a state may opt out of the rate approval section in the Plan. If a state opts out, the Rehabilitator will file an application to increase rates for policies issued in that state to the If Knew Premium level. The regulator for the opt-out state will render a decision on the Rehabilitator's rate increase application; if it is only partially approved, the Rehabilitator will downgrade the benefits under the affected policies accordingly. Cantilo testified that policyholders in an opt-out state will still have four options, although they are not exactly the same as those offered in the Second Amended Plan. This does not render the Issue-State Rate Approval Option "coercive" or "nominal," as the Intervening Regulators assert; rather, it provides the issue state with a meaningful way to control the mix of benefit reductions and premium rate increases. It prevents the opt-out state from interfering with Pennsylvania's ability to rehabilitate SHIP. In sum, the Second Amended Plan gives a "healthy regard" for the insurance laws of other states by "relying on the contours of [Pennsylvania insurance law] as a benchmark for its analysis." *Hyatt I*, 538 U.S. at 499.

The Second Amended Plan does not follow the ordinary rate review process for a solvent insurer, but it preserves the substantive rights of SHIP's policyholders to have their premium reviewed by a qualified actuary and an insurance regulator to ensure that the rate is actuarially justified and reasonable in relation to the benefits. The Plan changes the forum for the premium determinations to the state responsible for the rehabilitation of SHIP, *i.e.*, Pennsylvania. The conflict between Pennsylvania law and the laws of Maine, Massachusetts, and Washington, if any, is one of procedure, to which this Court owes no deference. *See*

Wilson v. Transport. Ins. Co., 889 A.2d 563, 571 (Pa. Super. 2005) (citation omitted) (the “choice of law” analysis applies only to conflicts of substantive law, which “creates the rights and duties of the parties to a judicial proceeding”).

The insistence of the Intervening Regulators that the Rehabilitator submit rate increase applications to 46 states, the District of Columbia, and the U.S. Virgin Islands renders a rehabilitation of SHIP an impossibility. Pennsylvania has a compelling interest in enforcing Article V, which protects “the interests of insureds, creditors, and the public generally” through

(i) early detection of any potentially dangerous condition in an insurer, and prompt application of appropriate corrective measures; (ii) improved methods for rehabilitating insurers, involving the cooperation and management expertise of the insurance industry; (iii) enhanced efficiency and economy of liquidation, through clarification and specification of the law, to minimize legal uncertainty and litigation; (iv) equitable apportionment of any unavoidable loss; (v) lessening the problems of interstate rehabilitation and liquidation by facilitating cooperation between states in the liquidation process, and by extending the scope of personal jurisdiction over debtors of the insurer outside this Commonwealth; and (vi) regulation of the insurance business by the impact of the law relating to delinquency procedures and substantive rules on the entire insurance business.

Section 501(c) of Article V, 40 P.S. §221.1(c) (emphasis added).¹⁸ Furthermore, as this Court observed in *Mutual Fire I*,

the benefits of rehabilitation—its flexibility and avoidance of inherent delays—are preferable to the static and cumbersome procedures of statutory liquidation. The statute’s purpose is, in the end, that to which we must give effect. That legislatively

¹⁸ Section 501(b) of Article V states that its provisions “shall be liberally construed to effect the purpose stated in subsection (c).” 40 P.S. §221.1(b).

stated purpose is “the protection of the interests of insureds, creditors, and the public generally....” and the “equitable apportionment of any unavoidable loss” through, *inter alia*, “improved methods for rehabilitating insurers....” Section 501 of the Act, 40 P.S. §221.1. No interest is served by adding to the delay which has already occurred in this case. On the contrary, the goals of Article V of the Act are better served by a rehabilitation which effectively ensures more distribution in a shorter period of time than would occur in liquidation.

572 A.2d at 803.

Here, the evidence established that the ordinary rate filing process often involves 6 to 12 months of preparation and years of review in some states. “No interest is served by adding to the delay which has already occurred in this case.” *Mutual Fire I*, 572 A.2d at 803. Further, a state-by-state rate filing process would not address the inconsistent rate approvals from state insurance regulators, which leave SHIP with less revenue than needed and similarly situated policyholders paying vastly different premiums for the same coverage. Cantilo credibly testified that the Plan’s premium rate methodologies and approval mechanisms are necessary to address the inequities in SHIP’s current rate structure. The use of the If Knew Premium across all policies will put all policyholders on a level playing field because it is calculated on a seriatim basis.

In sum, under Article V, the Rehabilitator has the authority to propose, and this Court has the authority to approve, the Second Amended Plan’s provisions regarding the establishment of premium rates for the four policyholder options in Phase One. The Full Faith and Credit Clause does not require the Rehabilitator to submit these premium rates to 46 states, the District of Columbia, and the U.S. Virgin Islands for their review and approval. This would fracture Pennsylvania’s “own legitimate public policy” in the rehabilitation of SHIP, a Pennsylvania-

domiciled insurer. *Hyatt I*, 538 U.S. at 497. In no way does this aspect of the Second Amended Plan reflect “a policy of hostility to the public Acts of a sister State.” *Id.* at 499. To the contrary, the interests of Maine, Massachusetts, and Washington in ensuring that long-term care insurance premium rates are not excessive, unfairly discriminatory, or unreasonable to the benefits provided will be advanced, rather than impaired, by the Plan.

Finally, the Court rejects the Intervening Regulators’ arguments on comity. Application of comity is “a matter of judicial discretion,” and Pennsylvania courts exercise comity “when application of another state’s law contradicts no public policy of Pennsylvania and instead furthers a Pennsylvania policy.” *Chestnut v. Pediatric Homecare of America, Inc.*, 617 A.2d 347, 350 (Pa. Super. 1992). The Plan has “sensitively applied principles of comity with a healthy regard” for the insurance laws of other states by “relying on the contours of [Pennsylvania insurance law] as a benchmark for its analysis.” *Hyatt I*, 538 U.S. at 499.

Once this Court renders a judgment on the Second Amended Plan, it is Maine, Massachusetts, and Washington that owe this Court’s judgment full faith and credit. *See Underwriters National Assurance Co. v. North Carolina Life and Accident and Health Insurance Guaranty Association*, 455 U.S. 691 (1982). *See also* 1 COUCH ON INSURANCE 3d §5:31 (discussing state court’s violation of Full Faith and Credit Clause by refusing to treat prior judgment of another state’s insurance rehabilitation court as *res judicata*).

2. The Plan Satisfies all Constitutional Requirements

The Intervening State Insurance Regulators argue that the Second Amended Plan is unconstitutional because it does not satisfy the standard that “[c]reditors and policyholders must fare at least as well under a rehabilitation plan

as they would under a liquidation.” *Koken v. Fidelity Mutual Life Insurance Co.*, 803 A.2d 807, 826 (Pa. Cmwlth. 2002) (citing *Neblett v. Carpenter*, 305 U.S. 297 (1938)). In applying the *Carpenter* standard, this Court is guided by the three-part test adopted in *Mutual Fire II*.¹⁹ The “threshold inquiry” is whether the state action “has operated to substantially impair a contractual relationship” in violation of Article I, Section 10 of the United States Constitution and Article I, Section 17 of the Pennsylvania Constitution.²⁰ *Mutual Fire II*, 614 A.2d at 1094 n.4. An impairment of contractual rights is not a *per se* violation of law. *Id.* If a particular policyholder is found to be worse off under a rehabilitation plan, the impairment could be considered “substantial,” but the Court still needs to determine whether (1) the rehabilitator has acted for a legitimate and significant public purpose and (2) the adjustment of contractual rights is reasonable and of a nature appropriate to that public purpose. *Id.* To that end, the Court must be mindful that Article V is intended to protect “the interests of insureds, creditors, and the public generally[.]” Section 501(c) of Article V, 40 P.S. §221.1(c).

i. The Plan Satisfies Pennsylvania’s Interpretation of *Carpenter*

Under the so-called “*Carpenter* test,” a rehabilitation plan should be confirmed if creditors will fare at least as well under the plan as they would in liquidation. *Mutual Fire II*, 614 A.2d at 1093-94. As our Supreme Court has

¹⁹ Several of the objectors to the Mutual Fire rehabilitation plan argued that the plan impaired their contractual rights. In analyzing their argument, our Supreme Court expressly adopted the three-part test announced by the United States Supreme Court in *Energy Reserves Group, Inc. v. Kansas Power and Light Co.*, 459 U.S. 400, 411 (1983), for determining when a state law may impair a contractual right. *Mutual Fire II*, 614 A.2d at 1094 n.4. Thus, whether an alleged contractual impairment is caused by a receiver’s workout plan or a statute, the analysis is the same.

²⁰ Article I, Section 10 of the United States Constitution states, in pertinent part: “No State shall ... pass any ... Law impairing the Obligation of Contracts[.]” U.S. CONST. art. 1, §10. Article I, Section 17 of the Pennsylvania Constitution states: “No ... law impairing the obligation of contracts ... shall be passed.” PA. CONST. art. I, §17.

explained, this does not mean that every single policyholder must satisfy that test. *See id.* at 1102 (“individual interests might have to be sacrificed or compromised in order to preserve the ultimate goal of [the rehabilitation] process[.]”); *see also Penn Treaty*, 63 A.3d at 453 (“[*Carpenter*] did not establish the broad principle that a rehabilitation plan is *per se* invalid unless every policyholder will fare as well in rehabilitation as in liquidation.”). Instead, the Court is guided by the three-part test established by *Mutual Fire II. Penn Treaty*, 63 A.3d at 453.

Under that test, if a particular policyholder is found to be worse off under a rehabilitation plan than in liquidation, and that impairment is “substantial,” the Court should confirm the plan so long as the Rehabilitator has acted for a legitimate and significant public purpose and the contractual modification is reasonable and appropriate to that public purpose. *Id.* In this regard, “[t]he Court must consider the greater good, including the consequences to the larger class of policyholders and the taxpaying public.” *Id.* (citing *Vickodil v. Insurance Department*, 559 A.2d 1010, 1013 (Pa. Cmwlth. 1989)).

The Second Amended Plan meets that test. Even assuming, *arguendo*, that the Plan substantially impairs policies, it serves a legitimate and significant public purpose, and the policy modifications are reasonable and appropriate to that purpose. At the hearing, Special Deputy Rehabilitator Cantilo aptly observed:

And the question that we were debating [was], is it reasonable, if a policyholder has been paying a quarter for a dollar’s worth of insurance for decades, to adopt, as the workout plan, a plan in which the taxpayers step up to pay their remaining 75 cents.

And what we concluded is that we could right size the policy, and we could create a set of options for policyholders that would enable them to get fundamental [long term care] coverage but pay reasonable rates like the rest of the country for that coverage and not shift all that burden to the taxpayers.

N.T., 5/17/2021, at 78-79. In short, the Plan narrows the Funding Gap, promotes fairness and equity among policyholders, and appropriately balances the interests of the policyholders and the broader taxpaying public.

ii. The Intervening Regulators' Interpretation of *Carpenter* is Flawed

The Intervening Regulators urge a rigid application of *Carpenter*, *i.e.*, that all policyholders must fare as well in rehabilitation as they would in liquidation. To that end, the Intervening Regulators compared the net present value of the benefits policyholders will receive under the Second Amended Plan with the net present value of the benefits they can expect to receive in a liquidation. Notably, the Court in *Carpenter* was comparing the cash payment to policyholders under a rehabilitation plan with the cash payment they would receive in a liquidation, at a time when there was no guaranty association protection for policyholders. Here, the alternatives are not cash payments but continued insurance coverage. The value comparison of coverage to SHIP policyholders in a rehabilitation as compared to a liquidation cannot be reduced to dollar amounts.

The Intervening Regulators' metric is one not actually used by policyholders when making the decision to purchase long-term care insurance. As testimony from Cantilo and Bodnar established, consumers choose their policy benefits and limits according to their personal circumstances. For example, a policyholder may wish to protect his estate against dissipation by an extended stay in a nursing home. Each policyholder will have different goals and different financial situations that will affect the type and amount of coverage they purchase. Not a single witness testified that the liquidation value of a policy figures into this analysis. Cantilo and Bodnar opined that the comparison methodology policyholders use is the maximum policy value, not the *Carpenter* value. Cantilo

provided compelling examples of actual SHIP policyholders whose *Carpenter* value, using the Intervening Regulators’ proposed net present value metric, would, in fact, produce a poor option for that policyholder. *See* Ex. RP-56 at 102-03. The Court credits Cantilo’s statement that “[t]here are many cases where the raw projection of future benefits less future premiums [doesn’t] really tell you what the real value of the policy is.” N.T., 5/17/2021, at 177.

In any event, even under the Intervening Regulators’ metric, 85% of SHIP policyholders will be offered one option with a value equal to or higher than the value of the policy they will have in liquidation. Several other metrics produced even higher percentages of policyholders who will fare at least as well under the Plan as in liquidation.

3. The Plan is Feasible to the Extent Required by Pennsylvania Law

The Intervening Regulators argue that the Second Amended Plan is not feasible because it is unlikely to eliminate the Funding Gap and restore SHIP to solvency. To begin, there is no statutory requirement in Pennsylvania that a rehabilitation plan must be “feasible” in order to be approved, nor has that standard been adopted in our decisional law. The only reference to feasibility anywhere in Pennsylvania law occurred in the Mutual Fire receivership during the implementation of an already approved rehabilitation plan. *Mutual Fire II*, 614 A.2d 1086. The Intervening Regulators have not cited any other case in which “feasibility” appears. Notably, in *Mutual Fire*, the rehabilitator raised “feasibility” to support a request to modify the Court-approved rehabilitation plan. *Id.* at 1090. The Intervening Regulators’ attempt to read a non-existent pre-approval “feasibility” requirement into Article V has no support in *Mutual Fire II*.

The Intervening Regulators argue that a “feasible” rehabilitation plan must be “reasonably likely to succeed in restoring the company to solvency” in order to be approved. Intervening Regulators’ Post-Hearing Memorandum at 5.

First, the Court notes that the meaning of “company solvency” is context specific. The peak of SHIP’s activity in the insurance marketplace was in the late 1990s, when it had more than 300,000 policies in force. N.T., 5/17/2021, at 40; Ex. RP-56 at 18. By 2003, when SHIP discontinued writing new business and went into run-off, the number of policies in force was already in a steep decline. N.T., 5/17/2021, at 40; Ex. RP-56 at 18. The Second Amended Plan, if successful, will restore SHIP to what it was pre-receivership, *i.e.*, an insurer winding down its long-term care insurance business and able, as a going concern, to continue coverage and pay the claims of its existing policies. The Court rejects the Intervening Regulators’ suggestion that a return to solvency by SHIP requires more than a return to its pre-receivership status. SHIP had long ceased being an active and growing presence in the insurance marketplace.

Second, the Pennsylvania Supreme Court has stated that “[s]o long as the rehabilitation properly conserves and equitably administers ‘the assets of the involved [insurer] in the interest of investors, the public and others, (with) the main purpose being the public good’ the plan ... is appropriate.” *Mutual Fire II*, 614 A.2d at 1094 (quoting 2A COUCH ON INSURANCE 2d §22.10). Simply, the Court rejected the notion that a rehabilitation plan must contemplate a resuscitation of the insolvent insurer’s operations.

Under any outcome, the Second Amended Plan will materially reduce the Funding Gap and significantly improve SHIP’s financial condition. The Intervening Regulators offered no substantive evidence to overcome the

Rehabilitator's evidence on this issue. The Intervening Regulators correctly point out that the ultimate goal of the Mutual Fire rehabilitation plan was to restore the company to solvency. The Second Amended Plan has, as its ultimate goal, SHIP's return to solvency. It "does not have to restore the company to its exact original condition." *Mutual Fire II*, 614 A.2d at 1094.

Further, as a matter of public policy the rehabilitation of an insurer, where possible, is the preferred course. *Penn Treaty*, 63 A.3d at 440 (recognizing liquidation as a remedy of last resort); *Koken v. Legion Insurance Co.*, 831 A.2d 1196, 1230 (Pa. Cmwlth. 2003) (same); and *Mutual Fire II*, 614 A.2d at 1094 (same). As this Court explained, "a liquidation, no matter how 'successful,' is certain to cause harm to the policyholders, creditors and taxpaying public[.]" *Penn Treaty*, 63 A.3d at 461.

In summary, Article V does not require the Second Amended Plan be "feasible" in order to be approved, and the Intervening Regulators' arguments to the contrary simply voice a disagreement with the Rehabilitator's exercise of discretion. The Plan will eliminate or reduce the Funding Gap, which is a legitimate purpose. The ultimate goal of the Second Amended Plan is to return SHIP to the level of solvency needed to run-off its long-term care insurance business.

4. The Plan is Fair and Equitable

As stated, SHIP's current premium rate structure is unfairly discriminatory because policyholders with substantially similar coverage are not paying the same premium, thereby burdening some policyholders with subsidizing the premium payments of other policyholders. This Court has recognized that eliminating these unfair "subsidies between policyholders in different states and

between different groups of policyholders” is itself a legitimate goal of rehabilitation. *Penn Treaty*, 63 A.3d at 443, 460.

The Intervening Regulators argue that unless the Plan maintains SHIP’s current unequal treatment of policyholders on a state-by-state basis, then the Plan is unlawful. The Intervening Regulators’ position fails for several reasons.

First, the Intervening Regulators lack standing to assert the claim that the Plan treats “policyholders in different States differently.” Intervening Regulators’ Post-Hearing Memorandum at 32. They expressly disavowed that they were appearing in a *parens patriae* or other representative capacity for policyholders in their states. N.T., 5/19/2021, at 541-47. Even so, the Intervening Regulators failed to present any evidence showing how policyholders in their respective states would be unfairly treated by the Plan’s proposal to eliminate unfair subsidies between groups of policyholders.

Second, the Plan will end the existing unequal treatment of similarly situated policyholders. The Intervening Regulators strain to characterize some policyholders as receiving “more” by “suffering smaller benefit cuts” when compared to other policyholders receiving “less” by “suffering greater benefit cuts.” Intervening Regulators’ Post-Hearing Memorandum at 38. This is a function of the fact that many policyholders presently pay an inadequate premium. The Court rejects the Intervening Regulators’ characterization of right sizing premium to policy coverage as itself an act of unequal treatment.

To eliminate the unfair subsidies between policyholders, the change in rates or coverages will have a greater impact on the more underpriced (and over-subsidized) policies that have benefited at the expense of other policyholders. The Plan will require similarly situated policyholders to pay the same premium coverage.

The Plan's elimination of unfair subsidies between policyholders aligns with this Court's precedent in the Penn Treaty receivership, which recognized that a rehabilitation plan may properly eliminate such subsidies. *Penn Treaty*, 63 A.3d at 443, 460.

Third, the Intervening Regulators improperly invoke Section 544(b) of Article V, 40 P.S. §221.44(b), which states that no subclasses may be created within the policyholder class in a liquidation. As a threshold matter, this is a rehabilitation, not a liquidation. More fundamentally, the Plan does not give "some policyholders greater consideration than others." Intervening Regulators' Post-Hearing Memorandum at 35. To the contrary, the Second Amended Plan treats similarly situated policyholders the same regardless of the state in which their policy was issued.

D. Other Concerns and Objections Raised at the Hearing are Overruled or Have Been Adequately Addressed

1. Intervening Regulators' Application for Reconsideration

At the close of the hearing on May 21, 2021, this Court granted the Rehabilitator's oral motion "for judgment in the nature of a directed verdict" against the Intervening Regulators regarding the Issue State Rate Approval Option in the Second Amended Plan. N.T., 5/21/2021, at 981. The Rehabilitator argued that the Intervening Regulators did not present any evidence that their interests would be harmed by the Issue State Rate Approval Option, and as such, their objection to the Issue State Rate Approval Option cannot serve as a basis for this Court to disapprove the Plan. *Id.* at 986-88.

On June 1, 2021, the Intervening Regulators filed an application for reconsideration for the stated reason that the Rehabilitator's motion was vague, was made without notice and lacked support in the applicable court rules. More

specifically, the Intervening Regulators contend that the term “[I]ssue [S]tate [R]ate [A]pproval [O]ption” is not “meaningful,” as “it is impossible to tell” whether it was referring to the “opt-out” provision under the Second Amended Plan. Application for Reconsideration at 7. They also contend that a motion for a directed verdict can be filed only in a “jury case” or an “adversarial proceeding,” which is not the case here. *Id.* at 8, 12. Even so, to grant a motion for a directed verdict requires this Court to consider “all of the evidence before it in the light most favorable to the [Intervening] Regulators.” *Id.* at 14. They assert that the Rehabilitator’s motion “[f]ails on the [r]ecord” because Cantilo and Bodnar testified that the Plan seeks to “supersede the existing state rate approval system,” which would impact state regulators and policyholders. *Id.* at 14-15. The Intervening Regulators’ arguments are not persuasive.

To begin, the Rehabilitator’s motion for a directed verdict was not vague. In moving for a directed verdict, the Rehabilitator’s counsel stated that “the [Intervening Regulators] have failed to put on any evidence which would or could support an interest they purport to represent with respect to the issue[] state rate approval option.” N.T., 5/21/2021, at 981-82. Counsel went on to assert that “absent any testimony as to the ways in which a regulator is constrained or harmed by that option, the [Intervening Regulators] here have no argument to present which would show that [the option] does not sufficiently address the concerns that they have raised at some earlier stage in these proceedings.” *Id.* at 986. The Intervening Regulators objected to the motion for the reason that granting a directed verdict would be improper under the circumstances as the case presents “significant open legal issues.” *Id.* 989. The Rehabilitator’s counsel responded:

To be clear, we’re only seeking the directed verdict on the [I]ssue [S]tate [R]ate [A]pproval [O]ption issue. I don’t have here where

it was raised in the memorandum. We're not seeking a directed verdict as to, generally, the questions of whether the [P]lan is fair and equitable or the exercise of the [R]ehabilitator's discretion generally. This is a narrow motion, Your Honor, on the [I]ssue [S]tate [R]ate [A]pproval [O]ption and the opt-out offer thereunder[.]

Id. at 991.

After hearing arguments from both parties, the Court granted the motion. It stated that “there is an opt-out option that preserves the right of the [] ... state of issue to pursue a state rate approval powers and [Intervening Regulators’] witness did not address why the [P]lan was deficient ... in that way.” *Id.* at 994. In short, the motion was not vague.

This Court also rejects the Intervening Regulators’ argument that the Rehabilitator’s motion for a directed verdict lacked due notice. The Intervening Regulators do not cite, and this Court did not find, any legal authority which would have required such notice. The Rehabilitator did not need to disclose her litigation strategy at the hearing with the Intervening Regulators. In any event, the Intervening Regulators were given an opportunity to file with this Court an application for reconsideration, which they did on June 1, 2021.

Nor did the Intervening Regulators cite any legal authority to support their proposition that a directed verdict can only be entered in a jury trial. Notably, the Intervening Regulators’ proposition is at odds with their earlier position that this Court should have ruled on the legal issues before holding an evidentiary hearing on the Second Amended Plan.

Pennsylvania Rule of Appellate Procedure 106 provides:

Unless otherwise prescribed by these rules the practice and procedure in matters brought before an appellate court within its original jurisdiction shall be in accordance with the appropriate

general rules applicable to practice and procedure in the courts of common pleas, so far as they may be applied.

PA. R.A.P. 106. However, the Intervening Regulators point to Pennsylvania Rule of Appellate Procedure 3783(b), which provides that “[t]he Pennsylvania Rules of Civil Procedure shall apply to adversarial proceedings.”²¹ PA. R.A.P. 3783(b). Because an action to rehabilitate an insurer pursuant to Article V is a “formal proceeding,” not an “adversarial proceeding,” PA. R.A.P. 3772(f), the Intervening Regulators argue that it is not subject to the Rules of Civil Procedure.

The Intervening Regulators overlook the precept that the Court has discretion to conduct a statutory proceeding as is expedient and appropriate to move the case to a conclusion in a methodical fashion. *See, e.g., In re Tax Sale Held September 10, 2003 by Tax Claim Bureau of County of Lackawanna*, 859 A.2d 15, 18 (Pa. Cmwlth. 2004) (recognizing that while a trial court is not required to use the Pennsylvania Rules of Civil Procedure in tax sale proceedings, it has discretion to use the Rules of Civil Procedure where appropriate).

Here, the Rehabilitator seeks approval of the Second Amended Plan in this Court’s original jurisdiction.²² Pennsylvania Rule of Civil Procedure 226(b)

²¹ Rule 3772(c) defines “adversarial proceeding” as

[a]ny action (1) initiated by the rehabilitator or liquidator against persons other than the insurer, (2) asserting a right or interest afforded by Article V and for which neither Article V nor prior orders of the Court provide an avenue for redress, and (3) that the Court determines shall be governed by Pa. R.A.P. 3783 (adversarial proceedings) as an adversarial proceeding.

PA. R.A.P. 3772(c). Pennsylvania Rules of Appellate Procedure 3771 to 3784 (Summary and Formal Proceedings Against Insurers) apply to all actions in the Commonwealth Court arising under Article V. PA. R.A.P. 3771-3784.

²² 42 Pa. C.S. §761(a)(3) (This Court has “original jurisdiction of all civil actions or proceedings ... [a]rising under Article V of the act of May 17, 1921 (P.L. 789, No. 285), known as ‘The Insurance Department Act of 1921.’”).

provides that a trial court may, “[a]t the close of all the evidence ... direct a verdict upon the oral or written motion of any party.” PA. R.C.P. No. 226(b). This Court has affirmed the entry of a directed verdict following a single-judge bench trial. *See, e.g., Geschwindt v. Wagner*, 1 A.3d 970 (Pa. Cmwlth. 2010) (affirming directed verdict entered by trial court following bench trial). This Court has entered directed verdicts in matters brought within its original jurisdiction. *See, e.g., Pennsylvania Human Relations Commission v. School District of Philadelphia*, 651 A.2d 177 (Pa. Cmwlth. 1993) (granting a school district’s motion for a directed verdict by treating it as a motion for a compulsory nonsuit²³ against the Pennsylvania Human Relations Commission on the ground that it had failed to demonstrate that mandatory desegregation measures were feasible).

A directed verdict can be entered in one of two circumstances:

one, the movant is entitled to judgment as a matter of law and/or two, the evidence is such that no two reasonable minds could disagree that the outcome should have been rendered in favor of the movant. With the first, the court reviews the record and concludes that, even with all factual inferences decided adverse to the movant, the law nonetheless requires a verdict in his favor. Whereas with the second, the court reviews the evidentiary record and concludes that the evidence was such that a verdict for the movant was beyond peradventure.

Hall v. Episcopal Long Term Care, 54 A.3d 381, 395 (Pa. Super. 2012) (quoting *Campisi v. Acme Markets, Inc.*, 915 A.2d 117, 119 (Pa. Super. 2006)).

²³ While the trial court may, “[a]t the close of all the evidence ... direct a verdict upon the oral or written motion of any party,” PA. R.C.P. No. 226 (emphasis added), “the court, on oral motion of the defendant, may enter a nonsuit on any and all causes of action if, *at the close of the plaintiff’s case on liability*, the plaintiff has failed to establish a right to relief.” PA. R.C.P. No. 230.1(a)(1) (emphasis added).

The issue raised in the Rehabilitator's motion for a directed verdict is a narrow one: whether the Issue State Rate Approval Option is unlawful as the Intervening Regulators alleged. This is a mixed question of law and fact. The Intervening Regulators assert that the Issue State Rate Approval Option is coercive and provides them with no meaningful review of the rate filings. In their application for reconsideration, the Intervening Regulators contend that the "opt-out" provision cannot be "separated from the larger concern over superseding [s]tate rate approval statutes[.]" Application for Reconsideration at 7.

The Intervening Regulators did not present any evidence to support their challenge to the opt-out provision of the Plan. Cantilo credibly testified that if a state chooses to exercise the Issue State Rate Approval Option, the Rehabilitator will file an application on a seriatim basis to increase rates for policies issued in that state. The Intervening Regulators assert that the requirement that opt-out states act within 60 days and review the rate filings on a seriatim basis is "inconsistent" with "state practices." Application for Reconsideration at 16. However, no evidence in the record supports this claim.

In sum, the Intervening Regulators did not show that the Issue State Rate Approval Option is unconstitutional or otherwise is harmful to their interests. Collectively, those interests involve approximately 2,000 of the 39,000 policyholders affected by the Plan. Ex. RP-22 at 2. This Court properly entered a directed verdict on the Intervening Regulators' objection to the Issue State Rate Approval Option. However, this Court disagrees with the Rehabilitator's proposition that the Intervening Regulators should be dismissed from the rehabilitation proceeding. The Rehabilitator's motion was a narrow one, as was this Court's order granting the motion.

For the foregoing reasons, this Court denies the Intervening Regulators' application for reconsideration.

2. Policy Restructuring

NOLHGA and Lapinski raised concerns about the policy restructuring provisions in the Second Amended Plan that impact SHIP's tax liability. The restructuring will address potential taxable income owed by SHIP for cancellation of indebtedness and will bifurcate policy liabilities into funded and unfunded portions. This policy restructuring will not affect coverage for policyholders either now or in the event of a liquidation. Cantilo testified that the restructuring does not affect policyholder choices and will not be performed on a seriatim basis. N.T., 5/17/2021, at 143.

As a result of the concerns raised at the hearing, the Rehabilitator will file a separate application with this Court to address the restructuring and tax issues. N.T., 5/21/2021, at 996. All parties will have an opportunity at that point to raise objections.

3. Policyholder Communications

NOLHGA raised concerns regarding policyholder communications, especially with respect to information related to guaranty associations and their coverage limit. However, NOLHGA's president and fact witness, Peter Gallanis, acknowledged that the Rehabilitator has not refused to engage with NOLHGA regarding its concerns with the Plan or consider NOLHGA's proposed changes. N.T., 5/20/2021, at 686. NOLHGA is free to propose modifications to the Plan and continue to communicate with the Rehabilitator, as NOLHGA has done to date. Gallanis acknowledged that the Rehabilitator is a "capable commissioner" who understands the "important aspects" of the guaranty association system. *Id.* at 680.

4. COVID-19 Pandemic

Policyholder James Lapinski raised concerns regarding the impact of COVID-19 on long-term care insurance experience through higher mortality and lower claim incidence. With regard to this issue, Cantilo credibly testified that SHIP has experienced a moderate increase in mortality since the beginning of the pandemic in 2020, which generated a moderate increase in lapses of policies. The pandemic also caused a small increase in morbidity and adversely affected SHIP's expected yield on invested assets. However, the actuarial report prepared by Oliver Wyman shows that the aggregate effects of the pandemic had a moderate impact on SHIP's financial condition and are not material to the implementation of the Second Amended Plan. N.T., 5/17/2021, at 26; N.T., 5/21/2021, at 944.

Lapinski requested that the Second Amended Plan's discussion on COVID-19 be updated with more recent data. Oliver Wyman's actuarial report noted the evolving nature of COVID-19's impact and stated that while certain assumptions "were developed based on claims data predating the effects of COVID-19[,] [the actuarial team] will consider the effects of COVID-19 when [they] update [their] actuarial assumptions in 2021." Ex. RP-16 at 28. As Bodnar testified, upon approval of the Plan, Oliver Wyman will prepare an actuarial memorandum in support of the If Knew Premium rates, similar to one that would ordinarily be submitted to state regulators in a rate increase filing. All parties will have an opportunity at that point to raise objections.

5. Funding Gap and SHIP's Balance Sheet

Lapinski questioned the size of SHIP's Funding Gap and the decline of SHIP's capital and surplus and value of its bond holdings as reflected in its balance sheet ending December 31, 2020. In that regard, Cantilo provided extensive

testimony on SHIP's hazardous financial condition, the causes of SHIP's insolvency, and the actions taken by the Pennsylvania Insurance Department prior to rehabilitation. The evidence that the Second Amended Plan will substantially reduce the Funding Gap and address SHIP's inequitable rate structure was extensive. As for the decline in the value of SHIP's bond holdings, Cantilo credibly explained that it was due to a decline in yield in the markets in which SHIP's bonds were invested, which added to SHIP's deficit from 2019 to 2020. N.T., 5/21/2021, at 950-51.

6. Timing

Finally, Lapinski raised concerns with the timing of the rehabilitation proceeding and stated his desire for SHIP to avoid the lengthy process that Penn Treaty went through prior to liquidation. This Court shares Mr. Lapinski's desire to address SHIP's financial condition swiftly, as does the Rehabilitator. Cantilo testified that the Plan can be implemented quickly: within eight months of approval, the Rehabilitator anticipates receiving policyholder elections, which will enable her to measure the precise impact of Phase One on SHIP's Funding Gap. N.T., 5/18/2021, at 339-40.

V. Conclusions of Law

1. The Rehabilitator is authorized to "take such action as he deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate the insurer." Section 516(b) of Article V, 40 P.S. §221.16(b). This includes preparing "a plan for the reorganization, consolidation, conversion, reinsurance, merger or other transformation of the insurer." Section 516(d) of Article V, 40 P.S. §221.16(d).

2. Upon application of the Rehabilitator for approval of a plan of rehabilitation, and after notice and a hearing thereon, "the court may either approve

or disapprove the plan proposed, or may modify it and approve it as modified. If it is approved, the rehabilitator shall carry out the plan.” Section 516(d) of Article V, 40 P.S. §221.16(d).

3. “[I]t is not the function of the courts to reassess the determinations of fact and public policy made by the Rehabilitator[]” in formulating a plan of rehabilitation. *Mutual Fire II*, 614 A.2d at 1091. “Rather, the involvement of the judicial process is limited to the safeguarding of the plan from any potential abuse of the Rehabilitator’s discretion.” *Id.*

4. The Rehabilitator’s evidence established that the Second Amended Plan will conserve and equitably administer the assets of SHIP in the interest of policyholders, creditors and the public, “with the main purpose being the public good.” *Id.* at 1094. The Plan is designed to return SHIP to its pre-receivership status as a run-off company able to meet its obligations as they come due.

5. The Rehabilitator’s evidence established that the Second Amended Plan will reduce or eliminate the Funding Gap and eliminate SHIP’s inequitable and discriminatory premium rate structure by offering policyholders meaningful choices to modify their long-term care insurance policies.

6. The Rehabilitator’s evidence established that policyholders will fare as well or better under the Second Amended Plan than they would in liquidation. The Plan will provide the benefits of rehabilitation, such as flexibility and the accelerated disposition of claims, which is preferable to the static procedures of liquidation.

7. The Rehabilitator is authorized under Article V to establish actuarially sound premium rates for SHIP policyholders, as needed to rehabilitate

SHIP, and without the additional approval of the state insurance department where the policy was initially issued.

8. The Rehabilitator did not abuse her discretion in formulating the Second Amended Plan.

VI. Conclusion

The Rehabilitator has made a compelling case in support of her Second Amended Plan of Rehabilitation. Indeed, her evidence was not contradicted on any material fact. The Intervening Regulators suggest that they would have exercised their discretion differently, but this is not a basis for the Court to disapprove the Plan.

The opposition of the Intervening Regulators is based upon their belief that the state-by-state regulation of premium rates must be the starting point of any plan to rehabilitate an insolvent insurer. The Court has several responses.

First, the standard for an appropriate premium rate is substantially the same in every state: the premium must be reasonable in relation to the coverage provided in the policy. The evidence presented at the hearing demonstrated that the premium rates used in the four options in Phase One of the Second Amended Plan will satisfy that standard. The Rehabilitator will be tasked with proving satisfaction of that standard in her actuarial memorandum. The Intervening Regulators presented no evidence that she cannot or will not be able to do so.

Second, the Issue State Rate Approval Option preserves the state-by-state procedure for those states that share the concerns of the Intervening Regulators. To the extent a state does not believe that the Rehabilitator, and this Court, should be solely responsible for the task of establishing the seriatim premiums used for the four policyholder options in Phase One, the state can assume responsibility to do so by opting out of this aspect of the Second Amended Plan.

Neither SHIP's policies nor state rate regulatory statutes insulate policyholders from paying a reasonable premium for their coverage. To the contrary, they require the opposite. The Second Amended Plan will advance, not undermine, a reasonable and non-discriminatory premium rate structure, which is the point of rate regulation.

Essentially, the Intervening Regulators exalt the process by which insurance premium rates are set over the rehabilitation of an insolvent insurer whose condition was caused by an inadequate and discriminatory premium structure. As was established by the Rehabilitator's evidence, a rehabilitation of SHIP cannot be accomplished by placing the correction of the company's premium rates into the hands of 46 states.

In all respects, the Second Amended Plan satisfies applicable constitutional requirements. Neither the Full Faith and Credit Clause nor principles of comity require this Court to apply the insurance rate regulatory laws of other states when considering a plan to rehabilitate SHIP, a Pennsylvania domiciled insurer in receivership. Nevertheless, the Second Amended Plan, consistent with Article V, does not evidence "a policy of hostility" to the laws of sister states. Rather, it advances their shared interests in insurance premium rates that are not unfairly discriminatory and reasonable in relation to the benefits provided in the policy.

The Intervening Regulators support a liquidation because it will require guaranty associations to solve SHIP's Funding Gap. However, a liquidation will do nothing to address SHIP's discriminatory premium structure. As NOLHGA's actuary, Matthew Morton, explained, guaranty associations can make rate filings with the state of issue but only on a cohort basis, for the segment of policies covered by the filing guaranty association. As a consequence, Morton opined that in a

liquidation, many SHIP policyholders will pay more than the If Knew Premium rate for their coverage while others will pay less. Guaranty associations have no opportunity to propose or implement the seriatim If Knew Premium rate that is central to the Second Amended Plan's correction of the current inadequate and discriminatory premium rate structure. This reason alone supports the Rehabilitator's decision not to liquidate SHIP.

There is nothing unfair about expecting every policyholder to pay an actuarially justified premium for their coverage. That is expected in any insuring system. In the case of SHIP, it will not happen in the absence of the implementation of the Second Amended Plan.

The Rehabilitator has persuaded the Court that rehabilitation is preferred for another reason. A liquidation will place the burden of an actuarially justified premium upon the policyholders of member insurers of the applicable guaranty associations and, ultimately, upon the taxpayers in those states. No one has provided the Court with an explanation as to why, as a matter of policy, the premium burden of SHIP's policyholders should be borne by others.

For these reasons, the Court rejects the arguments of the Intervening Regulators. The Court concludes that the Rehabilitator has appropriately exercised her discretion in devising a plan that will address SHIP's financially hazardous condition while protecting the interests of the policyholders, creditors and public generally.

s/Mary Hannah Leavitt

Mary Hannah Leavitt, President Judge Emerita

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

IN RE: Senior Health Insurance :
 Company of Pennsylvania :
 In Rehabilitation : No. 1 SHP 2020

ORDER

AND NOW this 24th day of August, the Court hereby ORDERS as follows:

1. The Application for Approval of the Plan of Rehabilitation for Senior Health Insurance Company of Pennsylvania (SHIP) filed by Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as Statutory Rehabilitator of SHIP, is GRANTED. The Second Amended Plan of Rehabilitation, filed on May 3, 2021, is APPROVED, with the exception of Section VI.N of the Plan (relating to suspension of agent and broker commissions).
2. The Court defers resolution of the Joint Application for Approval of Settlement Agreement, filed by the Rehabilitator and Intervenors ACSIA Long Term Care, Inc., Global Commission Funding LLC, LifeCare Health Insurance Plans, Inc, Senior Commission Funding LLC, Senior Health Care Insurance Services, Ltd., LLP, and United Insurance Group Agency, Inc., pending a hearing to be scheduled by separate order. The Rehabilitator shall continue paying commissions until Phase One of the Second Amended Plan of Rehabilitation is implemented.
3. The Rehabilitator shall promptly submit an actuarial memorandum in support of the If Known Premium rates to be used in Phase One of the Second Amended Plan of Rehabilitation to the Pennsylvania Insurance Department for its review and approval.

4. The Rehabilitator, in her capacity as Insurance Commissioner, shall designate an appropriate deputy insurance commissioner to review the actuarial memorandum submitted to the Insurance Department. Thereafter, the Rehabilitator shall submit the approved actuarial memorandum to the Court.

s/Mary Hannah Leavitt
Mary Hannah Leavitt, President Judge Emerita

EXHIBIT M

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

IN RE: Senior Health Insurance :
 Company of Pennsylvania :
 In Rehabilitation : No. 1 SHP 2020

BEFORE: HONORABLE MARY HANNAH LEAVITT, Judge

OPINION NOT REPORTED

MEMORANDUM OPINION
 BY JUDGE LEAVITT

FILED: September 13, 2021

Before the Court is a Joint Application for Approval of Settlement Agreement filed by Insurance Commissioner Jessica K. Altman, in her capacity as the Statutory Rehabilitator (Rehabilitator) of Senior Health Insurance Company of Pennsylvania (SHIP), and Intervenors ACSIA Long Term Care, Inc., Global Commission Funding LLC, LifeCare Health Insurance Plans, Inc., Senior Commission Funding LLC, Senior Health Care Insurance Services, Ltd., LLP, and United Insurance Group Agency, Inc. (collectively, Intervening Agents and Brokers). Also before the Court is Intervenor James Lapinski's¹ motion to strike the Joint Application.

By way of background, on January 29, 2020, this Court granted the Rehabilitator's application for an order placing SHIP in rehabilitation under Article V of The Insurance Department Act of 1921, Act of May 17, 1921, P.L. 789, *added by the Act of December 14, 1977, P.L. 280, as amended*, 40 P.S. §§221.1-221.63. The Rehabilitator's initial rehabilitation plan proposed to suspend the payment of

¹ James Lapinski is a SHIP policyholder and former long-term care insurance broker who sold SHIP policies.

agent commissions “until policyholders have been made whole, that is, all their contractual claims have been paid in full and adequate provision made for reasonably anticipated future claims.” Application for Approval (April 22, 2020), Exhibit A at 83. The initial plan also suspended the accrual of commissions as of the plan’s effective date, if approved. The Intervening Agents and Brokers intervened to contest these aspects of the plan; to date, no other persons have sought leave to intervene to protect an interest in agent commissions.

On May 3, 2021, the Rehabilitator filed a Second Amended Plan of Rehabilitation as the operative plan for which she sought the Court’s approval. The Court conducted a hearing from May 17 to May 21, 2021. The Intervening Agents and Brokers offered evidence and presented argument on their objections to Section VI.N of the Second Amended Plan, which will suspend the payment and accrual of agent commissions until SHIP emerges from rehabilitation. No other party objected to Section VI.N of the Second Amended Plan. Following the hearing, the Rehabilitator and the Intervening Agents and Brokers negotiated the Settlement Agreement that is the subject of the instant Joint Application.

Under the terms of the Settlement Agreement, the Rehabilitator agrees to pay the Intervening Agents and Brokers \$350,000, which payment will be made within seven business days of the date on which the Court approves the Settlement Agreement (Effective Date). If SHIP remains in rehabilitation on the third anniversary of the Effective Date, then the SHIP estate (or any successor) shall resume accruing and remitting to the Intervening Agents and Brokers 50% of the commissions to which they would otherwise be entitled (Ongoing Commissions). Payment of Ongoing Commissions will continue as long as SHIP remains in rehabilitation, but no later than the seventh anniversary of the Effective Date. In

return, the Intervening Agents and Brokers agree to withdraw their objections to the Second Amended Plan.

If the Settlement Agreement is approved, the Rehabilitator will, prior to implementing the Second Amended Plan, file an amended plan with the following recitation added to Section VI.N: “Certain Agents & Brokers formally objected to this Section VI.N, but per settlement with the Rehabilitator, withdrew their objections as moot.” Joint Application at 8, ¶33. Approval of the Settlement Agreement limits the applicability of Section VI.N of the Plan to only the Intervening Agents and Brokers. It will not change the impact of Section VI.N on any other party or non-party claiming an interest in commissions.²

On August 24, 2021, this Court approved the Second Amended Plan, with the exception of Section VI.N, on which the Court deferred a decision for 30 days to allow for a hearing on the Joint Application. The Court conducted a hearing on September 8, 2021. Counsel for the Rehabilitator, counsel for the Intervening Agents and Brokers, and Mr. Lapinski, *pro se*, all presented their positions.

In considering the Joint Application, the Court applies the same principles that it applied in its review of the Second Amended Plan. Section 516(b) of Article V authorizes the Rehabilitator to “take such action as [she] deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate the insurer. ... [She] shall have full power ... to deal with the property and business of the insurer.” 40 P.S. §221.16(b). The legislatively stated purpose of Article V is “the protection of the interests of

² In the event SHIP is placed in liquidation, the Rehabilitator agrees to treat a claim submitted by the Intervening Agents and Brokers for any unpaid Ongoing Commissions that accrued prior to the liquidation order as a claim under Section 544(a) of Article V, 40 P.S. §221.44(a), subject to Court approval.

insureds, creditors, and the public generally....” and the “equitable apportionment of any unavoidable loss” through, *inter alia*, “improved methods for rehabilitating insurers....” *Grode v. Mutual Fire, Marine and Inland Insurance Co.*, 572 A.2d 798, 803 (Pa. Cmwlth. 1990) (*Mutual Fire I*) (single-judge opinion) (quoting Section 501 of Article V, 40 P.S. §221.1).

The Court concludes that the Settlement Agreement is in the best interests of SHIP’s policyholders and other creditors and will effectuate the goals of the Second Amended Plan. It will suspend the payment of most agent commissions while avoiding expensive and time-consuming litigation to resolve the legal claims of the Intervening Agents and Brokers. The consideration provided by each of the settling parties is fair and reasonable. Because the Intervening Agents and Brokers presented the only objections to Section VI.N of the Second Amended Plan, there are effectively no outstanding objections to Section VI.N.

In his motion to strike the Joint Application, Intervenor James Lapinski argues that the Joint Application was untimely because it was filed after the deadline for post-hearing submissions set by the Court in its May 24, 2021, scheduling order. Mr. Lapinski further asserts that, if the Court does not strike the entire Joint Application, it should strike Paragraphs II.A, B and F; III.C; and IV.A, C and D of the Settlement Agreement. He contends that the settling parties have violated his right to due process by depriving him of notice of filings related to the settlement. Finally, Mr. Lapinski asserts that he is owed \$292,000 in broker commissions, a claim that he has not asserted to date because of his belief that commissions were not paid to agents and brokers in the liquidation of long-term care insurer Penn Treaty Network America Insurance Company.

Mr. Lapinski's arguments lack merit. To begin, the Court entered the May 24, 2021, scheduling order at the conclusion of the hearing on the Second Amended Plan to set deadlines for post-hearing memoranda. That order is inapplicable to the Joint Application. Mr. Lapinski has not identified any legal or factual defect in the above-referenced paragraphs of the Settlement Agreement, or any basis for striking those provisions. He offers no legal support for his conclusory arguments that the settling parties "have violated due process, open and complete disclosures, etc. required by law, constitutions." Motion to Strike at 2. Mr. Lapinski's claimed violation of his right to due process is belied by the fact that he filed the instant motion to strike and participated in the hearing on September 8, 2021. As for his claimed lack of notice of relevant filings, every document filed by the settling parties has been publicly available on the SHIP Court Documents webpage³ and upon request from the Court's Prothonotary's Office. Finally, any claim that Mr. Lapinski may have against the SHIP estate for commissions is irrelevant to the Joint Application.

For all of the foregoing reasons, the Court grants the Joint Application and enters the attached order.

s/Mary Hannah Leavitt
MARY HANNAH LEAVITT, President Judge Emerita

³ See <https://www.shipltc.com/court-documents> (last visited September 10, 2021).

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

IN RE: Senior Health Insurance :
 Company of Pennsylvania :
 In Rehabilitation : No. 1 SHP 2020

ORDER

AND NOW, this 13th day of September, 2021, upon consideration of the Joint Application for Approval of Settlement Agreement filed by Insurance Commissioner Jessica K. Altman, in her capacity as the Statutory Rehabilitator (Rehabilitator) of Senior Health Insurance Company of Pennsylvania (SHIP), and Intervenor ACSIA Long Term Care, Inc., Global Commission Funding LLC, LifeCare Health Insurance Plans, Inc., Senior Commission Funding LLC, Senior Health Care Insurance Services, Ltd., LLP, and United Insurance Group Agency, Inc., it is ORDERED that the Joint Application is GRANTED and the proposed Settlement Agreement filed as Exhibit A to the Joint Application is APPROVED. It is further ORDERED that:

1. The Rehabilitator is authorized to make any payments required under the Settlement Agreement so long as SHIP is in rehabilitation.
2. In accordance with Paragraph 1 of the Court's order of August 24, 2021, approving the Second Amended Plan of Rehabilitation for SHIP, the Court approves Section VI.N of the Plan, subject to the following modification to be inserted at the end of Section VI.N: "Certain Agents and Brokers formally objected to this Section VI.N, but per settlement with the Rehabilitator, withdrew their objections as moot."

3. Prior to implementing the approved Second Amended Plan, the Rehabilitator shall file with the Court an amended rehabilitation plan which includes the modification identified in Paragraph 2.

4. Intervenor James Lapinski's Motion to Strike the Joint Application is DENIED.

s/Mary Hannah Leavitt
MARY HANNAH LEAVITT, President Judge Emerita

STATE OF SOUTH CAROLINA

RICHLAND COUNTY

IN THE COURT OF COMMON PLEAS

FIFTH JUDICIAL CIRCUIT

Raymond G. Farmer, as Director of the South
Carolina Department of Insurance, and the
South Carolina Department of Insurance,

Plaintiffs,

vs.

Jessica K. Altman, as Rehabilitator of Senior
Health Insurance Company of Pennsylvania,
Patrick H. Cantilo, as Special Deputy
Rehabilitator of Senior Health Insurance
Company of Pennsylvania, and Senior Health
Insurance Company of Pennsylvania in
Rehabilitation,

Respondents.

Civil Action No. 2020-CP-40-05802

**PLAINTIFFS' MOTION FOR
TEMPORARY INJUNCTION
AND MEMORANDUM IN SUPPORT**

**A Priority Matter Pursuant To
Rule 40(H), SCRCF**

PLEASE TAKE NOTICE that Plaintiffs Raymond G. Farmer, as Director of the South Carolina Department of Insurance, and the South Carolina Department of Insurance, by and through the undersigned counsel, hereby move the Court, pursuant to Rule 65, SCRCF, for an Order issuing a temporary injunction prohibiting Defendants Jessica K. Altman, as Rehabilitator of Senior Health Insurance Company of Pennsylvania, Patrick H. Cantilo, as Special Deputy Rehabilitator of Senior Health Insurance Company of Pennsylvania, and Senior Health Insurance Company of Pennsylvania in Rehabilitation from taking any action in furtherance of their expressed plans to, without first obtaining required regulatory approval from the State, raise premium rates and/or reduce benefits under certain binding contracts of insurance issued in the State of South Carolina or held by residents of this State, including, but not limited to, notifying policyholders of proposed rate or benefit changes or requesting that they select rates or benefits different from those authorized by the

Department and called for under the terms of the contract, charging additional premium or withholding, delaying or encumbering benefits in whole or in part.

The grounds for the temporary injunction sought by Plaintiffs are (1) Plaintiffs are likely to prevail on the merits; (2) irreparable injury, loss or damage will result to policyholders and the State in the absence of a temporary injunction; (3) a temporary injunction is necessary to prevent (a) irreparable damage to Plaintiffs' ability to discharge their legislatively-charged duty to enforce the insurance laws of this State, (b) significant disruption of the insurance marketplace within this State and (c) unnecessary confusion among and harm to policyholders; and (4) no adequate remedy at law exists. The following facts and circumstances demonstrate that a temporary injunction is proper and necessary to enforce the insurance laws of this State and to protect policyholders:

1. Plaintiff Raymond G. Farmer is the Director of the South Carolina Department of Insurance (the "Director").

2. Plaintiff South Carolina Department of Insurance (the "Department") is an agency of the State of South Carolina created and charged by the South Carolina General Assembly to regulate the business of insurance in this State. *See generally* S.C. Code Ann. §§ 38-1-10 *et seq.* ("The Insurance Law").

3. Defendant Jessica K. Altman is the Commissioner of Insurance for the Commonwealth of Pennsylvania and has been appointed Rehabilitator of Senior Health Insurance Company of Pennsylvania (the "Rehabilitator") by order of the Commonwealth Court of Pennsylvania ("Commonwealth Court") dated January 29, 2020 (the "Rehabilitation Order").

4. Defendant Patrick H. Cantilo was appointed by the Rehabilitator as Special Deputy Rehabilitator (the "SDR") of Senior Health Insurance Company of Pennsylvania. He generally has the power to act on behalf of the Rehabilitator, subject to the control and direction of the

Rehabilitator.

5. Defendant Senior Health Insurance Company of Pennsylvania (“SHIP”) is a stock limited life and health insurance company that administers a closed block of long-term care (“LTC”) insurance policies. It is domiciled in the Commonwealth of Pennsylvania.

6. SHIP was issued a certificate of authority to conduct the business of insurance in South Carolina on April 8, 1988. Its book of business consists almost entirely of policies covering long-term care services. SHIP has not sold new policies since 2003, and only a fraction of its original LTC business remains in force.

7. The average SHIP LTC policyholder age is approximately 87 years of age, and the average claimant is approximately 90 years old. At present, there are approximately 300 policies issued in South Carolina by SHIP, and Plaintiffs are informed and believe that there may be other SHIP policyholders residing in South Carolina whose policies were issued in other states.

8. SHIP has been insolvent since at least December 31, 2018, when it reported a deficit of approximately a half-billion dollars as of that date. (Exhibit A, Transcript of Pa. Proceedings (excerpt) at p. 46 ln. 9-10.) Since then, SHIP’s financial condition has continued to deteriorate, and the current deficit is approximately \$1.2 billion. (Exh. A at p. 45 ln. 2-5, p. 240 ln 17-25, p. 292 ln. 11-12.)

9. Despite SHIP being hopelessly insolvent, the Pennsylvania Insurance Department (“PID”) has not sought a declaration of insolvency, which would have triggered guaranty association coverage and protection for policyholders in the affected states.

10. PID did file an application to place SHIP into rehabilitation in the Commonwealth Court of Pennsylvania on January 23, 2020. *See generally* <https://www.shipltc.com/court-documents>.

11. Neither Plaintiffs nor SHIP policyholders were parties to these proceedings, and policyholders were not represented by class representatives or counsel.

12. A Second Amended Rehabilitation Plan (Plan) was filed on or about May 3, 2021 and approved by a single judge of the Commonwealth Court of Pennsylvania by order filed on August 24, 2021, which was amended by order entered on November 4, 2021. An appeal is pending before the Pennsylvania Supreme Court, as is an application for stay.

13. Central to the Plan is a scheme under which Defendants will impose rates for use nationwide, bypassing individual state regulatory approval statutes. These increases are extreme, in some cases more than doubling the amount of premium to be paid and can reasonably be expected to force unnecessary policy lapses. Policyholders may be able to avoid some of the increases, but only if they agree to lower their contractually-guaranteed benefits. (Exhibit B, Rehab. Plan (excerpt)).

14. The Plan contains a so-called “opt-out” process under which SHIP submits rates to individual states that “opt-out” of the nationwide rate under those states’ respective rate approval statutes. However, it also contains the coercive proviso that if an “opt-out” state does not approve the rate demanded, that state’s policyholders will be punished in the form of a further downgrade to their benefits. (Exh. B at p. 108-118.)

15. The punitive nature of the “opt-out” provision not only renders this feigned deference to state laws meaningless, but it also increases the already adverse effect of the Plan on affected policyholders. Moreover, the benefit reduction strategy described in the amended plan will adversely impact policyholder rights when the plan fails, and SHIP is eventually placed into liquidation.

16. Although Defendant Cantilo has characterized the receivership as involving a “workout plan,” by definition, such plans are a negotiated agreement between the debtor (which in

this case would be SHIP) and its creditors (which would be policyholders). (Exh. B at p. 79 ln. 3-6.)

Here, however, the so-called “workout plan” consists of the debtor *unilaterally* (a) dictating the new terms in a contract under which the creditors have fully performed, (b) imposing draconian terms on the creditors in the form of extreme premium increases and reduced benefits, both of which are likely to force policy lapses and (c) stripping out of those policies the statutory protections relating to those policies that became part and parcel of the contract at the time of its formation. *E.g., Nakatsu v. Encompass Indem. Co.*, 390 S.C. 172, 700 S.E.2d 283 (Ct. App. 2010) (statutory provisions relating to an insurance contract are part of the contract as a matter of law); *see also* S.C. Code Ann. § 38-61-10 (2015) (contracts of insurance on property, lives, or interests in this State and all contracts of insurance the applications for which are taken within the State are made within this State and are subject to its laws).

17. The Defendants have given states only until November 15, 2021, to provide written notice, under oath, of their decision to “opt-out” of a Plan they never opted in. (Exhibit C, SHIP Notice & FAQs, Notice at p.2 & State Opt-Out Election Form.)

18. Like all LTC insurers licensed in this State, SHIP has always submitted proposed rate increases to the South Carolina Department of Insurance for review and approval in accordance with South Carolina law. Over the past decade, SHIP has submitted proposed rate increases to the South Carolina Department of Insurance in 2011, 2012, 2013, 2017, and 2018, all of which were approved. The sole exception is the 2018 rate increase, which the Department disapproved in 2019 after it was clear that SHIP was hopelessly insolvent.

19. The Defendants acknowledge that the Plan places additional burdens on policyholders and is intended to decrease SHIP’s deficit by increasing premium revenue and reducing policyholder benefits. (Exhibit B at p. 11-21).

20. Defendant Cantilo has admitted under oath that, “it is not likely that we will magically restore SHIP to solvency, but it is likely that the plan . . . would substantially reduce the deficit.” (Exhibit A at p. 80 ln. 6-12.). The sole purpose of the Plan is not to honor its policyholder obligations but to reduce the liabilities of the Plan before it goes into liquidation.

21. The Defendants have also admitted that SHIP will benefit at the expense of policyholders and that the opt-out provision further harms policyholders: “In general, the Rehabilitator believes that states opting out is likely to help reduce SHIP’s deficit more than states opting in. This is because it is anticipated that Opt-out States will approve lower rate increases than the Rehabilitator seeks. This will result in *additional downgrades which reduce the deficit faster than additional premium*. However, the Rehabilitator DOES NOT recommend that states *opt out* because that *is generally expected to be disadvantageous to affected policyholders*.” (Italics supplied.) (Exhibit C, FAQ 9.)

22. The Defendant Cantilo has also admitted that the purpose of the Plan is to transfer the burden of insolvency from legislatively-crafted guaranty associations and their member insurers. (Exh. A at p. 78 ln. 19-23, p. 79 ln. 4, p. 83-84 ln. 20-18, p. 289 ln. 9-18 & p. 292 ln. 11-25.) Specifically, he spoke in terms of “taxpayers,” however, this is a euphemistic and tangential reference to tax offsets for guaranty association assessments on large insurers. Provisions in some state guaranty association statutes provide for partial premium tax offsets for member insurers that are assessed by their guaranty association to pay claims against insolvent insurers. *E.g.*, 40 Pa. Stat. § 991.1711 (credits for assessments paid); S.C. Code Ann. § 38-29-160. The larger an insurer’s market share in total premium, the larger its assessment. The larger the assessment, the larger the offset to premium tax. In attempting to disguise their desire to limit assessments on large insurers as anxious concern for taxpayers, Defendants make the unspoken (and speculative) assumption that

other taxpayers will be required to make up for any revenue lost to such premium tax offsets. Thus, Defendants have crafted a plan to circumvent not only state laws regulating rates and forms, but also legislatively-crafted mechanisms for the distribution of the costs of paying claims against insolvent insurers. In doing so, they elevate the interests of large insurance companies over those of policyholders and usurp the policy decisions of democratically-elected legislatures.

23. In other words, despite SHIP's inevitable liquidation, or perhaps because of it, Defendants are attempting to use the rehabilitation proceedings to coerce vulnerable elderly policyholders into paying confiscatory rates, accepting substantially less benefits than what they are entitled to under their contracts, or even lapsing on their policies altogether, all while skirting the laws of other states. The purpose of this otherwise feckless exercise is to permanently reduce the amount of guaranty association protection benefits each policyholder would receive in a liquidation, resulting in savings to large insurers in the form of substantially smaller guaranty association assessments.

24. Defendants estimate that the costs of administration of the rehabilitation plan are approximately \$200,000,000, which costs are paid from SHIP's assets; however, the Pennsylvania proceedings do not provide for an accounting. (Exhibit B at p.28, Table 1, ln. 2.).

25. With the passage of the McCarran–Ferguson Act, 15 U.S.C. §§ 1011-1015, in 1945, “Congress . . . declare[d] that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.”

26. “The primary state insurance regulatory functions remain as they have been since the enactment of [the] McCarran-Ferguson [Act]. This allows . . . states to perform solvency oversight of

the U.S. insurance industry and to regulate insurer behavior in the marketplace.” *State Insurance Regulation*, National Association of Insurance Commissioners (NAIC), Center for Insurance Policy and Research (CIPR) (2011), https://www.naic.org/documents/topics_white_paper_hist_ins_reg.pdf.

27. “State legislatures are the public policymakers that establish . . . broad policy for the regulation of insurance by enacting legislation providing the regulatory framework under which insurance regulators operate. They establish laws which grant regulatory authority to regulators and oversee state insurance departments and approve regulatory budgets.” *Id.*

28. “State insurance regulatory systems are accessible and accountable to the public and sensitive to local social and economic conditions. State regulation has proven that it effectively protects consumers and ensures that promises made by insurers are kept. Insurance regulation is structured around several key functions, including insurer licensing, producer licensing, product regulation (review and approval of rates (including benefits) and forms), market conduct, financial regulation and consumer services.” *Id.*

29. “State regulators protect consumers by ensuring that insurance policy provisions comply with state law, are reasonable and fair, and do not contain major gaps in coverage that might be misunderstood by consumers and leave them unprotected. The nature of the regulatory reviews of rates, rating rules and policy forms varies somewhat among the states depending on their laws and regulations.” *Id.*

30. The South Carolina General Assembly has properly delegated regulatory authority under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, to the Department, prescribing and approving detailed and extensive statutes and regulations governing LTC policies and rates, including provisions for the approval of rates by the Department. S.C. Code Ann. §§ 38-72-10 *et seq.*; S.C. Code Regs. § 69-44.

31. In S.C. Code Ann. § 38-25-10, the South Carolina General Assembly makes the following Declaration:

(a) The General Assembly declares that it is concerned with the protection of residents of this State against acts by insurers not authorized to conduct an insurance business in this State, by the maintenance of fair and honest insurance markets, by protecting authorized insurers which are subject to regulation from unfair competition by unauthorized insurers, and by protecting against the evasion of the insurance regulatory laws of this State. In furtherance of this state interest, the General Assembly herein provides . . . [for] proceeding[s] by the director or his designee to enforce or effect full compliance with the insurance laws of this State. In so doing, the state exercises its powers to protect residents of this State and to define what constitutes transacting an insurance business in this State and also exercises powers and privileges available to this State by virtue of Public Law 79-15, 79th Congress of the United States, Chapter 20, 1st Session, S. 340, 59 Stat. 33; 15 U.S.C., Sections 1011 to 1015, inclusive, as amended [the McCarran-Ferguson Act], which declares that the business of insurance and every person engaged therein are subject to the laws of the several states.

32. Pursuant to S.C. Code Ann. § 38-3-10 (2015), the General Assembly “established a separate and distinct department of this State, known as the Department of Insurance. The department must be managed and operated by a director appointed by the Governor upon the advice and consent of the Senate.”

33. Pursuant to S.C. Code Ann. § 38-3-60 (2015), “The director or his designee must follow the general policies and broad objectives enacted by the General Assembly regarding the operation of the insurance industry in this State.”

34. S.C. Code Ann. § 38-3-110 (2015) sets forth the Director’s responsibilities, which include the duty to:

(1) supervise and regulate the rates and service of every insurer in this State and fix just and reasonable standards, classifications, regulations, practices, and measurements of service to be observed and followed by every insurer doing business in this State. Nothing contained in this title authorizes or requires a review by the department or the director of any order of the director's designee or the deputy director under the Administrative Procedures Act. This item does not grant any additional authority to the director or his designee with regard to insurance rates

other than the ratemaking authority specifically granted to the director or his designee, or the Department of Insurance for certain kinds of insurance in other provisions of this title;

and to:

(2) see that all laws of this State governing insurers or relating to the business of insurance are faithfully executed and make regulations to carry out this title and all other insurance laws of this State, the enforcement or administration of which is not otherwise specifically provided for.

35. Pursuant to S.C. Code Ann. § 38-61-10 (2015), “All contracts of insurance on property, lives, or interests in this State are considered to be made in the State and all contracts of insurance the applications for which are taken within the State are considered to have been made within this State and are subject to the laws of this State.”

36. Pursuant to the Long-Term Care Insurance Act, S.C. Code Ann. §§ 38-72-10 *et seq.*, “All premium rate schedules for long-term care insurance must be filed with the [South Carolina Department of Insurance] and are subject to the prior approval of the director or his designee.” S.C. Code Ann. § 38-72-75(A). An insurer may not charge a premium to an insured under a policy or contract of long-term care insurance before the applicable premium rate is filed and approved, and an insurer may not change the premium charged to an insured under a policy or contract of long-term care insurance until the applicable premium rate change has been filed with and approved by the Director or his designee. *Id.*

37. In addition, “the director or his designee may hold a public hearing or solicit public comments as a part of the process to review long-term care insurance rate filings received by the director or his designee.” S.C. Code Ann. § 38-72-75(C). Each decision of the Director or his designee about premium rates is subject to review under the Administrative Procedures Act (APA), S.C. Code Ann. § 38-72-75(D).

38. S.C. Code Regs. 69-44 provides for the comprehensive regulation of LTC policies, including rates, forms and required market practices.

39. The public policy of this State is that because the authority to determine what insurance premium rates are just and reasonable is vested in the Department, not even courts should adjudicate what a reasonable rate might be in a collateral proceeding. *Cf. Temporary Services, Inc. v. American Intern. Group, Inc.*, 388 S.C. 348, 351, 697 S.E.2d 527, 529 (2010); § 2:34. Rates—Judicial review, 1 Couch on Ins. § 2:34 (“Ratemaking is generally not a judicial function. Indeed, many jurisdictions have adopted the filed rate doctrine which expressly prohibits courts from imposing rates different than those approved by the state insurance department.”)

40. Pennsylvania’s highest court has made clear that as a creature of statute, an insurance commissioner acting as a rehabilitator “can only exercise those powers which have been conferred upon it by the Legislature in clear and unmistakable language.” *Aetna Cas. and Sur. Co. v. Com., Ins. Dept.*, 638 A.2d 194 (Pa. 1994) (quoting *Commonwealth, Human Relations Commission v. Transit Casualty Insurance Company*, 478 Pa. 430, 438, 387 A.2d 58, 62 (1978)). *See also Koken v. Legion Ins. Co.*, 831 A.2d 1196 (Pa. Commw. 2003), *aff’d sub nom. Koken v. Villanova Ins. Co.*, 878 A.2d 51 (Pa. 2005).

41. Defendants Rehabilitator and SDR have only those powers conferred upon them by 40 Pa. Stat. Ann. §§ 221.1 *et seq.*, which are limited and equivalent to those of new management, and they and insurance companies in rehabilitation, including SHIP, must therefore obey the insurance laws of each the states in which they conduct the business of insurance. *See id.* ((Rehabilitator has “full power to direct and manage” the insurer)). Nowhere in the rehabilitation statutes is there “clear and unmistakable language” permitting a rehabilitator to unilaterally set new rates and policy terms.

42. Although “liquidation” contemplates the end of corporate existence, “rehabilitation” involves the continuance of corporate life and activities and is an effort to restore and reinstate the corporation to its former condition of successful operation and solvency. *Smalls v. Weed*, 293 S.C. 364, 360 S.E.2d 531 (Ct. App. 1987).

43. The Insurers Rehabilitation and Liquidation Act “provides for one procedure in actions involving a rehabilitator, and for a different procedure against a liquidator.” *Id.*

44. Another state’s rehabilitation proceedings do not grant that state jurisdiction over “the whole field.” *See id.*

45. Although the Pennsylvania Commonwealth Court exercises in rem jurisdiction in the rehabilitation proceedings, the res over which that jurisdiction is exercised is the corporation itself, the fictitious entity, not all of the corporation’s property for all purposes and certainly not the rights of all persons wherever situated. The Commonwealth Court may not, simply by reason of the *in rem* nature of the Pennsylvania rehabilitation proceedings, adjudicate the rights of South Carolina policyholders and claimants who are neither parties in the Pennsylvania proceedings nor subject to the jurisdiction of the Commonwealth Court.

46. “Before a court is bound by the judgment rendered in another State, it may inquire into the jurisdictional basis of the foreign court’s decree” and “[i]f that court did not have jurisdiction over the subject matter or the relevant parties, full faith and credit need not be given.” *Underwriters Nat’l Assurance Co. v. N.C. Life & Accident & Health Ins. Guar. Ass’n.*, 455 U.S. 691, 705 (1982).

47. Neither policyholders nor South Carolina were parties in the proceedings giving rise to this Plan, nor are they bound by the ruling of the Commonwealth Court.

48. The constitutional command of full faith and credit does not compel South Carolina

to defer to a Pennsylvania court's exercise of jurisdiction where, as here, the issue was neither fully and fairly litigated nor involved the same parties as the Pennsylvania litigation.

49. No state, including Pennsylvania, may bind a Nation, particularly as to matter on which the legislatures of each state have spoken. Pennsylvania's erroneous attempt to do so would represent a "policy of hostility to the public Acts" of each of the 45 affected states, resulting in a direct injury to their sovereignty in violation of the Full Faith and Credit Clause. *See Franchise Tax Bd. v. Hyatt*, 578 U.S. 171 (2016); *Allstate Ins. Co. v. Hague*, 449 U.S. 302 (1981); *Carroll v. Lanza*, 349 U.S. 408 (1955).

50. "The very nature of the federal union of states, to which are reserved some of the attributes of sovereignty, precludes resort to the full faith and credit clause as the means for compelling a state to substitute the statutes of other states for its own statutes dealing with a subject matter concerning which it is competent to legislate." *Pacific Employers*, 306 U.S. at 501; *see also Alaska Packers Ass'n v. Indus. Accident Comm'n.*, 294 U.S. 532, 547 (1935).

51. In addition to being deprived of the opportunity to negotiate the so-called "workout plan," policyholders have had their contract rights stripped of them without the benefit of due process. Policyholders did not receive proper service of process and were not represented by class representatives or independent legal counsel. The Rehabilitator has offered no justification for why policyholders were literally denied their day in court before being stripped of their contractual and procedural rights.¹ Indeed, it is a case cited by the Rehabilitator's own attorneys that provides an

¹ In contrast, several large insurers -- Anthem, Inc., Health Care Service Corporation, Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey, and UnitedHealthcare Insurance Company -- appeared as intervenors in the proceedings and were represented by counsel. Unsurprisingly, these companies fully supported the Plan. *See, e.g.*, Top 10 health insurance companies in the US, <https://www.insurancebusinessmag.com/us/news/healthcare/top-10-health-insurance-companies-in-the-us-212292.aspx> (23 Aug 2021); Horizon NJ Health, <https://www.horizonnjhealth.com/aboutus/company-overview/company-information>.

example of policyholders being represented by class representatives who engaged in “extensive negotiations” with the insurer and the receiver. *Underwriters Nat. Assur. Co. v. North Carolina Life and Acc. and Health Ins. Guar. Ass'n.*, 455 U.S. 691 (1982).

52. Insurance commissioners as receivers and their deputies are fiduciaries, and as part of their responsibilities are charged with preserving and protecting the rights of policyholders. *E.g.*, *McPherson v. U.S. Physicians Mut. Risk Retention Group*, 99 S.W.3d 462 (Mo. Ct. App. 2003); *Green v. Louisiana Underwriters Ins. Co.*, 571 So.2d 610 (La. 1990); *see also* NAIC Receiver’s Handbook for Insurance Company Insolvencies 333 (2018) (“A Receiver has a fiduciary responsibility to all of the receivership estate’s creditors and is charged with protecting the interests of insureds, creditors and the public generally.”) And yet, these policyholders, who number among the most vulnerable members of our society, now face having to shoulder a financial burden that would otherwise rest, as the legislatures of the affected states intended, with the insurance industry that created and sold the same kind of policies. It is impossible to reconcile the faithful performance of the Rehabilitator’s fiduciary duty with the casual disposal of the contractual and constitutional rights of policyholders.

53. Notwithstanding the clear mandate of South Carolina law, the limited reach of the Pennsylvania proceedings, and the numerous and serious defects in those proceedings, Defendants have made clear their position that SHIP is no longer subject to South Carolina law and that they have no intention to obey it, and have instead given Plaintiffs the deadline of November 15, 2021 to deliver a binding decision regarding the “opt-out” provision and have otherwise evinced their intent to move forward immediately with implementing changes to policies and rates.

54. Plaintiffs seek an order temporarily enjoining Defendants from taking any measure that purports to bypass, impede, supersede, diminish or interfere in any manner with the State of

South Carolina's regulatory authority over changes to the terms of policies and review and approval of insurance rates in this State, and further temporarily enjoining Defendants from communicating in any form or manner with South Carolina policyholders regarding proposed changes to policy terms or rates without prior written approval by the State.

55. A preliminary injunction pursuant to Rule 65(a), SCRCP is warranted under the circumstances.

56. "A preliminary injunction should issue only if necessary to preserve the *status quo ante*, and only upon a showing by the moving party that without such relief it will suffer irreparable harm, that it has a likelihood of success on the merits, and that there is no adequate remedy at law." *Poynter Invs., Inc. v. Cent. Builders of Piedmont, Inc.*, 387 S.C. 583, 694 S.E.2d 15 (2010) (citing *AJG Holdings, LLC v. Dunn*, 382 S.C. 43, 674 S.E.2d 505 (Ct. App. 2009). 1984). "When *prima facie* showing has been made entitling plaintiff to injunctive relief, a temporary injunction will be granted without regard to the ultimate termination of the case on the merits." *Id.* (quoting *D.W. Alderman & Sons Co. v. Wilson*, 69 S.C. 156, 48 S.E. 85 (1904)).

57. A temporary injunction to preserve *the status quo ante* is necessary to prevent irreparable harm to South Carolina policyholders. Plaintiffs are specifically charged by the South Carolina General Assembly to uphold the insurance laws of this State. Those laws are designed to protect the policyholders, whose contracts were formed in this State and are subject to its laws and regulations. The State has a strong interest in protecting policyholders and ensuring that its laws are enforced. If those laws are not enforced, and Defendants are permitted to implement their Plan immediately, Plaintiffs will have not upheld their statutory duty and policyholders will be permanently denied basic contractual, procedural and constitutional rights and suffer permanent and substantial economic harm. Even if Plaintiffs were to fine SHIP or suspend or revoke its license,

such after-the-fact measures would not reinstate any permanent or temporary loss of benefits or premium overcharges. The same is true of any lawsuit to recover lost benefits or premium overcharges, which would also be impractical given the advanced age and typically limited means of the victims. They would also not undo the substantial confusion and disruption of the marketplace that would have occurred. Conversely, Defendants need do no more than refrain from violating South Carolina law. If they wish to file for a rate increase in accordance with the laws of the applicable state, including, this one, they have done so in the past and may do so again.

58. Plaintiffs are also likely to prevail on the merits. Defendants' Plan is founded on a clearly erroneous reading of the law that is likely to be overturned on appeal and suffers from several other underlying legal defects. Regardless, the order approving that Plan is not binding on Plaintiffs or policyholders. Both federal and State statutory law support Plaintiffs' position that insurers licensed by Plaintiffs must obey the laws of this State and those contracts issued in this state are subject to South Carolina law.

59. Plaintiffs have therefore made the necessary showing that they are entitled to a temporary injunction - irreparable harm, likelihood of success on the merits, and no adequate remedy at law, thereby establishing grounds for relief pursuant to Rule 65, SCRPC.

60. For the foregoing reasons, Plaintiffs respectfully request that the Court grant their Motion for Temporary Injunction prohibiting the Defendants taking any action that would result in prejudice to the rights of policyholders with respect to contracts of insurance subject to the laws of this State or from otherwise interfering with the orderly administration and enforcement of the insurance laws of this State.

61. This motion, and the relief sought herein, are based on and supported by the statutory and decisional law of this State and the United States, the South Carolina Rules of Civil Procedure,

the pleadings and filings in the underlying lawsuit, and such other submissions that may be filed with the Court.

62. Pursuant to Rule 11, SCRCP, the undersigned certifies that consultation with the attorneys for the Defendants prior to the filing of this motion would not serve any useful purpose.

WHEREFORE, Plaintiffs respectfully pray the Court for an order temporarily enjoining Defendants from implementing or enforcing the rehabilitation plan in this State, otherwise interfering with the rights of SHIP policyholders in South Carolina or otherwise violating the insurance laws of this State pertaining to long-term care insurance until the resolution of the appeal in Pennsylvania, with Plaintiffs given leave to apply for an extension upon a showing that it is necessary to protect policyholders and uphold the laws of this State.

Respectfully submitted,

November 12, 2021

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One of the Attorneys for Petitioner

EXHIBIT A

IN THE COMMONWEALTH OF PENNSYLVANIA

- - -

IN RE: Senior Health : NO. 1 SHP 2020

Insurance Company of :

Pennsylvania in :

Rehabilitation :

- - -

Monday, May 17, 2021

- - -

Proceeding in the above-captioned matter held before THE HONORABLE MARY HANNAH LEAVITT, at the Commonwealth Court of Pennsylvania, 601 Commonwealth Avenue, Harrisburg, Pa., commencing at 10:00 a.m., on the above date, before Karen A. Nickel, Certified Realtime Reporter and Notary Public in and for the Commonwealth of Pennsylvania.

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1 So you can see that we are now at
2 the point at which the volume of claims is
3 outpacing the premium that the company is
4 collecting, and what's more troublesome for us
5 is that of the total premium that SHIP is
6 expected to collect from the expiration of the
7 policies in force, which is about \$7.4 billion,
8 we have already collected 7.1 billion. We only
9 have about \$300 million in premium we expect to
10 collect.

11 On the other hand, we expect total
12 claims to be paid during that period of,
13 approximately, \$11 billion, of which we have
14 only paid about \$7.7 billion so far. So we
15 expect to be paying another \$3 billion in
16 claims or so in the absence of a plan, but only
17 collecting \$300 million in premium.

18 This is not atypical. Long-term
19 care insurers expect to collect a lot of
20 premium upfront, invest that money, put it
21 aside, and then when the curve starts rising on
22 the claim side -- because policyholders might
23 be applying for benefits, and clearly you have
24 a big part of money set aside from previously
25 collected and invested premium.

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1 I'm sorry, 23. That table, which also appears
2 on Exhibits 31 and Exhibit 55, which are two
3 versions of the plan, summarizes the financial
4 history of SHIP for the last 11 years, and you
5 can see that back in 2009, shortly after it was
6 spun off, it had reportedly serviced 193
7 million, run out before 2019 with a deficit and
8 for 2020 that has gone up about 300 million to
9 a deficit of 1.2 billion. It has been a steady
10 decline, as you can see on this table, and I
11 think the larger drop from 2014 to 2015, maybe
12 even the one from 2013 to 2014, led the company
13 to become a lot more concerned.

14 They started that special
15 examination for 2016. By the time those
16 numbers came in in 2017, you can see the
17 company had halved its surplus from 55 million
18 to 28 million.

19 And then that was cut in half again
20 for the 2017 annual statement, which is
21 actually filed in March of 2018, about the time
22 I was involved. So it's been a little bit of a
23 grim picture.

24 Slide 23 -- I'm sorry, 24 has more
25 updated information. That actually has the

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1 Unfortunately, when you stop selling
2 new business, as SHIP did 18 years ago, the
3 premium curve starts flattening and the claim
4 curve starts rising. And in the case of SHIP,
5 the investment income has been much lower than
6 anticipated, for reasons I will explain a
7 little bit later on.

8 But as I said, right now the picture
9 is a little bit grim because we are going to be
10 paying ten times as much in claims as we are
11 collecting in premium.

12 Q. What portion of SHIP's policyholders
13 for LTC are on claim?

14 A. I think we are about 13 percent
15 right now, which is a little bit above the
16 industry average. But as you can see on Slide
17 21, which is also part of Exhibit 33, that
18 curve is also expected to continue, so that by
19 the time the block runs off, we are probably
20 going to be about one in three policyholders on
21 claim.

22 Q. Mr. Cantilo, I'm going to turn to
23 the current financial condition of SHIP. Can
24 you describe it for me, please?

25 A. Sure. If we can put up Slide 20 --

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1 detailed numbers from last year, and you can
2 see that now, we are at a little bit under \$1.4
3 billion in assets with about \$2.6 billion in
4 liabilities, creating the \$1.2 billion deficit
5 that I described earlier.

6 That deficit has probably stabilized
7 a little bit. It's even possible it's a little
8 bit lower by the end of 2021 or projected to be
9 a little bit lower by the end of 2021 than it
10 is now, but either way, it's not going to be
11 material to the plan.

12 On the next slide, Slide 25, I
13 actually have a graph that is part of Exhibit
14 36, or proposed Exhibit 36, I should say, that
15 tracks the relationship between assets and
16 liabilities over the same 11-year period, and
17 you can see how that relationship has grown,
18 the gap has grown between the two.

19 And on the next slide, 26, you can
20 see how the company's capital and surplus has
21 dropped.

22 Now, these are reported numbers, and
23 I emphasize that, Your Honor, because I don't
24 want the Court to misinterpret my testimony as
25 saying that we believe that the reported

12 (Pages 42 to 45)

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1 surplus of 2009 or even 2016 is accurate.
2 That's just a number the company was reporting.

3 It wasn't until 2017 that we have
4 material influence in the way in which the
5 company was reporting its financial condition.
6 And by 2018, as I will explain in a few
7 minutes, they have made some adjustments we
8 requested, and that's why you saw the company
9 go from a \$12 million surplus to a half a
10 billion dollar deficit in that one-year period.

11 Q. Mr. Cantilo, let's dig into the
12 causes of the insolvency that SHIP faces. Can
13 you summarize how we got here?

14 A. There are a number of factors. I
15 think the most important factor in terms of
16 volume is what we believe to be erroneous
17 actuarial assumptions made when the policies
18 were first issued and as reserves were
19 calculated in the ensuing years.

20 The key actuarial assumptions to
21 which I am referring are morbidity, the rate at
22 which people become ill and require care,
23 morbidity improvement, the rate at which they
24 become healthier so they need less care, rate
25 of mortality, how many people died in a given

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1 year, and the rate of which policies terminate
2 for any of a number of reasons.

3 So we suspect and have confirmed
4 that the company was operating on understated
5 morbidity assumptions, that is, they
6 underestimated how many people would become ill
7 and qualify for benefits. They overestimated
8 how quickly people would become healthier and
9 stop needing as much care. That's what the
10 industry calls morbidity improvement. They
11 overstated mortality which, as I say,
12 ironically, mortality rates help the company
13 because they remove insureds from the pool of
14 people who can get benefits. They assume more
15 people would die than actually died. And then
16 they overstated or overestimated a number of
17 policies that would lapse because of death or
18 non-payment of premium.

19 Apart from the problems with the
20 actuarial assumptions, of which I'm sure we
21 will return, the company has had a pretty poor
22 history with its investments. The problems are
23 primarily in two categories. The broader
24 capital markets have seen dramatic drops in
25 yields from the time these policies were first

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1 sold in the '70s and '80s to today, and, in
2 addition, the company has made some unfortunate
3 investment decisions that have also removed
4 some capital from the picture.

5 There was a concern that the
6 company's operating costs were also high, and
7 we made some efforts working with management to
8 reduce those operating costs. So although they
9 were a factor, I would not say that those were
10 a major factor.

11 And then the last big component,
12 which, again, is common in the industry, is
13 that when SHIP management realized that its
14 premium rates were too low because of the
15 understated or misstated actuarial assumptions
16 and attempted to increase its premium rates, it
17 received mixed responses from regulators around
18 the company with twin bad effects of, A, not
19 getting enough additional rate to help with the
20 problems, and, B, creating a hopscotch of very
21 different rates across the country so that two
22 policyholders of similar characteristics with
23 similar coverage, with policies issued in
24 different states, might be paying widely
25 different premiums, sometimes a factor of four

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1 or five times the premium, just because
2 different states reacted to rate requests in a
3 different manner.

4 Q. So Mr. Cantilo, let's focus on
5 certain of these causes of deterioration, the
6 assumption. How big a problem were the
7 actuarial assumption errors you described?

8 A. We have a slide, slide 29, in which
9 we have aggregated what we think is the impact
10 of just the actuarial assumptions and, as you
11 can see, we projected it through 2040, which is
12 when we think most of the block will have run
13 off, and as of that date, we expect that the
14 aggregate effect of these assumptions beginning
15 only in 2012 is about the size of our deficit,
16 \$1.2 billion. We have not gone back to project
17 the effect of the assumption before 2012.

18 Q. I think the next item on your list
19 referred to investment performance projections.

20 A. Right. So SHIP, like everyone else
21 investing in the American market, has
22 experienced lower yields from its invested
23 assets. If you look at Table 30, that -- those
24 two graphs which come from Exhibit 40 are the
25 United States Treasury bond curves for the

13 (Pages 46 to 49)

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1 analysis was whether we should go into
2 liquidation or rehabilitation or come to this
3 Court, I should say, with a liquidation or
4 rehabilitation plan. And for reasons that I
5 can explain in more detail later, the decision
6 was made that rehabilitation was appropriate
7 here.

8 And the key components of that were,
9 there is enough money left at SHIP to be able
10 to provide fundamental coverage to our
11 remaining 40,000 policyholders, albeit not the
12 rich coverage that a lot of those policies
13 provide, and this is, and it sounds a little
14 counterintuitive, but this is a major factor;
15 we knew that a lot of policyholders had been
16 underpaying for their policies for a long
17 period of time, decades, and we knew that if we
18 came to this Court requesting a liquidation
19 order, that a likely consequence is that the
20 guaranty associations would be triggered, then,
21 ultimately, the taxpayers would be asked to
22 step up and contribute hundreds of millions of
23 dollars to pay claims under those policies.

24 And the question that we were
25 debating is, is it reasonable, if a

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1 policyholder has been paying a quarter for a
2 dollar's worth of insurance for decades, to
3 adopt, as the workout plan, a plan in which the
4 taxpayers step up to pay their remaining 75
5 cents.

6 And what we concluded is that we
7 could right size the policy, and we could
8 create a set of options for policyholders that
9 would enable them to get fundamental LTC
10 coverage but pay reasonable rates like the rest
11 of the country for that coverage and not shift
12 all that burden to the taxpayers.

13 I don't mean to minimize the policy
14 because it made every penny -- whether that's
15 the case or not, the fact is they were
16 mispaying for the coverage and we thought the
17 plan could have a proper goal the right size of
18 the policy, so that the relationship between
19 the premium and the benefits was reasonable.

20 That, after all, is a fundamental
21 requirement of rate regulation. When
22 regulators across the country approve rates for
23 insurance policies, the key consideration is
24 between rates and benefits are reasonable.

25 We concluded, for SHIP, that was no

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1 longer the case and we thought a rehabilitation
2 plan could be put together that would remedy
3 that. And we thought if we did that, it would
4 result in reduction of liabilities and it would
5 offset the deficit to a large degree.

6 I will be very candid with the
7 Court, as we always have been, it is not likely
8 that we will magically restore SHIP to
9 solvency, but it is likely that the plan that
10 we were trying to design would substantially
11 reduce the deficit and substantially improve
12 the inequitable rate structure for the company.

13 That was the goal when we sat down
14 to put a plan together.

15 Q. Did you consider any other options
16 besides the plan?

17 A. Of course. There were things that
18 we had considered earlier in the case of Penn
19 Treaty and we thought maybe they would work
20 here.

21 So the first thing we looked at is
22 selling the company, but a company with a \$1
23 billion deficit and a losing book of business
24 and not selling any new business does not
25 attract a lot of buyers.

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1 So that one didn't get very far.

2 We looked at a good bank/bad bank
3 structure, which is a structure we had worked a
4 lot on in the Penn Treaty case, but, unlike
5 Penn Treaty that had two licensed insurers,
6 SHIP is only one licensed insurer and for good
7 bank and bad bank to work, you have to have a
8 good bank and bad bank around the country and
9 that was --

10 Q. Can I just ask you to pause and
11 explain for the record what good bank/bad bank
12 would entail?

13 A. So it means a lot of different
14 things to a lot of different people, but the
15 context in which I am using good bank/bad bank
16 is a scheme in which you separate the bad part
17 of the insurance business and put in a
18 liquidation vehicle and put the good part of
19 the insurance business in a surviving vehicle
20 that you hopefully will restore to solvency.

21 Q. So now, the third item, ancillary
22 approval of modifications, what does that mean?

23 A. Well, we recognize that the only way
24 a rehabilitation plan would work is to modify
25 the insurance policies, and we anticipated that

21 (Pages 78 to 81)

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1 there might be resistance, especially to
2 premium rate increases from other states, not
3 because we didn't think that we had the legal
4 authority to do that, but because it is
5 unprecedented.

6 The reality is that most companies
7 that went to rehabilitation are not collecting
8 premium, so the notion of premium increases
9 doesn't come up in rehabilitation.

10 And we -- the first thing we decided
11 is, look, everyone understands we can change
12 the benefit, so surely if we can change the
13 benefits, we can change the premium. So two
14 sides of the same equation. We realized, even
15 if that seemed logically the case, that
16 regulators tend to feel strongly about the
17 exercise of authority on rates, and so to avoid
18 a fight on the issue, one of the things we
19 considered early on is to subject the policy
20 and rate modifications to each of the states as
21 part of the rehabilitation plan.

22 But we concluded pretty early on
23 that that approach overlooked all of the
24 history where the company had the checkerboard
25 experience from rate increase across the

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1 country and it would take far too long for the
2 plan to become effective in time to do much
3 good. So we thought ancillary approval of the
4 modifications just wasn't going to be an
5 effective strategy for SHIP.

6 Then we thought about excluding the
7 policies of states that didn't want this Court
8 and Jessica Altman, the Insurance Commissioner,
9 to modify. But that created an unfairness or
10 inequity problem because we would have a plan
11 that would benefit some and not others, and it
12 wouldn't be the policyholders that get to make
13 that choice; it would be regulators. So we
14 thought of that option for the same reason.

15 We spent a lot more time on
16 regulation and, as I said earlier, we concluded
17 we could do a lot more good for policyholders
18 and for the company with this plan than with a
19 flat-out liquidation.

20 Q. I believe you testified earlier that
21 a liquidation would shift a burden to the
22 taxpayers. Can you just explain briefly how
23 that worked?

24 A. Certainly. So if we were to place
25 SHIP on a liquidation, as Penn Treaty has been,

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1 for example, the guaranty associations and each
2 of the states in which SHIP's policyholders
3 reside would be triggered and required to
4 guarantee, assume or reinsure, or cause to be
5 guaranteed, assumed or reinsured, all of the
6 policies in force in that state.

7 And the obligations of the guaranty
8 associations would be capped at a stated dollar
9 amount, typically \$300,000, and the guaranty
10 associations would first collect at least a
11 portion or maybe all of SHIP's assets, and then
12 assess other insurers around the country to pay
13 those claims.

14 When they do that, the assessed
15 insurers themselves, in turn, get to reduce
16 their premium tax payments over, typically, a
17 five-year period by the amount of the
18 assessment, and they pay for failed insurers.

19 There are exceptions in California,
20 for example, a set of premium tax offsets, the
21 insurers get to surcharge on for the
22 assessment.

23 But one way or another, the
24 assessments are first borne by the insurance
25 company and then passed on to taxpayers or

Page 85

1 policyholders. If we put SHIP in the equation,
2 that is who would pay 75 percent on the
3 hypothetical underpricing.

4 Q. So we will return to a comparison of
5 rehabilitation and liquidation, but first, I
6 would like you to tell the Court how you and
7 the others assisting the Rehabilitator in
8 developing the plan, how did you come to the
9 plan?

10 A. So we benefited from having had the
11 experience of doing a lot of this work in Penn
12 Treaty, so we were able to hit the ground
13 running. Our group, including Oliver Wyman,
14 some people from the department and from
15 management, set out to define the broad strokes
16 or the basic elements of the plan. As I said a
17 little bit earlier, one of the keys was to be
18 able to provide coverages to policyholders that
19 the company could afford but would not be so
20 expensive.

21 So we looked, for example, if we can
22 look at Slide 55 -- I'm sorry, 59. My age is
23 catching up with me.

24 This is an illustration of the
25 things at which we were looking. This graph

22 (Pages 82 to 85)

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1 Q. The exhibits that counsel just --
 2 A. I do not.
 3 Q. You don't. Okay. Well, with your
 4 indulgence, then, I would --
 5 A. I have them on the screen.
 6 Q. Do you recognize the Oliver Wyman
 7 actuarial report on the screen?
 8 A. I do.
 9 Q. Are you familiar with it?
 10 A. Somewhat. I am not an actuary, but
 11 I have read it.
 12 Q. As the special deputy liquidator,
 13 this actuarial report, would it be something
 14 you would read and --
 15 A. Yes, sir.
 16 Q. -- seek to understand?
 17 A. Yes, sir.
 18 Q. Okay. Let's go to Page 11 of this
 19 report, if we could. Can you see that on the
 20 screen, Mr. Cantilo?
 21 A. I can.
 22 Q. Okay. I draw your attention to the
 23 first line, there are two blocks of
 24 illustrations here, and I want to draw your
 25 attention to the first line entitled Current

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1 which exceeds the guaranty fund limits, does
 2 that leave you with a \$600 million gap you
 3 would otherwise have to fill in order for the
 4 plan to fill and satisfy the funding gap?
 5 A. It leaves 600 million.
 6 Q. If the gross premium reserves
 7 reflect covered and uncovered liabilities,
 8 being the covered and uncovered liabilities of
 9 the guaranty funds, does that mean that
 10 approximately \$600 million of covered benefits
 11 need to either buy the voluntary action of
 12 policyholders or through the operation of the
 13 plan have to be reduced?
 14 A. If you are asking me in order to
 15 reduce the liabilities to fully cover
 16 liabilities, the \$600 million in liabilities
 17 have to be eliminated, hypothetically, that
 18 makes sense.
 19 Q. So the financial statements of SHIP,
 20 are they filed in accordance with statutory
 21 accounting principles?
 22 A. They were before SHIP was placed
 23 under rehabilitation.
 24 Q. When you filed the 2020 financials,
 25 were those prepared in accordance with

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1 Reserves in the topmost block.
 2 Do you see that?
 3 A. I do.
 4 Q. So the gross premium reserve, can
 5 you explain what that is?
 6 A. It is the projection for the total
 7 liabilities expected to arise under the
 8 policies in force in excess of the premium
 9 available to fund them.
 10 Q. Is this a present value calculation
 11 of those obligations net of a present value of
 12 premium?
 13 A. Yes.
 14 Q. So present value underlies the
 15 calculation of the gross premium reserve?
 16 A. Correct.
 17 Q. And the next number is the funding
 18 gap, which is \$1.2 billion. The uncovered
 19 reserve, what is that?
 20 A. That is a portion of the projected
 21 liabilities that is expected to exceed the
 22 applicable guaranty association limits for
 23 those policyholders.
 24 Q. Okay. So if we take the funding gap
 25 of \$1.2 billion and subtract the \$606 million

Page 242

1 statutory accounting principles?
 2 A. There were no 2020 financials filed.
 3 Q. Filed. Okay. Could we draw up
 4 Exhibit RP 12. We'll be going back to this
 5 exhibit. Okay.
 6 So when you used the word "filed,"
 7 do you mean filed with the various states?
 8 A. I interpreted your question to be
 9 asking about that, and that's the way in which
 10 I intended that response.
 11 Q. This financial statement, was it
 12 prepared in accordance with statutory
 13 accounting principles?
 14 A. I did not prepare that statement so
 15 I can't answer the question.
 16 Q. Was it prepared under your
 17 supervision?
 18 A. I requested it be prepared.
 19 Q. Is this number critical to analysis
 20 of the financial condition of SHIP?
 21 A. It is important.
 22 Q. Doesn't this calculate the funding
 23 gap; isn't the funding gap dependent upon these
 24 financial statements?
 25 A. The funding gap is not dependent on

11 (Pages 239 to 242)

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1 Q. The pricing, the actuarial
2 assumptions that underlay pricing assumed
3 certain investment returns; correct?
4 A. Correct.
5 Q. And then there were actual
6 investment returns, that's correct, too; right?
7 A. Correct.
8 Q. And the difference had an impact?
9 A. Correct.
10 Q. And that impact contributed to the
11 funding gap?
12 A. Absolutely.
13 Q. Do you have a sense of whether that
14 was material?
15 A. Yes, it was material.
16 Q. Okay. And do you have a sense of
17 whether it was as material as the -- as the
18 rate deficiency?
19 A. Because I don't have a quantity for
20 that sum, I can't say whether it was more or
21 less material than the underpricing, but it was
22 definitely material.
23 Q. And yesterday you testified about a
24 couple of investment decisions that had been
25 made and the losses that SHIP endured from

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1 gap?
2 A. Is there a question?
3 Q. I am asking you if you agree with
4 that or not; is that correct?
5 A. Do I agree that those things
6 affected the funding gap, yes.
7 Q. Materially?
8 A. Yes.
9 Q. Is it your opinion that the
10 Rehabilitator of an insolvent life insurer has
11 the discretion to impose the entire cost burden
12 of the insolvency on the insurer's current
13 policyholders and not trigger the guaranty
14 associations?
15 A. Are you asking me if I think that's
16 the law?
17 Q. Is that your opinion, yes.
18 A. My opinion is that the discretion of
19 Rehabilitators and rehabilitation Courts can
20 include that, yes.
21 Q. So if the policy -- so the
22 policyholders of SHIP need to address through
23 these options or -- let me try it a different
24 way.
25 The five options made available

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1 those decisions.
2 A. Yes.
3 Q. I believe you estimated the range of
4 those impacts as between 150 and \$200 million;
5 is that right?
6 A. It could even exceed that.
7 Q. And so would that also be
8 contributing materially to the funding gap?
9 A. Absolutely.
10 Q. And so, you know, that 150 to 2 or
11 \$300 million, that number seems to correlate to
12 the 300 or so of premium that was foregone as
13 well through regulator action, so it's a
14 material number that contributed to the gap;
15 right?
16 A. Is your question whether it's
17 similar or whether it's material?
18 Q. Was it material?
19 A. It was material.
20 Q. So \$300 million of premium rate,
21 premiums not approved, a material effect due to
22 the drop in the capital markets and several
23 hundred million dollars, a couple, 300,
24 whatever, range due to investment decisions,
25 all of that affecting materially the funding

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1 under Phase One of the plan, are they intended
2 to reduce the funding gap of \$1.2 billion?
3 A. The plan as a whole is intended to
4 reduce the funding gap.
5 Q. Is the goal to -- is the purpose of
6 the plan to eliminate the funding gap of \$1.2
7 billion?
8 A. It would be good if it did that, but
9 the plan would not fail, in my opinion, if it
10 failed to do that, no.
11 Q. So the reduction of the funding gap,
12 through the plan, who is bearing the burden of
13 that reduction?
14 A. If you describe the adjustments of
15 the policies as bearing the burden, the
16 policyholders would.
17 Q. Is there anyone other than the
18 policyholders that's bearing the burden of
19 those adjustments?
20 A. Putting aside tax considerations,
21 probably not.
22 Q. So that's about 20,000 policyholders
23 based on your testimony earlier in this cross?
24 A. No.
25 Q. No? How many policyholders?

23 (Pages 287 to 290)

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1 A. Well, if you eliminate the
2 non-forfeiture options, 30,000.

3 Q. And you don't further reduce it for
4 the policyholders already paying the If Knew
5 Premium?

6 A. I think we already talked about
7 that. Those policyholders will have the
8 ability to voluntarily select Options 2, 2A or
9 3.

10 Q. Okay. But you would agree, then,
11 that the \$1.2 billion would be addressed by the
12 30,000 long-term care policyholders?

13 A. The projected \$1.2 billion funding
14 gap would be addressed by them, yes.

15 Q. Exclusively?

16 A. No.

17 Q. Okay. Who else?

18 A. As I said, the taxpayers.

19 Q. The taxpayers?

20 A. Yes.

21 Q. Who?

22 A. To the extent that our plan is
23 successful, we will eliminate potentially
24 hundreds of millions of dollars in federal
25 income tax liability. Doing that, I suppose,

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1 Q. Now, you're a highly experienced
2 specialist in insurance company receiverships.
3 Do you understand or could you tell us why the
4 life and health guaranty funds were created?

5 A. I do understand why they were
6 created.

7 Q. Why were they created?

8 A. They were created in part because
9 there was a concern that in the absence of a
10 state-based mechanism for the protection of
11 policyholders of failed insurers, there was
12 going to be a shift from state to federal
13 regulation of the insurance industry.

14 Q. So the exclusive purpose for
15 creating the life and health guaranty funds was
16 to avoid federal guaranty fund statutes?

17 A. I don't think so.

18 Q. Was there a policyholder protective
19 purpose expressed with regard to the creation
20 of a life and health guaranty fund?

21 A. Absolutely.

22 Q. Okay. Do guaranty funds spread the
23 loss beyond the policyholders of an insolvent
24 insurance company?

25 A. Yes.

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1 arguably shifts that burden to other taxpayers.

2 Q. I don't pretend to be a tax expert,
3 and yesterday I believe you testified that you
4 weren't either, for which you deserve credit,
5 but I'm going to just stick with the \$1.2
6 billion, because I don't believe it's net of
7 any kind of tax benefit; is it?

8 A. I think we're mixing apples and
9 oranges.

10 Q. I do, too.

11 A. \$1.2 billion is the projected
12 deficit for the company.

13 Q. And the policyholders of SHIP, the
14 30,000 long-term care policyholders of SHIP are
15 going to bear that through higher premium or
16 reduced benefits; right?

17 A. If the entire deficit is eliminated
18 under the plan, the answer is yes.

19 Q. Any portion of the deficit
20 eliminated by the plan is being borne by the
21 policyholders; isn't it?

22 A. Yes.

23 Q. Rather than spread to the guaranty
24 fund system?

25 A. Correct.

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1 Q. You have testified that they spread
2 that loss in ways that are borne by taxpayers;
3 is that correct?

4 A. In part, yes.

5 Q. In part. So one of the purposes of
6 the life and health guaranty fund system is to
7 spread the loss of an insolvency broadly so as
8 not to concentrate it on the policyholders,
9 exclusively the policyholders of the insolvent
10 insurer; do you agree with?

11 A. I think that's one of the effects.
12 I'm not sure whether that was the purpose.

13 Q. Does it have that effect? Does the
14 triggering of the guaranty association spread
15 the loss broadly across the United States?

16 A. I just said I think that is the
17 effect, yes.

18 Q. And so why did the Rehabilitator of
19 SHIP decide that it was better to impose the
20 burden exclusively on the policyholders of
21 SHIP?

22 A. As I explained yesterday, there were
23 several factors. One is that the plan offers
24 policyholders benefits that would not be
25 available in liquidation.

EXHIBIT B



**SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA, *IN REHABILITATION*
APPROVED REHABILITATION PLAN**

JESSICA K. ALTMAN, REHABILITATOR
PATRICK H. CANTILO, SPECIAL DEPUTY REHABILITATOR

HOW TO PROVIDE COMMENTS AND OBJECTIONS

Comments may be addressed to Patrick H. Cantilo, Special Deputy Rehabilitator, at Senior Health Insurance Company of Pennsylvania, In Rehabilitation, 550 Congressional Blvd., Suite 200, Carmel, IN 46032, or by electronic mail to plan.comments@shipltc.com.

Formal Comments were required to be made by September 15, 2020, in compliance with the June 12, 2020 Case Management Order of the Commonwealth Court of Pennsylvania, which is available at www.shipltc.com. No provision has been made by the Court for additional Formal Comments.

THIS PLAN DOCUMENT PROVIDES DETAILS ABOUT THE PLAN APPROVED BY THE COMMONWEALTH COURT OF PENNSYLVANIA ON AUGUST 25, 2021, FOR SHIP'S REHABILITATION (THE "PLAN"). IT DESCRIBES IN DETAIL THE OPTIONS FROM AMONG WHICH SHIP POLICYHOLDERS CAN CHOOSE UNDER THE PLAN. EACH LONG-TERM CARE ("LTC") POLICYHOLDER WILL RECEIVE PERSONALIZED INFORMATION BEFORE HE OR SHE IS ASKED TO CHOOSE AN OPTION UNDER THE PLAN. THIS INFORMATION WILL BE PROVIDED IN A SIMPLIFIED FORMAT.

This version dated September 30, 2021, corrects an omission on page 19 of the September 24 version regarding disposition of the agent's commissions issue left open in the Court's August 25, 2021, Memorandum Opinion approving the Plan.

in both general and policyholder-specific circumstances. The cost and delay attendant to making the calculations for every policyholder in advance are not justified given that the results will may not be sufficiently accurate to be meaningful. However, beginning at page 68 there are illustrations of Plan options for several representative policyholders. This Plan Document therefore provides relative and directional guidance about Plan options rather than precise policy-level details for each one.

UNTIL THE PLAN EFFECTIVE DATE POLICYHOLDERS WILL HAVE THE SAME RIGHTS, BENEFITS, OPTIONS, AND OBLIGATIONS AS THEY DO NOW UNLESS THE PLAN SPECIFICALLY PROVIDES OTHERWISE.

A. SUMMARY DESCRIPTION OF THE PLAN

The following description of the Plan is intended to provide policyholders the basic general information required for them to understand the options that will be available to them under the Plan. Much more detail about the Plan and related matters is provided in the sections that follow.

1. GOAL AND PHASES OF THE PLAN

Recognizing that SHIP faces a substantial Funding Gap (described on page 87), the aim of the Plan is to increase revenues and reduce liabilities so as to narrow or eliminate that gap through a combination of *Policy Modifications* for most of the approximately 39,000 policies in force as of the filing of this Second Amended Rehabilitation Plan. Although the Plan has certain default provisions that apply when policyholders fail to make effective choices, it is structured to maximize policyholder choice, based on each person's individual circumstances and preferences. In proposing the Plan, the Rehabilitator recognized that many policyholders have costly policies that provide far more coverage than the policyholders are reasonably likely to require. Accordingly, a key element of the Plan is to enable policyholders to remove coverages that are not essential or even necessary to cover reasonable long-term care expenses. That is expected to help narrow the Funding Gap and potentially reduce their own premium, or at least avoid part or all of a necessary premium rate increase.

The Plan is designed to operate in three phases. *Phase One*, commencing now, is the principal phase and will strive to reduce substantially or eliminate the Funding Gap. In this phase it will be determined which policies require modification because their Current Premium is below the *If Knew Premium* for the benefits offered by the policies. The If Knew Premium is an accepted methodology for setting premiums for long-term care insurance ("LTCI") policies, more fully explained at page 27. Policyholders with Current Premium (see page 122) below the If Knew Premium will have to increase their premiums or reduce their benefits so that the premium will be adequate on an If Knew Premium basis. Policyholders whose Current Premium is at or above the If Knew Premium will not be required to modify their policies (increase their premiums or reduce their benefits) but may choose to make some such modifications if they prefer to do so, as explained below.

In **Phase Two**, the results of Phase One will be evaluated and additional Policy Modifications may be necessary for certain policies. It is expected that modifications in Phase Two will largely be based on **Self-sustaining Premiums** as explained at page 27. The goal of Phase Two will be to eliminate any Funding Gap not eliminated in Phase One. Only policies that meet the following conditions may be modified in Phase Two:

- a. Their premiums are not already Self-sustaining,
- b. They are not **Fully Covered** (i.e., they are not within the limits of, or otherwise not covered by, the applicable Guaranty Association - see page 123), and
- c. The policyholders have not selected **Option Two (a or b)** or **Option Three** (described below) in Phase One.

In **Phase Three**, the Company will complete the run-off of the LTCI business in force. If there are sufficient funds to do so, in Phase Three the Rehabilitator will make payments to policyholders and other creditors on account of any amounts owed to them apart from policy liabilities (addressed in Phase One and Two).

2. POLICYHOLDER ELECTIONS

This section describes the key elements of these policyholder options. They are described in full detail beginning on page 24. In Phase One every policyholder whose Current Premium (including the premium they would be paying but for a premium waiver) is below the If Knew Premium for the policy's benefits will be required to elect one of four options. Those whose Current Premium (including the premium they would be paying but for a premium waiver) is at or above the If Knew Premium may keep their current policies without modification or may elect Option Two or Option Three, described below.

- a. Option One will be to continue paying the Current Premium or to maintain the premium waiver if one is in effect, but if Current or waived Premium is less than the If Knew Premium, have benefits reduced in accordance with Plan provisions so that the premium for the reduced benefits (including waived premium) is equal on an If Knew Premium basis to the Current Premium. The benefit reductions will be selected automatically by the Plan.
- b. Option Two will be to select certain policy endorsements that provide selected essential benefits (sometimes greater than the benefits provided by Option One) at a lower premium than Option Four. This option, of which an enhanced alternative will also be available, will not be subject to further rate increases or benefit reductions in Phase Two of the Plan. Option Two is designed to provide reasonable coverage at reasonable premium rates.

- c. Option Three will be a ***Non-forfeiture Option*** (NFO) through which the policyholder will receive a Reduced Paid-up (RPU) policy providing limited benefits but for which no future premiums will be charged. Under the Plan, this option will include more generous benefits than the typical industry non-forfeiture option or reduced paid-up policy, most notably in that it will offer as much as a 30-month benefit period unless the current policy has a shorter benefit period. Moreover, policyholders who select this option will never have to pay additional premiums and this policy will never lapse.
- d. Option Four will be to retain the current policy benefits and pay the corresponding If Knew Premium (unless equal to or lower than the Current Premium that the policyholder is paying). For many policyholders this may require a substantial increase in premiums.

Policyholders paying premium at or above the If Knew Premium may choose to make no changes (i.e., make no election at all and leave their policies unchanged) or may elect Option Two or Option Three if preferable for their individual circumstances. Options One and Four would not result in any changes for such policyholders.

Before being required to make an election, each policyholder will receive information detailing the premiums and benefits of each option. Special rules apply to policyholders who are not currently paying premium due to a Premium Waiver provision in their or their spouses' policies. These are explained fully beginning at page 31. Generally, such policyholders who elect Option Two or Option Four and whose Current Premium (the premium they would be paying but for the waiver) is lower than the If Knew Premium, will be required to pay a Differential Premium. The Differential Premium consists of the difference between (1) the premium they would be paying if there were not a waiver in effect (the Current Premium), and (2) the If Knew Premium corresponding to the policy. See Section II.E.7, page 29. If the Premium Waiver terminates, such policyholders will be required to pay the full applicable If Knew Premium (or Self-sustaining Premium if in Phase Two). Substantially the same options will be offered to policyholders on claim.

3. NO WORSE THAN LIQUIDATION

Every policyholder will be offered at least one option in Phase One that will provide him or her potential benefits equal to or exceeding those that would be available from the applicable Guaranty Association in the event of liquidation, but generally no more than the current policy benefits.

- a. Policyholders with Current Premium (including the premium they would be paying but for a premium waiver) at or above If Knew Premium in fact will not be required to make any changes in their policies. Thus they will be treated at least as well as they would in liquidation, and perhaps better if their policies offer benefits in excess of those that would be offered by Guaranty Associations in liquidation.

- b. Option Two will provide at least the benefit value that the Guaranty Association would provide in liquidation for every policyholder whose current policy provides benefits in excess of those limits. In many cases, other options will also provide the benefits that would be available from Guaranty Associations in liquidation. For policyholders with current benefits below Guaranty Association limits, Option Two will provide at least the current level of benefits.

In that respect, the Plan is designed to place policyholders in no worse off a position than they would face in a liquidation of SHIP.

4. DEFAULT OPTIONS

For every policyholder there will be a Default Option which will apply automatically if no proper election is made. In Phase One, for every policyholder whose Current Premium is at or above the If Knew Premium, the Default Option will be to leave the policy unchanged. However, if the Current Premium is below the If Knew Premium, there will be a Default Option that will be identified in the election materials (and is illustrated on page 67). In general, the Default Option will be Option One (the downgrade) for policyholders on Premium Waiver. However, if the Non-forfeiture Option (NFO) would provide these policyholders better benefits than the downgrade, the NFO will be the Default Option. For policyholders who are paying premium, Option Two (the Basic Policy Endorsements - see Section III.A.2.d, page 48) will be the Default Option.

In Phase Two, for every policyholder whose Current Premium is at or above the Self-sustaining level, the Default Option will be to leave the policy unchanged. However, if the Current Premium is below the Self-sustaining level, there will be a Default Option similar to Phase One. In general, the Default Option will be Option One (the downgrade) for policyholders on Premium Waiver. However, if the Non-forfeiture Option (NFO) would provide these policyholders better benefits than the downgrade, the NFO will be the Default Option. For policyholders who are paying premium, Option Two (the Basic Policy Endorsements) will be the Default Option.

The Default Option will apply if the policyholder fails to make an election by the applicable deadline or submits an election form that does not clearly identify the policyholder's election (for example because two or more options are elected). For a policyholder whose Current Premium is equal to, or higher than, the If Knew Premium (or Self-sustaining level in Phase Two), the Default Option will be to leave the policy unchanged, and no changes will be made to the policy unless specifically elected, even if the policyholder does not submit a proper completed election form. The Rehabilitator believes that between 25% and 40% of policyholders may be in this category in Phase One.

5. CHANGES IN POLICYHOLDER ELECTIONS

Policyholders will not have the opportunity to change their elections after the applicable ***Policyholder Election Date*** (the deadline for policyholder option elections under the Plan). Before the Policyholder Election Date, policyholders may change their elections by submitting new

Policyholder Election Forms if they are received before the applicable Policyholder Election Date. A new valid Policyholder Election Form received before the Policyholder Election Date will replace and invalidate a valid or invalid Policyholder Election Form submitted previously. If time permits, the Rehabilitator will attempt to reach policyholders who submit defective election forms (for example because they make no valid election or make more than one election) to attempt to correct the error. However, if there is insufficient time before the Policyholder Election Date, or if the Rehabilitator cannot reach the policyholder, the result of submitting a defective election form will be that the Default Option will be selected automatically under the Plan.

6. PHASE TWO ELECTIONS

Similar options as those offered in Phase One will be offered to policyholders in Phase Two of the Plan, but the premium modification will be based on attaining Self-sustaining Premiums. It is important to note that policyholders who elect Option One or Option Four in Phase One, and whose policies after Phase One are not Self-sustaining or Fully Covered (*i.e.*, within Guaranty Association limits), may face additional premium rate increases or benefit reductions (sometimes substantial) in Phase Two. Policyholders who elect Option Two (including the enhanced alternative) or Option Three will NOT face additional rate increases or benefit reductions in Phase Two of the Plan. In addition, policyholders who select Option Three will never pay any more premiums.

7. EFFECT OF ELECTIONS

Policyholder Elections under the Plan will be permanent. This means that if the Plan does not succeed in rehabilitating SHIP fully and the Company has to be placed in liquidation, the policies to which guaranty association coverage and limits (see Section VI.J, page 92) will apply will be those as modified as a result of the Policyholder Elections. The elections are not intended to, and will not, eliminate the Unfunded Benefit Liability described in the discussion of policy restructuring (Section VI.H, page 91).

B. KEY CONSIDERATIONS FOR POLICYHOLDERS

For every policyholder there will always be two competing considerations: the anticipated need for LTC benefits and the cost of maintaining coverage for those benefits. As is true of many similar LTCI blocks in the market, many of SHIP's policies have historically been substantially underpriced and policyholders have not been asked to pay the premium that would have been necessary to assure that those benefits will be available when needed. This is not a sustainable model and is a key contributor to SHIP's present financial challenge. The Plan is designed to enable policyholders to balance these competing considerations in the context of their individual circumstances. Put simply, not every policyholder will need the same level of benefits in the future and not every policyholder will be in a position to pay an appropriate premium for the most generous combinations of LTC benefits.

In determining which option to elect, each policyholder should consider what is a reasonable level of benefits to be provided by his or her policy given his or her likely future needs, and the

ability of the policyholder to pay for such benefits. For example, there are very material differences between the costs of a policy that provides 5% compound Inflation Protection, one that provides 2% simple Inflation Protection, and one that provides no Inflation Protection at all. Similarly, there are material differences between the costs of a policy with lifetime benefits, one with a five-year benefit period, and one with a two-year benefit period. Moreover, features like Premium Waivers, Restoration of Benefits, Return of Premium, short Elimination Periods, indemnity rather than reimbursement, and “traditional” benefit triggers can all add materially to the cost of a policy but may not be indispensable to every policyholder.

The Plan is constructed to offer an array of options that can be responsive to the widely divergent circumstances of SHIP’s policyholders. For example, for policyholders who cannot afford any premium rate increases, Option One (maintaining Current Premium and reducing benefits) may be the best option in that it eliminates rate increases in Phase One of the Plan. However, for some of those policyholders, the reduction in benefits necessary to achieve that goal may leave the policies with benefits deemed by the policyholders to be insufficient. Moreover, policyholders who select Option One may face additional rate increases or benefit reductions in Phase Two of the Plan. For such policyholders Options Two or Three may be preferable. Option Two is designed to provide a reasonable combination of benefits at a reasonable premium. The enhanced version of Option Two provides more generous benefits in the form of a longer benefit period and some inflation protection. For many policyholders it is likely that the premium required for Option Two will be less than what would be required for Option Four in order to maintain the current policy benefits. On the other hand for these policyholders, the benefits offered in Option Two may be more acceptable than those provided by Option One. An advantage of Option Two is that it would not be subject to rate increases or benefit reductions in Phase Two of the Plan. For other policyholders, Option Three (the Non-forfeiture Option) may be optimal. That would be a policy with modest benefits but for which no more premium would ever be required, even if the Company were placed in liquidation.

For those fortunate policyholders who can afford material rate increases, Option Four might be attractive in that it would enable them to retain the most generous benefits, even at high premium rates. Many of these policyholders would face very large rate increases when selecting Option Four. This is because, in many cases, the premiums being paid for those policies are substantially lower than what they should be relative to the benefits promised. Moreover, policyholders selecting Option Four would face the possibility of additional substantial rate increases or benefit reductions in Phase Two of the Plan.

There will also be a number of policyholders whose Current Premiums are already appropriate. Such policyholders will not be required to make any election. For these policyholders, selecting Option One or Option Four would be meaningless because neither their premiums nor benefits would change in either case. However, they will be given the opportunity to select Option Two (including the enhanced alternative) or Option Three if that would be better for their circumstances.

It is not practical to offer enough options to meet precisely every policyholder’s expectations or preferences. Doing so would make the Plan too complicated and costly. The Special Deputy

Rehabilitator has led a team that has devoted intense efforts to the development of a manageable array of options that recognizes the major differences in policyholders' circumstances. While no one option may be ideal for a particular policyholder, the differences among the options are such that it is hoped that every policyholder will find at least one option that will enable that policyholder to emerge from SHIP's rehabilitation with adequate long-term care protection at reasonable premiums.

C. COVID-19

In December 2019, a new virus emerged in Wuhan, China, identified in due course as severe acute respiratory syndrome coronavirus 2, resulting in a pandemic of coronavirus disease 2019 ("COVID-19"). As of the filing of the Second Amended Plan, at least 140 million people had been infected worldwide, resulting in at least 3 million deaths. In the U.S., the first cases were reported in January 2020, with total estimates by then exceeding 32 million and fatalities exceeding 570,000. COVID-19 is particularly threatening to the elderly and those with impaired respiratory systems or other underlying health conditions. While intense work continues around the globe, no effective cure has yet emerged. There has been substantial progress in efforts to develop and distribute several effective vaccines. At the time the Second Amended Rehabilitation Plan was filed, more than one quarter of the U.S. population had been fully vaccinated, more than 40% having received at least one of two vaccines. The emphasis on vaccinating the older population first had resulted in nearly three quarters of those over 65 having received at least one dose, more than 60% having been fully vaccinated. As a result, COVID-19 mortality in nursing home and assisting living facilities has plummeted, approaching pre-pandemic levels after having peaked in December 2020. All told, more than 1.1 million residents and staff had by then been infected with the virus, and more than 133,000 succumbed to it.

The full impact of the COVID-19 pandemic on the U.S. insurance industry remains to be determined. The life insurance industry makes the following observations. Between March 2020 and February 2021, the number of actual deaths was 120% higher than the number of expected deaths.¹ This led to a 14% increase in mortality rates among group life claimants in the first quarter of 2020.² Excess deaths were concentrated "among those in the preferred underwriting class, particularly those ages 60 and older."³ However, this has not increased life insurance premiums or decreased policy offerings.⁴

¹ Susan Rupe, What Record Mortality Rates Mean for the Life Insurance Industry, INSURANCE NEWS NET (Apr. 14, 5:00 PM), <https://insurancenewsnet.com/conference-post/what-record-mortality-rates-mean-for-the-life-insurance-industry>.

² Id.

³ Id.

⁴ Andrew Keshner, Has COVID-19 Made Life Insurance More Expensive? MARKET WATCH, (Apr. 12, 12:00 PM), <https://www.marketwatch.com/story/has-covid-19-made-life-insurance-more-expensive-these-researchers-say-they-have-the-answer-2020-12-07>.

The impact on health insurers differs somewhat. Due to unemployment caused by COVID-19, between 3.1 and 27 million Americans lost employer-sponsored health insurance in 2020.⁵ Health spending also dropped considerably, because of the cancellation of elective surgeries.⁶ This loss was concentrated in the first half of 2020 but persisted enough to cause a 2.7% drop in non-prescription medical spending from 2019 to 2020.⁷ This drop in spending could result in higher-than-average premium rebates for insureds.⁸ Overall, health insurers fared well, with average gross margins at the end of the third quarter of 2020 for individual market and fully-insured group market plans almost 25% higher than in 2019.⁹ Medicaid Advantage plans saw a 35% average gross margin increase over the same time period.¹⁰ As a result, 2021 health insurance premiums are expected to remain largely unchanged.¹¹

For long-term care insurance, the effects of the pandemic have been mixed. COVID-19 seemed to reduce long-term care insurance costs by (1) shortening the amount of time some insureds used benefits either because they died or because they left long-term care facilities, or (2) preventing some insureds from starting to use long-term care services.¹² A Fitch Ratings report indicates that the long-term care insurance industry gained roughly \$2.5 billion in net operating profits from 2019 to 2020.¹³ Actuaries are unsure about what effect COVID-19 will have on long-term care insurance over the long run, as COVID-19 could have “accelerated the deaths of people who were likely to die

⁵ Lola Butcher, How Health Insurance is Faring Under COVID, THE WEEK (Apr. 14, 2:00 PM), <https://theweek.com/articles/975895/how-health-insurance-faring-under-covid>.

⁶ Cynthia Cox, Krutika Amin, and Rabah Kamal, How Have Health Spending and Utilization Changed During the Coronavirus Pandemic, PETERSON-KFF HEALTH SYSTEM TRACKER (Apr. 12, 1:00 PM), <https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/#item-start>.

⁷ Id.

⁸ Id.

⁹ Daniel McDermott, et al., Health Insurer Financial Performance Through September 2020, KFF (Apr. 14, 4:00 PM), <https://www.kff.org/private-insurance/issue-brief/health-insurer-financial-performance-through-september-2020/>.

¹⁰ Id.

¹¹ Cox, *supra* note 12.

¹² Long-Term Care Insurance Dashboard: 2020, FITCH RATINGS, (Apr. 14, 4:00 PM), <https://www.fitchratings.com/research/insurance/long-term-care-insurance-dashboard-2020-improved-results-view-of-reserve-adequacy-unchanged-06-04-2021>.

¹³ Id.

soon . . . and spared healthier older people.”¹⁴ This would mean that the surviving elderly population could spend more time using long-term care services.¹⁵

However, this seems to vary from insurer to insurer. A Milliman survey covering April to September 2020 found that the overall use of long-term care benefits remained unchanged.¹⁶ While active life mortality increased for most responding insurers, 40% of responding insurers saw a decrease or no change.¹⁷ The death rate for insureds already receiving benefits decreased by 5% or more for two-thirds of responding insurers.¹⁸ An American Academy of Actuaries issue brief suggests that the bulk of COVID-19 deaths in long-term care facilities “may be associated with Medicaid funded-homes, which might not house a meaningful number of insureds.”¹⁹

The implications of COVID-19 for SHIP and the Plan fall in three major areas.

CASE MANAGEMENT: Restrictions on travel and personal contact imposed as preventive measures have cause SHIP to revise, at least temporarily, the manner in which it confirms eligibility for benefits and other aspects of case management. Although current protocols emphasize other means of communication, the Company remains attentive to the needs of its insureds as well as to the important function of preventing fraud, waste and abuse. At this juncture, these changes are not expected to have a material effect on the Plan or on the options it will offer to eligible policyholders.

MORTALITY AND MORBIDITY: Although sufficient reliable data is not yet available, preliminary data indicates that COVID-19 may be causing a decrease in the number of SHIP insureds filing claims and an increase in the number of deaths among the aging population insured by SHIP. While these unfortunate developments may combine to reduce slightly SHIP’s deficit, it is possible that, at least in part, they are temporary. The Rehabilitator cannot yet project what, if any permanent impact, these consequences will have on the Plan but they are not expected to be material.

SUSPENSION OF PREMIUM PAYMENTS: Many SHIP policyholders had delayed making their required premium payment. While SHIP had delayed lapsing or cancelling policies for non-payment of premiums because of the exceptional circumstances, protracted delays in making these payments

¹⁴ Keshner, *supra* note 5.

¹⁵ *Id.*

¹⁶ Allison Bell, Long-Term Care Insurers Reveal Early COVID-19 Effects, THINK ADVISOR (Apr. 14, 3:30 PM), <https://www.thinkadvisor.com/2021/03/18/long-term-care-insurers-reveal-early-covid-19-effects/> (of the 4 insurers that responded, one saw a 5-10% increase in benefit use, two saw a less than 5% decrease in benefit use, and one saw no change).

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ Impact of COVID-19 on Long-Term Care Insurance, AMERICAN ACADEMY OF ACTUARIES (Apr. 15, 10:15 AM), <https://www.actuary.org/node/14151>

could have aggravated substantially SHIP's financial difficulties. Some regulatory agencies had requested or required that insurers (including SHIP) accommodate some premium deferrals, but many or most of these deferrals are also expiring or will soon expire. The net effect of the delays, therefore are also not expected to be material. Continued non-payment of premium beyond the expiration of the deferral period is expected to result in an increased number of policy terminations. The Rehabilitator has already observed a slight increase in the number of policy terminations that appear not to be the result of increased insured mortality. However, in the aggregate they are not expected to be material to the Plan.

D. TIMELINE

The order placing SHIP in rehabilitation required the Rehabilitator to submit to the Court a preliminary plan for SHIP's rehabilitation by April 22, 2020, and a subsequent case management order provided for policyholders and other interested parties to comment on the Plan through September 15, 2020. Over 100 people have submitted comments, some formal but most informal, and a few parties have also been admitted as intervenors. The Approved Rehabilitation Plan reflects the analysis of those comments and continuing work by the rehabilitation team.

At page 35 is a sequence of past and expected events in the presentation and implementation of the Plan. While it is difficult to predict future events in a matter of this complexity and under the current exceptional circumstances, a hearing on the Plan was held beginning on May 17, 2021. On August 25, 2021, The Court filed a Memorandum Opinion and Order approving the Second Amended Rehabilitation Plan with the exception of Section VI.N. relating to the suspension of agents' commissions, which was addressed in a separate hearing on September 8, 2021, and approved on September 13, 2021, along with a settlement between certain intervening agents and the Rehabilitator. Implementation of the Plan commenced following the entry of the Court's Memorandum Opinion and Order. We anticipate that most policyholders will be sent Policyholder Election Packages around year-end and be asked to make their elections by around mid March, 2022, becoming effective in April of next year. The details of options available to some policyholders and these dates may differ because of changes in their circumstances (see Subsection II.L.3, page 37) or decisions made by the senior insurance regulator of the states in which their policies were issued (see Section VI.V, page 108). It is also possible that changes in circumstances generally may result in changes in these dates. This matter is complex and delays in this timetable remain possible.

E. RATIONALE FOR THE PLAN

The Plan hinges on two essential assumptions: (1) in order to maximize policyholder protection, the Plan must strive to reduce the Funding Gap by increasing revenue and reducing liabilities; and (2) while premium rate increases can increase revenue by some increment, elimination by policyholders of long-term care coverage they may not truly need or be able to afford, especially at adequate premium rates, will go much further in remedying the Company's dire financial situation. The Rehabilitator believes that the Plan structure, which is the product of extended analysis by industry experts, offers a reasonable prospect of success based on sound principles.

1. The Plan gives policyholders more control over their fates, allowing each to elect the path best suited to his or her circumstances.
2. All policyholders will have at least one option for preserving their current coverage and at least one option for preserving their Current Premium.
3. Target premiums under the Plan take rate increase history and product differences into account, improving the equity of the premium rate structure. Generally, policyholders whose policies were issued in states that have approved comparatively more rate increases over preceding years will face lower premium increases or benefit reductions under the Plan.
4. It is important to note that Plan premium rate increases are not based on state of issue or state of residence. They are based exclusively on the characteristics of each individual policy, including the difference between Current Premium and If Knew Premium (in Phase One) or Self-sustaining Premiums (in Phase Two).
5. In every case, policyholders will have at least one option (Option Two) calibrated to provide outcomes no less favorable than liquidation, including applicable Guaranty Association benefits.
6. The revenue from rate increases under the Plan will go to pay claims and expenses of implementing the Plan whereas, in liquidation, Guaranty Association rate increases have historically been used to reduce assessment burdens for member insurers and not to increase the ability to pay claims.
7. Though certainly not guaranteed, the Plan structure inherently creates the possibility of greatly reducing, if not eliminating, the Company's deficit.

F. PLAN PROJECTIONS

The magnitude of SHIP's Funding Gap or deficit as of the Effective Date is difficult to predict because it is dependent on several changing circumstances over which the Rehabilitator has little or no control. However, the Rehabilitator believes that, depending on policyholder elections, Phase One of the Plan could greatly reduce, if not eliminate, the Funding Gap. Solely for purposes of directional guidance, the Rehabilitator has prepared some hypothetical results that could be expected from operation of the Plan. For purposes of these projections, it is assumed that SHIP's Funding Gap as of the Effective Date will be \$1.2 billion. It should be emphasized that these are hypothetical projections dependent on future events that may evolve in a manner different from the assumptions in the projections. Subject to these caveats, it is the belief of the Rehabilitator that the Plan would produce the following results:

1. If 100% of disabled SHIP LTC policyholders and 80% of active SHIP LTC policyholders elect Option Four (retaining the current policy benefits and paying the rate increases necessary to reach If Knew Premium), the Funding Gap will be reduced by about \$500

II.E.4.e, page 28. Again, for purposes of this determination “expected” consists of best estimate assumptions.

- d. **Allocable Assets** is a notional determination consisting of the Company’s invested assets less reserves for costs of administration, contingencies, and certain debts of higher priority. The **Asset/Premium Ratio** is the ratio of Allocable Assets to the aggregate Accumulated Premiums for all LTC policies. **Accumulated Premium** is the total Gross Premiums paid, and premiums waived, under a policy or group of policies from inception until the valuation date.
- e. **Allocated Assets** are the portion of the Company’s Allocable Assets notionally allocated to a particular policy in accordance with the terms of, and solely for the purposes of calculations described in, the Plan. Such asset allocations are nominal and do not give a policyholder a right to any Allocated Assets or any particular sum of money. The assets allocated to each policy equal the product of the policy’s Accumulated Premium times the Asset/Premium Ratio. This approach is designed to allocate assets equitably among policyholders solely for the purpose of calculating Phase Two premiums.

TABLE 1: ILLUSTRATION OF ASSET ALLOCATION		
1	Total Invested Assets	\$1,500,000,000
2	Reserve for Costs of Administration	-\$200,000,000
3	Contingencies	-\$10,000,000
4	Priority Debts	-\$50,000,000
5	Total Allocable Assets (L1 - (L2...L4))	\$1,240,000,000
6	Total Accumulated Premium	\$3,480,000,000
7	Asset/Premium Ratio (L5/L6)	35.63%
8	Accumulated Premium - Hypothetical Policy	\$50,000
9	Allocated Assets Hypothetical Active Policy (L7 X L8)	\$17,816

5. For policyholders on claim in Phase Two, the Self-sustaining Premium will be determined as if they were not on claim. For this purpose, assets will be allocated notionally to policies on claim as explained above.
6. Although this Plan Document assumes that in Phase Two determinations will be based on Self-sustaining Premiums, it is possible that, depending on the outcome of Phase One and other relevant considerations, in Phase Two the Plan will utilize an alternative premium

department of the opt-out state will make the rate increase determinations for those policies and the benefits under Plan provisions will be adjusted to correspond to the premium rates approved by the opt-out state. The Rehabilitator proposed this approach and it is now part of the Approved Rehabilitation Plan. Section VI.V, below at page 108, describes the basic elements of the mechanism for enabling states to make their own rate increases decisions within the context of the Plan. Note that, apart from the rate increase determinations, under this approach the policies issued in the opt-out state will still be administered by the Rehabilitator under the Plan so that the opt-out state will not have to provide that administration.

8. CONCLUSION

On balance, the Rehabilitator concluded that the best approach is the Plan as approved by the Court, with the component as described in alternative seven, above. Accordingly, the Approved Plan now includes the additional following section.

V. ISSUE-STATE RATE APPROVALS

This Section describes the issue-state rate approval alternative for states that object to the Rehabilitator and the Commonwealth Court modifying rates as part of the Plan for SHIP LTC policies issued in those states, and which elect to make their own determinations as to such rate increases themselves (*Opt-out States*).

While this Section was added to the Plan to accommodate that objection, the Rehabilitator makes an important observation. In order to reduce policyholder subsidization and overall burden, and in an effort to achieve the best result possible under the circumstances, the Rehabilitator has undertaken the development of a model that allows her to address each policy individually in a seriatim fashion. Most, if not all, material policyholder calculations under the Plan (including premium rate adjustments) are performed individually for each long-term care policy. As noted more fully below, if a state elects to make its own determination for the rates charged for the policies issued in that state in groups rather than individually, the result may be disadvantageous to many policyholders. In determining whether or not to “opt out” a state should consider carefully its ability to address the circumstances of each policy individually, as does the Rehabilitator. If a state is unable or unwilling to do this, it may want to evaluate whether the results of its premium rate increase decisions may prove to be inferior to those proposed by the Rehabilitator, all things considered.

1. SUMMARY

If the chief insurance regulator (“Commissioner”) of an issue-state formally advises the Rehabilitator that his or her state elects to “opt-out” of the rate increase component of the Approved Rehabilitation Plan, the Plan will not apply in the same way to the policies issued in that state (the *Opt-out Policies*). In that case, the Rehabilitator will file in the Opt-out State a premium rate increase request for the Opt-out Policies the Current Premiums of which are below If Knew

premiums. **Holders of Opt-out Policies with Current Premiums equal to or greater than If Knew Premium will be unaffected and will retain their current policies without modification.** The holders of the Opt-out Policies with Current Premium below If Knew Premium will not be able to elect from among the Plan options and will instead have the choices described below, determined by how the Opt-out State responds to the Rehabilitator's premium rate increase request.

THE INTENT OF THIS SECTION IS TO ENABLE STATES THAT OBJECT TO THE REHABILITATOR OR COMMONWEALTH COURT SETTING PREMIUM RATES UNDER THE PLAN WITHOUT THEIR APPROVAL TO REVIEW AND APPROVE (ENTIRELY OR PARTIALLY) OR DISAPPROVE THE PLAN'S PREMIUM RATES THEMSELVES. HOWEVER, THE EFFECTS OF A STATE "OPTING OUT" UNDER THIS SECTION MAY INCLUDE A REDUCED NUMBER OF MEANINGFUL OPTIONS FOR AFFECTED POLICYHOLDERS AND SOME OF THOSE POLICYHOLDERS PAYING HIGHER PREMIUMS THAN THEY WOULD UNDER THE PLAN. IN ADDITION, SOME POLICYHOLDERS WHO DO NOT MAKE AN ELECTION MAY FACE INVOLUNTARY BENEFIT REDUCTIONS.

IT SHOULD ALSO BE NOTED THAT THE DECISIONS OF OPT-OUT STATES WILL AFFECT POLICYHOLDERS RESIDING IN OTHER STATES WHOSE POLICIES HAD BEEN ISSUED IN THE OPT-OUT STATE. CONVERSELY, THOSE DECISIONS WILL NOT AFFECT POLICIES HELD BY RESIDENTS OF THE OPT-OUT STATES BUT ISSUED IN OTHER STATES.

2. OPT-OUT ELECTIONS

- a. In the next few weeks, the Rehabilitator will provide every state in which SHIP policies in force (and not in NFO status) have been issued the opportunity to opt out of the rate approval provisions of the Plan. Every state that has not by the specified deadline (the ***Opt-out Deadline***) communicated to the Rehabilitator an election to opt out will be deemed to have opted into the Plan and the rest of this Section will not apply to the policies issued in that state. The Rehabilitator will endeavor to provide states at least thirty (30) days to make the Opt-out Election. States may, but are not required to, affirmatively opt into the Plan. States that do not timely communicate an appropriate Opt-out Election to the Rehabilitator will be deemed to have opted into the Plan.
- b. The communication necessary to Opt Out (the ***Opt-out Election***) must be signed and sworn by the Commissioner, Director, Superintendent or other senior insurance regulatory official of the state. The communication need not take any particular form but must contain the following statement:

On behalf of the State [or Commonwealth] of [X], and in the exercise of my authority as [X]'s senior insurance regulatory official I hereby elect to withdraw from the premium rate increase approval provisions of the Rehabilitation Plan for Senior Health Insurance

Company of Pennsylvania (SHIP) all of the in force long-term care insurance policies currently held by SHIP and first issued by SHIP or its predecessors in [X]. I have read the Plan and understand the consequences of this election.

- c. The original signed and sworn Opt-out Election must be received by the Rehabilitator at the address specified no later than the Opt-out Deadline, but the Opt-out Election will be effective if an electronic form (including a facsimile) of the Opt-out Election is received by the Rehabilitator on or before the Opt-out Deadline and the original signed and sworn Opt-out Election is received by the Rehabilitator no later than ten days after the Opt-out Deadline. **It is recommended that states commence the evaluation of whether they want to opt out of the Plan as soon as possible so that they will have ample time to finalize and communicate their decision once they receive the opt-out election notice. The Rehabilitator will be pleased to answer any question that may assist a state in evaluating this matter. States have not been required to take any action under this Section before the Plan was approved.**
- d. The Rehabilitator will acknowledge every Opt-out Election in writing. An Opt-out Election sent in advance of the Opt-out Deadline may be canceled by the Opt-out State in a communication sent in the same manner and received by the Rehabilitator no later than the Opt-out Deadline so long as it contains the following language:

On behalf of State [or Commonwealth] of [X], and in the exercise of my authority as [X]'s senior insurance regulatory official, having first elected by communication dated [Opt-out Election date] to withdraw from the premium rate increase approval provisions of the Rehabilitation Plan for Senior Health Insurance Company of Pennsylvania (SHIP) as to all of the in force long-term care insurance policies currently held by SHIP and first issued by SHIP or its predecessors in [X], I hereby revoke the Opt-out Election. Accordingly, I request that all of the SHIP long-term care insurance policies issued in [X] be included in the premium rate increase approval provisions of SHIP's Rehabilitation Plan. I have read the Plan and understand the consequences of this revocation.

- e. Opt-out Elections may only be revoked after the Opt-out Deadline with the Rehabilitator's written consent. Generally, such consent will be provided unless the revocation will have an adverse effect on the Plan or opt-in policyholders.
- f. An Opt-out Election will be effective as to all Opt-out Policies the Current Premium of which is below If Knew Premium, even if the Opt-out State determines to approve

some (but not all) of the premium rate increases sought by the Rehabilitator from the Opt-out State. A STATE MAY NOT OPT OUT AS TO ONLY SOME OF SHIP'S POLICIES ISSUED IN THAT STATE.

PHASE ONE

3. PREMIUM RATE INCREASE APPLICATION

- a. Following receipt of a valid Opt-out Election, the Rehabilitator will file in each Opt-out State a request for approval of the full amount of actuarially justified rate increases (on an If Knew Premium basis) for the SHIP LTC policies issued in that state the Current Premium of which is below If Knew Premium. The rate increase application will be submitted on a seriatim basis (that is, policy-by-policy, not in the aggregate or by policy form), seeking a specific rate increase for each policy. No rate increases will be sought for Opt-out Policies the premiums of which are already equal to or above the If Knew Premium or which are on premium waiver (including those in NFO status). If an Opt-out State does not respond to the application for rate increases as to any policy within 60 days, the request as to that policy will be deemed denied. If an Opt-out State does not respond to the Rehabilitator's rate increase application within 60 days, the request will be deemed denied in its entirety. An Opt-out State may approve premium rate increases for Opt-out Policies in whatever amount it deems appropriate and the approved percentages may vary among the Opt-out Policies the Current Premium of which is below If Knew Premium. The Opt-out State's decision as to the requested rate increases will govern the choices available to the holders of Opt-out Policies the Current Premium of which is below If Knew Premium.
- b. If the Opt-out State timely approves the requested rate increases in full for all Opt-out Policies, it will be treated as if it had not opted out of the Plan, it will be deemed to be an *Opt-in State*, and its policyholders will be included in the Plan just as those whose policies were issued in states that did not opt out (Opt-in States). If the Opt-out State does not timely approve the full rate increase sought by the Rehabilitator for all Opt-out Policies, all of the policies (including those on premium waiver) issued in that state the Current Premium (whether or not waived) of which is below If Knew Premium will be deemed Opt-out Policies subject to the following provisions.
- c. If the Opt-out State responds to the rate increase application in the aggregate or by group (such as by policy form) rather than seriatim (policy-by-policy), the Rehabilitator will apply the resulting increases on a policy-by-policy basis. Note that, for some policyholders, the state's approved rate might exceed the requested rate increase.

- d. APPROVAL OF THE RATE INCREASES IN THE AGGREGATE RATHER THAN SERIATIM (POLICY-BY-POLICY) COULD RESULT IN SOME POLICYHOLDERS BEING REQUIRED TO PAY A HIGHER PREMIUM RATE THAN REQUESTED BY THE REHABILITATOR AND HIGHER RATES THAN THEY WOULD PAY UNDER THE PLAN.
 - e. ALSO, APPROVAL OF THE RATE INCREASES IN THE AGGREGATE RATHER THAN SERIATIM COULD RESULT IN SOME POLICYHOLDERS PAYING A LOWER PREMIUM RATE THAN REQUESTED BY THE REHABILITATOR AND RECEIVING BENEFIT DOWNGRADES UNDER THE DEFAULT OPTION (OPTION A).
 - f. PRELIMINARY MODELING BY THE REHABILITATOR SUGGESTS THAT, IF A STATE WERE TO MAKE A RATE DETERMINATION FOR ALL OF THE LTC POLICIES ISSUED IN THAT STATE (INCLUDING THOSE WITH PREMIUM AT OR ABOVE IF KNEW PREMIUM AS TO WHICH THE REHABILITATOR DID NOT SEEK A RATE INCREASE) AS A GROUP, AS MANY AS 65% OF POLICYHOLDERS WILL PAY HIGHER PREMIUM RATES THAN THEY WOULD IF THE RATES WERE DETERMINED SERIATIM.
 - g. IN ADDITION, RATE APPROVAL IN THE AGGREGATE OR BY GROUP, RATHER THAN SERIATIM, MAY RESULT IN A MATERIAL INCREASE IN THE SUBSIDIZATION OF SOME POLICYHOLDERS BY OTHERS.
 - h. OPT-OUT POLICYHOLDERS MAY BE ADVISED BY THE REHABILITATOR THAT THE RESULTING PREMIUM RATES ARE THE RESULT OF DECISIONS MADE BY THE OPT-OUT STATE.
4. TREATMENT OF OPT-OUT POLICIES IN PHASE ONE - PREMIUM PAYING POLICIES
- a. Holders of Opt-out Policies with Current Premium below the If Knew Premium, will be able to choose from among several options described below. These options are designed to preserve as much choice as reasonably possible while giving effect to the Opt-out State's rate decision and avoiding or minimizing subsidies by other policyholders. Holders of Opt-out Policies with Current Premiums equal to or greater than If Knew Premium will be unaffected and will retain their current policies without modification unless the Opt-out State mandated a change in their premium rates. That could occur if such policies were part of a group for which the Opt-out State mandated a premium rate increase for the entire group.
 - b. In Phase One of the Plan, the choices for holders of Opt-out Policies with Current Premium below the If Knew Premium, and which are not subject to a premium waiver (*i.e.*, those paying premiums), will be:

OPTION A:

Pay the required premium (including approved premium rate increases) and keep the current policy. However, every opt-out policy with premiums below the If Knew level (after implementing the rate increase approved by the Opt-out State) will be downgraded to the benefit level supported (on an If Knew Premium basis) by the premium approved by the Opt-out State. The downgrade will be calculated using a method substantially similar to the Plan downgrade mechanism (see Section III.A.1.c, page 43). The Downgrade Process for Option A has fewer steps than the Plan downgrade mechanism for Opt-in policies in that Benefit Reductions Eight (extension of elimination period) and Ten (removal of waiver of premium) do not apply to Opt-out policyholders. The downgrade will be adjusted so that the resulting Maximum Policy Value (MPV) is no lower than the lesser of the policy's current MPV or the applicable guaranty association limits (the "MPV floor"). This will be accomplished by implementing the downgrade and extending the policy's Maximum Benefit Period (MBP) as necessary so that the resulting MPV satisfies that requirement. In the event that the MPV floor applies, Benefit Reductions Eight (extension of elimination period) and Ten (removal of waiver of premium) do not apply to Opt-out policyholders. Option A will be the default option for Opt-out Policies with Current Premium below If Knew Premium.

NOTE THAT, BECAUSE THIS IS THE DEFAULT OPTION, THE BENEFITS PROVIDED BY A POLICY FOR WHICH THE RATE APPROVED BY THE OPT-OUT STATE IS BELOW THE IF KNEW PREMIUM RATE WILL AUTOMATICALLY BE DOWNGRADED. POLICYHOLDERS CAN AVOID SUCH DOWNGRADES BY SELECTING OPTION D AND PAYING IF KNEW PREMIUMS.

Opt-out Policies as to which the premiums, taking into account the Opt-out State's decision on the Rehabilitator's rate increase application, are at or above the If Knew Premium will not be downgraded if they select Option A.

OPTION B:

In lieu of the approved rate increase, elect a specified benefit downgrade calibrated to the Current Premium (omitting approved premium rate increases) on an If Knew basis. The downgrade will be determined by a calculation substantially similar to the Plan downgrade mechanism and policyholders will not be able to select specific benefit changes. Unlike OPTION A, the downgrade in this case will not be "floored" at the lesser of the current MPV or applicable guaranty association limit. This option allows policyholders to avoid any rate increase.

OPTION C:

Select the Opt-out State-required reduced paid-up policy ("RPU") or Non-forfeiture Option ("NFO"). If the state does not require a particular RPU or NFO,

policyholders will be offered the RPU or NFO currently specified in their policies. If no RPU or NFO is specified in the policies, policyholders selecting this Option will be provided an NFO used by SHIP before the Plan. In all of these cases, this will be a paid-up policy of moderate benefits for which no premium need ever be paid again. OPT-OUT POLICYHOLDERS WILL NOT BE ABLE TO SELECT THE ENHANCED NFO OFFERED UNDER THE PLAN, WHICH GENERALLY OFFERS A LONGER BENEFIT PERIOD.

OPTION D:

Keep the current policy benefits and accept a premium increase to the If Knew Premium for the benefits provided by the policy even though such a rate increase has not been approved by the Opt-out State. This is strictly an elective option that will never apply by default and is intended to provide policyholders the ability to retain the current benefits when they are able and willing to pay the required premium. In other words, this option strives to avoid taking contractual benefits away from policyholders who are willing to pay for them. THIS PROVISION IS INTENDED TO REDUCE POTENTIAL DISADVANTAGES OF OPTING OUT.

5. **TREATMENT OF OPT-OUT POLICIES IN PHASE ONE - POLICIES ON PREMIUM WAIVER**
 - a. Every Opt-out Policyholder on premium waiver will retain the waiver as long as required by the policy, but if the Current (waived) Premium is below the If Knew level and the policy's current MPV is greater than the GA limit, the policy's MBP will be reduced to the longer of (1) what can be supported by the Current Premium (had it not been waived) on an If Knew basis, and (2) the MBP required to make the MPV no less than the GA limit. If the current MPV is lower than the GA limit, or if the waived premium is at or above the If Knew level, the MBP will be left unchanged. This is designed to provide substantially no less benefits than what would happen in liquidation while minimizing involuntary subsidies by other policyholders.
 - b. Once the waiver expires, such policyholders with waived premium below the If Knew level will be required to resume paying premium at the current rates and retain the reduced MBP (if it has been reduced as explained above).
 - c. In Phase One, Opt-out policyholders on premium waiver will not be subject to rate increases and will not be able to choose any other option.

PHASE TWO

6. **IMPLEMENTATION OF PHASE TWO FOR OPT-OUT POLICIES**
 - a. In general, if and when Phase Two of the Plan is implemented for policies issued in Opt-in States, it will also be implemented for Opt-out Policies. The implementation

will be similar to that described for Phase One, above but based on Self-sustaining Premiums rather than If Knew Premium. If the Rehabilitator adopts an alternative premium structure for Phase Two it will apply to Opt-out Policies as well. See Section II.E.6, page 28.

- b. In Phase Two, the Rehabilitator will file in the Opt-out State a new premium rate increase request for the Opt-out Policies the Current Premiums of which are below Self-sustaining Premiums and which are not on premium waiver. As in Phase One, the Phase Two rate increase application will be filed on a seriatim basis. The Opt-out State's decision as to the requested rate increases will govern the choices available to the holders of Opt-out Policies in Phase Two.
- c. Because the Opt-out State has already been deemed to have opted out in Phase One, timely approval of the Phase Two requested rate increases in full for all Opt-out Policies will NOT result in the state being treated as if it had not opted out of the Plan. All of the policies issued in that state have been deemed Opt-out Policies in Phase One and remain so in Phase Two.
- d. If the Opt-out State responds to the Phase Two rate increase application in the aggregate or by group rather than seriatim (policy-by-policy), the Rehabilitator will apply the resulting increases on a policy-by-policy basis. AS IN PHASE ONE, THIS COULD RESULT IN SOME POLICYHOLDERS BEING REQUIRED TO PAY A HIGHER PREMIUM RATE THAN REQUESTED BY THE REHABILITATOR AND HIGHER RATES THAN THEY WOULD PAY UNDER THE PLAN. That would occur if the state's approval exceeded the requested rate increase for one or more policies.
- e. OPT-OUT POLICYHOLDERS MAY BE ADVISED BY THE REHABILITATOR THAT THE RESULTING PREMIUM RATES ARE THE RESULT OF DECISIONS MADE BY THE OPT-OUT STATE.
- f. Holders of Opt-out Policies with Current Premiums equal to or greater than Self-sustaining Premiums will be unaffected and will retain their current policies without modification unless the Opt-out State mandated a change in their premium rates. That could occur if such policies were part of a group for which the Opt-out State mandated a premium rate increase for the entire group. The holders of the Opt-out Policies with Current Premium below Self-sustaining Premiums would not be able to elect from among the Plan options and would instead have the choices described above but based on Self-sustaining Premiums, determined according to how the Opt-out State responds to the Rehabilitator's premium rate increase request.
- g. For purposes of calculating the Self-sustaining Premiums of Opt-out Policies in Phase Two, the Rehabilitator will use a separate pool of assets from those used in the calculation of Self-sustaining Premiums for policies in Opt-in States. Assets will be

allocated between the two pools in proportion to accumulated premium paid by the then current policyholders of each group of states.

7. **TREATMENT OF OPT-OUT POLICIES IN PHASE TWO - PREMIUM PAYING POLICIES**
 - a. If and when Phase Two is implemented for policyholders participating in the Plan, the process described above (with the same options) will be repeated for premium-paying Opt-out Policies using Self-sustaining Premiums instead of If Knew Premium. However, policies that would be fully covered by the applicable guaranty association if SHIP were placed in liquidation, are Self-sustaining, or have elected the NFO or RPU would not be affected in this second phase.
 - b. NOTE THAT THERE CAN BE A MATERIAL DIFFERENCE IN PHASE TWO PREMIUMS BETWEEN POLICIES THAT ARE FULLY COVERED AND THOSE THAT ARE NOT, EVEN IF THEY ARE OTHERWISE SIMILAR AND THEIR MPV DIFFERS BY A SMALL AMOUNT.
8. **TREATMENT OF OPT-OUT POLICIES IN PHASE TWO - POLICIES ON PREMIUM WAIVER**
 - a. Much as in Phase One, every Opt-out Policyholder on premium waiver will retain the waiver in Phase Two as long as required by the policy. If the waived premium is below the Self-sustaining Premium level and the policy's current MPV is greater than the GA limit, the policy's MBP will be reduced to the longer of (1) what can be supported by the Current Premium (had it not been waived) on a Self-sustaining Premium basis, and (2) the MBP required to make the MPV no less than the GA limit. If the current MPV is lower than the GA limit, or if the waived premium is at or above the Self-sustaining Premium level, the MBP will be left unchanged.
 - b. Once the waiver expires, such policyholders with waived premium below the Self-sustaining Premium level will be required to resume paying premium at the current rates and retain the reduced MBP (if it has been reduced as explained above).
 - c. As in Phase One, Opt-out Policyholders on premium waiver will not be subject to rate increases in Phase Two and will not be able to choose any other option.
9. Other provisions of the Plan not affected by these provisions would remain as applicable to the Opt-out Policies as to other policies. Additional details of the opt-out provisions will be specified depending on further discussions with other regulators and the Orders of the Court.
10. This approach is designed to defer to the issue-state for rate approval by making its decision the default option. It would reduce or eliminate the requirement that other policyholders subsidize the Opt-out Policies prospectively and provides Opt-out Policyholders benefits at

least equal to, and in many cases exceeding, what they would receive in liquidation. It would offer policyholders benefit downgrade options in lieu of the approved rate increases as well as a reduced paid-up policy option. In addition, to reduce the disadvantage of being excluded from the Plan, these policyholders would also be offered the option of retaining the current coverage if they are able and inclined to pay the required premium.

COMPARISON OF OPTIONS FOR OPT-IN AND OPT-OUT POLICYHOLDERS IN PHASE ONE

11. The options available to Opt-out policyholders differ in some respects from those available to Opt-in policyholders.
 - a. Option One for Opt-in policyholders is the same as Option B for Opt-out policyholders.
 - b. Opt-in policyholders do not have the equivalent of opt-out Option A - pay the approved rate and be downgraded to what that rate buys on an If Knew basis subject to the GA floor. That is because the “approved rate” for Opt-in policyholders would be the If Knew Premium, which would make Option A the same as Option D. The Opt-in policyholder option most similar to Option A for Opt-out policyholders is Opt-in Option Two, the Basic Policy Endorsement which, like Opt-out Option A, might entail both premium increases and benefit reductions. Note, however, that Option A does not exempt Opt-out policyholders from modifications in Phase Two, while Opt-in policyholders who elect Option Two in Phase One will not face additional rate increases or Benefit Reductions in Phase Two.
 - c. Opt-out policyholders do not have the equivalent of Opt-in Option Two, the Basic Policy Endorsements (which is the Default Option for premium-paying Opt-in policyholders) and enhanced Basic Policy Endorsements. The Basic Policy Endorsements consist of specific Policy Modifications intended to provide reasonable benefits and premiums that, if selected in Phase One, will be immune from changes in Phase Two of the Plan. Opt-in policyholders making this election will not face additional modifications in Phase Two of the Plan, except that they may be required to pay full premium rather than Differential Premium if a Premium Waiver becomes inactive.
 - d. Both Opt-in policyholders and Opt-out policyholders have an NFO option (Option Three for Opt-in policyholders and Option C for Opt-out policyholders); however, it is likely to be “richer” for Opt-in policyholders. For Opt-out policyholders, this is the only option that ensures that they will not face potential premium rate increases or benefit reductions in Phase Two.
 - e. Both groups have the same If Knew premium option – Option Four for Opt-in policyholders and Option D for Opt out policyholders. Note that Option Four in

Phase One for Opt-in policyholders is based on Phase One premium (the greater of the current premium and the If Knew premium) while Option D for Opt-out policyholders is based simply on if knew premium. However, they operate the same way because Opt-out policyholders with premium at or above If Knew premium will have no modifications, rate increases, or options. Thus, both Opt-in and Opt-out policyholders already paying at least If Knew premiums will be exempt from mandatory modifications. Although Opt-in policyholders with current premiums at or above If Knew premiums (and who therefore are not required to elect modifications under the Plan) can voluntarily select other options, Opt-out Policyholders with premiums at or above If Knew Premium will not have that option. They will simply retain their current premium and benefits.

- f. For policyholders on premium waiver, the major difference is that Opt-out policyholders will not be required to pay Differential Premium, while Opt-in policyholders will be required to pay a Differential Premium if they elect to keep their current benefits. However, if the waived premium for an Opt-out Policy is below the If Knew level and the policy's current MPV is greater than the GA limit, the policy's MBP will be reduced to the longer of (1) what can be supported by the current premium (had it not been waived) on an If Knew basis, and (2) the MBP required to make the MPV no less than the GA limit. If the current MPV is lower than the GA limit, or if the waived premium is at or above the If Knew level, the MBP will be left unchanged.

W. DISCLAIMERS AND SOURCES OF INFORMATION

The discussion of the Rehabilitation Plan in this document describes how it is proposed to be implemented by the Rehabilitator. If the Plan is modified by the Court or pursuant to subsequent amendments proposed by the Rehabilitator, its implementation may differ materially from the description herein.

The Plan includes information concerning SHIP's history and current and projected financial condition. This information was prepared based on information available to SHIP and the Rehabilitator, including information provided by SHIP to the Rehabilitator or available in historical public filings, and on actuarial projections that inherently include a degree of uncertainty. The Rehabilitator has yet to conclude an investigation of all the reasons that led to the Company's distressed financial condition. Pursuant to her statutory ability to do so, the Rehabilitator has delegated broad responsibility to the SDR and references in the Plan to the Rehabilitator should be interpreted as including the SDR unless specified otherwise. The Rehabilitator and SHIP do not make (and hereby disclaim) any warranty, express or implied, as to the accuracy or completeness of the information contained in the Plan. In particular, events and forces beyond the control of the Rehabilitator and SHIP may alter the assumptions upon which the disclosures in the Plan are based. The Plan Document includes certain projections, but they cannot forecast and reflect fully any events that may occur subsequent to the date hereof. Such events may have a material impact on the information contained in the Plan Document and any recovery or benefits that may be received by

EXHIBIT C



September 30, 2021

Via U.S. Mail and Email

**Opt-Out Election Notice for Senior Health Insurance Company of Pennsylvania (In Rehabilitation) -
Deadline: November 15, 2021**

Dear Commissioner:

This communication provides important information on a decision available to each state's Commissioner (or chief insurance regulator) affecting holders of long-term care insurance policies issued in their states by Senior Health Insurance Company of Pennsylvania ("SHIP") or its predecessors.

Background

As you are already aware, SHIP was placed in statutory rehabilitation on January 29, 2020, at the request of the Pennsylvania Insurance Commissioner, Jessica K. Altman (the "Commissioner"). On that day she appointed me Special Deputy Rehabilitator of SHIP. On April 22, 2020, the Commissioner as Rehabilitator filed a proposed Rehabilitation Plan with the Commonwealth Court of Pennsylvania ("Court"). Subsequently, on October 21, 2020, the Rehabilitator filed a proposed Amended Rehabilitation Plan and on May 3, 2021, she filed a proposed Second Amended Rehabilitation Plan ("Second Amended Plan"). A hearing on the Second Amended Plan was conducted by the Court the week of May 17, 2021. On August 25, 2021, the Court filed her Memorandum Opinion and Order approving the Plan. In accordance with its Order, an Approved Rehabilitation Plan (the "Approved

Senior Health Insurance Company of Pennsylvania (In Rehabilitation)
550 Congressional Boulevard, Suite 200, Carmel, IN 46032

Plan” or “Plan”) was filed with the Court on September 24, 2021. The Order approving the Plan and the Approved Plan can be found on the SHIP website (“Website”), www.shipltc.com/court-documents.

Issue-State Rate Approvals Introduction

The Approved Plan contains a section providing a rate approval alternative for states that object to the Rehabilitator and the Court modifying premium rates for SHIP long-term care insurance policies issued in those states, and which elect to make their own determinations as to such rate modification themselves. A state electing this alternative will be considered an Opt-out State. The process and additional information for the issue-state rate approval is provided in more detail in the Approved Plan beginning on page 108. **While this notice summarizes some aspects of that provision, the Plan and especially that section, must be read in its entirety to understand its requirements and consequences. In addition, we provide after this letter some frequently asked questions and their answers.**

The Opt-out deadline is November 15, 2021.

As described in that section of the Plan, the Rehabilitator has undertaken the development of a model that allows her to address each policy individually in a seriatim fashion. Most, if not all, material policyholder calculations under the Plan (including premium rate and benefit adjustments) are performed individually for each long-term care policy. This is a key component of the Plan’s mechanism for eliminating discriminatory or inequitable premium rates and policyholder subsidization prospectively. In determining whether or not to “opt out” a state should carefully consider its ability to address the circumstances of each policy individually, as does the Rehabilitator under the Plan. As explained in the Plan, setting rates in cohorts or groups could work to the disadvantage of some policyholders.

Process to Opt-Out of the Plan

Every state in which there are long-term care insurance policies in force issued by SHIP or its predecessors has the opportunity to opt out of the rate approval provision of the Plan. States may, but are not required to, affirmatively opt into the Plan. States that wish to opt out of the Plan must make an Opt-out Election as described below.

The Opt-out Election must be signed and sworn by the Commissioner, Director, Superintendent, or other senior insurance regulatory official of the state. The communication must contain the following statement, also found on the attached Opt-out Form:

On behalf of the State [or Commonwealth] of [X], and in the exercise of my authority as [X's] senior insurance regulatory official I hereby elect to withdraw from the premium rate increase approval provisions of the Rehabilitation Plan for Senior Health Insurance Company of Pennsylvania (SHIP) all of the in force long-term care insurance policies currently held by SHIP and first issued by SHIP or its predecessors in [X]. I have read the Plan and understand the consequences of this election.

As noted, November 15, 2021, is the Opt-out Deadline. All original signed and sworn Opt-out Elections must be received by the Rehabilitator at the following address by the Opt-out Deadline.

Senior Health Insurance Company of Pennsylvania (In Rehabilitation)
Attn: Administrator of State Opt-out Elections
550 Congressional Boulevard, Suite 200, Carmel, IN 46032

Alternatively, the Opt-out Election will be effective if an electronic form of the Opt-out Election is received by the Rehabilitator via email at rehabilitation@shipltc.com (or via facsimile at (317) 566-7588) on or before the Opt-out Deadline. The physical original signed and sworn Opt-out Election must be received by the Rehabilitator no later than ten days after the Opt-out Deadline, i.e., by November 25, 2021. **Every state that does not communicate to the Rehabilitator a proper election to opt out by the Opt-out Deadline will be deemed to have opted into the Plan. The Rehabilitator will not assert that submitting an Opt-out Election in accordance with the Plan constitutes an appearance in the Rehabilitation proceeding or submission to the Court's jurisdiction.**

The Rehabilitator will acknowledge every Opt-out Election in writing. An Opt-out Election sent in advance of the Opt-out Deadline may be canceled by the Opt-out State in a communication sent in the same manner as the Opt-out Election, received by the Rehabilitator no later than the Opt-out Deadline. It must contain the following language:

On behalf of State [or Commonwealth] of [X], and in the exercise of my authority as [X]'s senior insurance regulatory official, having first elected by communication dated [Opt-out Election date] to withdraw from the premium rate increase approval provisions of the Rehabilitation Plan for Senior Health Insurance Company of Pennsylvania (SHIP) as to all of the in force long-term care insurance policies currently held by SHIP and first issued by SHIP or its predecessors in [X], I hereby revoke the Opt-out Election. Accordingly, I request

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that all of the SHIP long-term care insurance policies issued in [X] be included in the premium rate increase approval provisions of SHIP's Rehabilitation Plan. I have read the Plan and understand the consequences of this revocation.

After the Opt-out Deadline, Opt-out Elections may only be revoked with the Rehabilitator's written consent. Generally, such consent will be provided unless the revocation will have an adverse effect on the Plan or opt-in policyholders.

After receiving an Opt-out Election, the Rehabilitator will file a premium rate application in the Opt-out state for all of the Opt-out Policies on an if knew premium basis (defined and explained in the Approved Plan). However, no rate increases will be sought for policyholders on premium waiver or, in Phase One, for those whose premium is at or above if knew premium.

If a state submits (and the Rehabilitator acknowledges) an Opt-out Election, and that state subsequently and timely approves the rate increases requested by the Rehabilitator in full for all Opt-out Policies, the state will be treated as if it had not opted out of the Plan. It will be deemed to be an Opt-in State, and its policyholders will be included in the Plan just as those whose policies were issued in states that did not opt out (Opt-in States).

Policyholder Data Available to Assist in Making Your Decision

A file of policyholder data has been prepared to assist in your decision about participation in the Plan's premium rate modification provisions. This policyholder file provides liabilities, premium, and Rehabilitation Plan coverage options information for individual policies in each state. Access to this file is available on the [SHIP Rehabilitation Plan secure data site](#).

Please note that this policyholder file contains data as of July 31, 2021. This is the data the Rehabilitator will use in implementing the Plan. If you previously requested and reviewed policyholder files for your state as of June 30, 2021, or an earlier date, the July 31, 2021, policyholder file is intended to replace those earlier files.

Access to the SHIP Rehabilitation Plan Secure Data Site

In February 2021, information was provided to you regarding the creation of a SHIP Rehabilitation Plan secure data site. If you do not already have access to this site, please send an email requesting access to rehabilitation@shipitc.com and access will be granted. As the chief insurance regulator in your state,

Senior Health Insurance Company of Pennsylvania (In Rehabilitation)
550 Congressional Boulevard, Suite 200, Carmel, IN 46032

you are authorized to have access to the secure data site which is being provided as a regulator-to-regulator confidential communication under the auspices of applicable NAIC confidentiality provisions. Please do not hesitate to contact us if you have any questions about these confidentiality provisions or about obtaining access to the secure data site.

Updated Information

SHIP's website will continue to be updated regularly with Court documents and related rehabilitation materials. You are encouraged to visit the website regularly for updated information.

The Rehabilitator, the Court, and other interested parties are aware that the effect of this Amended Plan may be substantial for some policyholders and creditors. Every reasonable effort has been made to design a plan that is consistent with the best interests of policyholders, consistent with applicable law, and in compliance with the orders of the Court.

We strongly encourage you to contact us if you have any questions about these matters. You can reach me at phcantilo@cb-firm.com and Robert L. Robinson, SHIP's chief rehabilitation officer, at rrobinson@shipltc.com and (609) 670-2367.

Thank you for your patience and cooperation during the rehabilitation process.

Sincerely yours,



Patrick H. Cantilo
Special Deputy Rehabilitator

Enclosures



Frequently Asked Questions about Issue-State Rate Approval Alternative ("Opt-Out Election")

Q1. What does opting out of the rate approval provisions of the Approved Plan mean for my policyholders?

If a state opts-out of the rate setting provisions of the Approved Plan, policyholders with SHIP long-term care insurance policies issued in that state will not be eligible to participate in the rate approval and certain other provisions of the Plan. Premium rates will be set by the Opt-out state and the Rehabilitator will adjust benefits accordingly to avoid requiring other policyholders to subsidize Opt-out policyholders. In other respects, those policies will be administered under the Plan. Opt-out policyholders will not have the same options as opt-in policyholders. In particular, they will not be able to select the basic policy endorsement, enhanced basic policy endorsement, or enhanced NFO. As explained in the Plan, under some circumstances Opt-out policyholders may end up paying a higher premium than they would have if the state had not opted out. Note also that, if after opting out a state approves in full the Rehabilitator's requested premium rate increases, the policies issued in that state will be treated as if the state had never opted out. See Q11, below.

Q2. How does a state opt-out of the Plan?

To opt out, the chief insurance regulator of a state must make an Opt-out Election using the attached form entitled "State Opt-out Election Form" or its own form containing the requisite provision, which will be signed and sworn by the chief insurance regulatory official of the state. The form must be mailed to the following address:

Senior Health Insurance Company of Pennsylvania (In Rehabilitation)
Attn: Administrator of State Opt-out Elections
550 Congressional Boulevard, Suite 200, Carmel, IN 46032

The form must be received by the Rehabilitator at the above address by the Opt-out Deadline, which is November 15, 2021. More detailed instructions can be found in the cover letter of this Notice and on pages 109 - 110 of the Approved Plan.

Q3. Will submitting an Opt-out Election subject a state to the jurisdiction of the rehabilitation court?

While the Rehabilitator obviously cannot predict what the Court will decide in cases that have not yet arisen, she hereby assures all the commissioners and chief insurance regulators that neither the Pennsylvania Insurance Commissioner, nor the Rehabilitator, will take the position with the Court that submitting an Opt-Out Election subjects a state to the jurisdiction of the Rehabilitation Court.

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550 Congressional Boulevard, Suite 200, Carmel, IN 46032

Q4. What happens when a state opts out of the Plan?

An Opt-out Election will be effective as to all the SHIP LTC policies issued in the Opt-out State. A state may not opt out as to only some of SHIP's policies issued in that state. The Rehabilitator will file a premium rate modification application in the Opt-out State and benefits will be adjusted depending on that state's decision in response to that application.

Additional details for the Premium Rate Increase Application begin on page 111 of the Approved Plan, including details of the treatment of opt-out policies in Phase One and Phase Two.

Q5. On what basis will the Rehabilitator file a rate modification application for Opt-out Policies?

The Rehabilitator's application will be on an if knew premium basis and submitted seriatim – policy-by-policy.

Q6. What will the Rehabilitator do if an Opt-out State rejects part or all of the requested premium rate modifications?

In that case, the Rehabilitator will adjust the affected premium rates to the amount approved by the Opt-out State. Depending on the option elected by the affected policyholder, benefits under the policy may be reduced to the amount that can be funded by the approved rate on an if knew basis. This is necessary to avoid forcing other policyholders to subsidize the Opt-out Policies prospectively. This matter is discussed in more detail in the Plan.

Q7. What will happen if an Opt-out State makes a rate decision for Opt-out Policies in groups rather than on a policy-by-policy basis?

In that case, the Rehabilitator will apply the new rates to the affected policies individually. Note that the result may be that some policyholders will get a larger rate increase than sought by the Rehabilitator without getting any additional benefits. For other policyholders this may result in an unintended mandatory downgrade. By way of illustration, assume that the Rehabilitator seeks a rate increase of 5% for Policyholder 1, 10% for Policyholder 2, and 15% for Policyholder 3. If the state approves a flat 10% increase for all three, Policyholder 1 will end up paying 5% more than he or she would have if the state had opted in and Policyholder 3 will face a 5% benefit reduction he or she would not have if the state had approved the 15% requested increase.

Q8. Will Opt-out Policies have the same options as Opt-in Policies?

No. While the Plan must be read in detail to understand this, in general three options available to Opt-in Policyholders will not be available to Opt-out Policyholders: (1) the basic policy endorsement, (2) the enhanced basic policy endorsement, and (3) the enhanced non-forfeiture option. These are described on pages 24, 48, 49 and 50 of the Plan. As noted above, if the state

approves the Rehabilitator's rate increase in full after opting out, the policyholders will be treated as if the state had not opted out and will have all the options available under the Plan.

Q9. How will states opting out affect the Plan?

It is difficult to predict future results but, in general, the Rehabilitator believes that states opting out is likely to help reduce SHIP's deficit more than states opting in. This is because it is anticipated that Opt-out States will approve lower rate increases than the Rehabilitator seeks. This will result in additional downgrades which reduce the deficit faster than additional premium. However, the Rehabilitator DOES NOT recommend that states opt out because that is generally expected to be disadvantageous to affected policyholders.

Q10. What policies will be affected by a state's opt-out decision?

The Opt-out Election only affects policies **issued** in the Opt-out State, not those **residing** in that state. On average, 15% of the policyholders reside in states other than the issue state. For some states, this percentage is as high as 40%. That means that the Opt-out State's rate decision will affect a significant number of policyholders residing in other states. Conversely, on average that rate decision will not affect 15% of SHIP's policyholders in the Opt-out State (because they were issued in other states), although this percentage is as high as 57% in some states.

Q11. What happens if a state that opts out of the Plan subsequently and timely approves the requested rate increases in full for all Opt-out Policies?

If a state submits and the Rehabilitator acknowledges an Opt-Out Election, then subsequently and timely approves the requested rate increases in full for all Opt-out Policies, it will be treated as if it had not opted out of the Plan. It will be deemed to be an Opt-in State, and for functional purposes its policyholders will be included in the Plan just as those whose policies were issued in states that did not opt out (Opt-in States). Additional information about the Premium Rate Increase Application following the receipt of a valid Opt-out Election can be found in the Approved Plan.



This form must be received by the
Opt-out Deadline – November 15, 2021

STATE OPT-OUT ELECTION FORM

Senior Health Insurance Company of Pennsylvania (In Rehabilitation)

If you desire to opt-out of the rate modification provisions of the Approved Plan, please fill in the blanks with the name of your state in the paragraph below, sign your name, and include your title and date in the blanks below the paragraph. The form must be notarized and received by the deadline.

On behalf of the State (or Commonwealth) of _____, and in the exercise of my authority as [_____]’s senior insurance regulatory official I hereby elect to withdraw from the premium rate increase approval provisions of the Rehabilitation Plan for Senior Health Insurance Company of Pennsylvania (SHIP) all of the in force long-term care insurance policies currently held by SHIP and first issued by SHIP or its predecessors in [_____]. I have read the Plan and understand the consequences of this election.

Printed Name: _____

Signature: _____

Title: _____

Date: _____

State of _____

County of _____

BEFORE ME appeared on the ____ day of _____, 2021 _____, known to me to be the person who signed the foregoing form and upon [his/her] oath stated that [he/she] executed the same for the purposes therein stated.

Notary public in and for _____

[NOTARY SEAL]

My commission expires _____

This form should be returned to:

Senior Health Insurance Company of Pennsylvania (In Rehabilitation)
Attn: Administrator of State Opt-out Elections
550 Congressional Boulevard, Suite 200, Carmel, IN 46032

STATE OF SOUTH CAROLINA
RICHLAND COUNTY

IN THE COURT OF COMMON PLEAS
FIFTH JUDICIAL CIRCUIT

Raymond G. Farmer, as Director of the South
Carolina Department of Insurance, and the
South Carolina Department of Insurance,

Plaintiffs,

vs.

Jessica K. Altman, as Rehabilitator of Senior
Health Insurance Company of Pennsylvania,
Patrick H. Cantilo, as Special Deputy
Rehabilitator of Senior Health Insurance,
Company of Pennsylvania, and Senior Health
Insurance Company of Pennsylvania in
Rehabilitation,

Defendants.

Civil Action No. 2020-CP-40-05802

**MOTION FOR TEMPORARY
RESTRAINING ORDER**

Plaintiffs, Raymond G. Farmer, as Director of the South Carolina Department of Insurance, and the South Carolina Department of Insurance, hereby move this Court, pursuant to Rule 65(b), SCRCF, to enter a temporary restraining order prohibiting the Defendants, their agents, employees, successors, attorneys, and all persons in active concert and participation with it or them, from communicating, implementing or enforcing in this State the Approved Rehabilitation Plan for Senior Health Insurance Company of Pennsylvania, in Rehabilitation dated September 30, 2021, otherwise interfering with the rights of policyholders of Senior Health Insurance Company of Pennsylvania (SHIP) in South Carolina, or violating the insurance laws of this State pertaining to long-term care insurance, pending a hearing and determination of Plaintiffs' Motion for a Temporary Injunction and Memorandum in Support filed with this Court on November 12, 2021. Defendants are in the process of implementing the Approved Rehabilitation Plan and will

begin contacting policyholders in December 2021 or sooner, asking them to make elections under the Approved Rehabilitation Plan. Plaintiffs further move the Court for an order setting a date for such hearing.

Unless this motion is granted, Plaintiffs and affected policyholders will suffer immediate and irreparable injury, loss, and damage as a result of the actions of Defendants before Defendants or their attorney can be heard in opposition to it, and before a hearing can be had on the merits of the Motion for Temporary Injunction, as more fully appears in the Motion for Temporary Injunction and Memorandum in Support, the exhibits thereto, and the Summons and Complaint previously filed in this matter.

Plaintiffs are notifying the Defendants of this Motion by automatic electronic service (South Carolina Courts E-File) and by electronic mail from counsel for Plaintiffs to Defendants' counsel of record.

WHEREFORE, Plaintiffs request that the Court enter a Temporary Restraining Order prohibiting the Defendants, their agents, employees, successors, attorneys, and all persons in active concert and participation with it or them, from communicating, implementing or enforcing in this State the Approved Rehabilitation Plan for Senior Health Insurance Company of Pennsylvania, in Rehabilitation dated September 30, 2021 or otherwise interfering with the rights of policyholders of Senior Health Insurance Company of Pennsylvania (SHIP) in South Carolina or otherwise violating the insurance laws of this State pertaining to long-term care insurance, and such other and further relief as the Court may deem just and proper.

This Motion is made pursuant to Rule 65(b), SCRPC and is based upon the papers and pleadings on file herein and any oral argument that this Court may allow.

Respectfully submitted,

November 18, 2021

s/ Geoffrey R. Bonham
S.C. Bar No. 13058
Associate General Counsel
S.C. Department of Insurance
P.O. Box 100105
Columbia SC 29202-3105

Capitol Center
1201 Main Street, Suite 1000
Columbia SC 29201

Telephone: 803-737-6200
Fax: 803-737-6229
Email: gbonham@doi.sc.gov

One of the Attorneys for Petitioner

STATE OF SOUTH CAROLINA

RICHLAND COUNTY

IN THE COURT OF COMMON PLEAS

FIFTH JUDICIAL CIRCUIT

Raymond G. Farmer, as Director of the South
Carolina Department of Insurance, and the
South Carolina Department of Insurance,

Plaintiffs,

vs.

Jessica K. Altman, as Rehabilitator of Senior
Health Insurance Company of Pennsylvania,
Patrick H. Cantilo, as Special Deputy
Rehabilitator of Senior Health Insurance,
Company of Pennsylvania, and Senior Health
Insurance Company of Pennsylvania in
Rehabilitation,

Defendants.

Civil Action No. 2020-CP-40-05802

VERIFICATION

PERSONALLY APPEARED BEFORE ME, Daniel N. Morris, Deputy Director for
Financial Regulation & Solvency, who, first being duly sworn, says the following:

1. As the Deputy Director for Financial Regulation & Solvency at the South Carolina
Department of Insurance, I am responsible for the licensing, financial analysis and examination of
insurance companies in South Carolina.

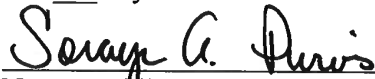
2. I have read the Complaint for Declaratory Judgment and Injunctive Relief, Plaintiffs'
Motion for Temporary Injunction and Memorandum in Support, and the Motion for Temporary
Restraining Order filed in the above-captioned action. The allegations contained therein are true
of my own knowledge and/or review of the official records and reports issued, received and
maintained by the Department pursuant to its powers under statute and regulation, except those

matters therein alleged upon information and belief and, as to them, I believe them to be true and correct to the best of my knowledge.



Daniel N. Morris
Deputy Director for
Financial Regulation & Solvency
South Carolina Department of Insurance
1201 Main Street, Suite 1000
Columbia, South Carolina 29201

Sworn to and Subscribed before me
this 18th day of November 2021



Notary Public for the State of South Carolina

My Commission Expires: 09/26, 2028

STATE OF SOUTH CAROLINA

RICHLAND COUNTY

IN THE COURT OF COMMON PLEAS

FIFTH JUDICIAL CIRCUIT

Raymond G. Farmer, as Director of the South Carolina Department of Insurance, and the South Carolina Department of Insurance,

Plaintiffs,

vs.

Jessica K. Altman, as Rehabilitator of Senior Health Insurance Company of Pennsylvania, Patrick H. Cantilo, as Special Deputy Rehabilitator of Senior Health Insurance, Company of Pennsylvania, and Senior Health Insurance Company of Pennsylvania in Rehabilitation,

Defendants.

Civil Action No. 2020-CP-40-05802

TEMPORARY RESTRAINING ORDER

This matter comes before the Court on Plaintiff's Motion for a Temporary Restraining Order pending the hearing and determination of Plaintiff's Motion for Temporary Injunction and Memorandum in Support, the Summons and Complaint previously filed in this matter, and the Verification of Daniel N. Morris, in which it appears that (1) Plaintiffs are specifically charged by the South Carolina General Assembly to uphold the insurance laws of this State, (2) those laws are designed to protect policyholders, whose contracts were formed in this State and are subject to its laws and regulations, (3) the State has a strong interest in protecting policyholders and ensuring that its laws are enforced, (4) if those laws are not enforced, and Defendants are permitted to continue to implement a plan of rehabilitation by implementing and communicating changes to premium rates and policy changes in December 2021 or sooner without required state regulatory approvals as planned, Plaintiffs will have not upheld their statutory duty and policyholders will be

permanently denied basic contractual, procedural and constitutional rights and suffer permanent and substantial economic harm, (5) even if Plaintiffs were to fine Senior Health Insurance Company of Pennsylvania in Rehabilitation (SHIP) or suspend or revoke its license, such after-the-fact measures would not reinstate any permanent or temporary loss of benefits or premium overcharges, (6) the same is true of any lawsuit to recover lost benefits or premium overcharges, which would also be impracticable given the advanced age and typically limited means of the victims, and (7) those actions would also not undo the substantial confusion and disruption of the marketplace that would have occurred.

On the basis of these pleadings and papers, it appears to the Court that Plaintiffs will suffer immediate and irreparable injury, loss, and damage before notice can be given of a hearing and a hearing can be held on Plaintiffs' Motion for Temporary Injunction in that if Defendants are permitted to implement changes to premium rates and policy changes without required approvals in December 2021 or sooner, it would irretrievably alter the *status quo* with respect to the enforcement of the insurance laws, the insurance marketplace and the rights of policyholders.

The Court is of the opinion that the temporary restraining order should be issued without hearing and without further notice, pending a hearing on Plaintiffs' Motion for Temporary Injunction and Memorandum in Support. Therefore, it is ordered that:

1. Defendants, their officers, agents, employees, successors, and attorneys, and all those in active concert or participation with them, are enjoined and restrained from communicating, implementing or enforcing in this State the SHIP rehabilitation plan approved by the Pennsylvania Commonwealth Court, otherwise interfering with the rights of SHIP long-term care insurance policyholders or otherwise violating the insurance laws of this State pertaining to long-term care insurance until such time as Plaintiffs' Motion for Temporary Injunction and

Memorandum in Support can be heard and determined and an order on said Motion and Memorandum is issued by this Court.

2. Pursuant to Rule 65(c), SCRCPP, no security shall be required of Plaintiffs as an officer and agency of the State.

AND IT IS SO ORDERED this ____ day of _____, 2021, to expire on _____, 2021, unless within that time the Order is extended by this Court or unless Defendants consent to an extension.

L. Casey Manning
Chief Administrative Judge
Fifth Judicial Circuit

November __, 2021
Columbia, South Carolina

STATE OF SOUTH CAROLINA
RICHLAND COUNTY

IN THE COURT OF COMMON PLEAS
FIFTH JUDICIAL CIRCUIT

Raymond G. Farmer, as Director of the South
Carolina Department of Insurance, and the
South Carolina Department of Insurance,

Plaintiffs,

vs.

Jessica K. Altman, as Rehabilitator of Senior
Health Insurance Company of Pennsylvania,
Patrick H. Cantilo, as Special Deputy
Rehabilitator of Senior Health Insurance,
Company of Pennsylvania, and Senior Health
Insurance Company of Pennsylvania in
Rehabilitation,

Defendants.

Civil Action No. 2020-CP-40-05802

**AMENDED NOTICE OF
HEARING ON PLAINTIFFS' MOTION
FOR TEMPORARY INJUNCTION**

TO THE ABOVE-NAMED DEFENDANTS OR THEIR ATTORNEYS:

YOU WILL PLEASE TAKE NOTICE that a hearing on Plaintiffs' Motion for Temporary Injunction in the above-captioned action, previously scheduled for November 29, 2021 at 2:00 p.m., will now be held before the Honorable L. Casey Manning, Judge of the Fifth Judicial Circuit on **Wednesday, December 15th at 10:30 a.m.**, in a courtroom to be determined, at the Richland County Judicial Center, 1701 Main Street, Columbia, South Carolina 29201.

Respectfully submitted

December 3, 2021

s/ Geoffrey R. Bonham
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ELECTRONICALLY FILED - 2021 Dec 03 4:09 PM - RICHLAND - COMMON PLEAS - CASE#2020CP4005802

STATE OF SOUTH CAROLINA

RICHLAND COUNTY

IN THE COURT OF COMMON PLEAS

FIFTH JUDICIAL CIRCUIT

Raymond G. Farmer, as Director of the South
Carolina Department of Insurance, and the
South Carolina Department of Insurance,

Plaintiffs,

vs.

Jessica K. Altman, as Rehabilitator of Senior
Health Insurance Company of Pennsylvania,
Patrick H. Cantilo, as Special Deputy
Rehabilitator of Senior Health Insurance,
Company of Pennsylvania, and Senior Health
Insurance Company of Pennsylvania in
Rehabilitation,

Defendants.

Civil Action No. 2020-CP-40-05802

CERTIFICATE OF SERVICE

I hereby certify that on December 3, 2021, I served the foregoing Amended Notice of
Hearing on Plaintiffs' Motion for Temporary Injunction via electronic mail and U.S. Mail on the
following counsel of record addressed as follows:

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December 3, 2021

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