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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 IV

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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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P R O C E E D I N G S

JUDGE LEAVITT: Good morning.
Please be seated. All right. We are here today on the Rehabilitator, Jessica Altman, Second Amended Rehabilitation Plan. All of you should have received the decorum order. Just to remind you, if you are speaking, you may remove your mask. And, in fact, I urge you to do so for the sake of the court reporter and for the sake of the Court.

Just as a point of order, we have a lengthy list of participants who wish to do cross-examination. It is up to you whether you want to conduct your cross-examination from the Respondent counsel table, which is on that side of the courtroom. If you prefer, you may use the podium. They are both set up for safe social distancing.

I think it makes best sense for the counsel, for example, for the state regulators, to move up to the counsel table, I believe there are two lawyers representing the state regulators, complete their cross-examination, return to their seat in the courtroom, and then we will move through the list to NOLHGA, same



1 January 2020?

2 A. In broad strokes I have. I have not
3 described all the meetings and all the specific
4 recommendations, but the recommendations were
5 revision of the assumptions, reduction of
6 operating costs, and extrication from the
7 Beechwood and Roebling Re transaction.

8 During my tenure as special
9 representative, I spent a fair amount of time,
10 I'm hesitant to use the word forcing, inducing
11 SHIP to get out of the Beechwood program and
12 the Roebling Re program.

13 Q. At a high level, what ultimately led
14 to the rehabilitation plan that you are now
15 proposing on behalf of the Rehabilitator to the
16 Court?

17 A. After we concluded that management's
18 corrective action plan should not be the
19 starting gates, we, and by "we," I mean the
20 Commissioner and other Department staff, and
21 the Oliver Wyman team, sat them down to
22 establish, A, what courses of action were
23 available to the department, and, B, what
24 should be the goal of those courses of action.

25 So we knew even then in 2018 and



1 2019 that if management wasn't able to fix the
2 problem, the Department would have to step in
3 and even move for rehabilitation or a
4 liquidation order.

5 So the first debate was which was
6 more important given the circumstances. And
7 then the second debate is what should be the
8 goal of whatever plan we implement that is not
9 a liquidation.

10 So we knew that a major problem for
11 SHIP was the rate structure. So we decided
12 early on that whatever plan we put together, it
13 had to do something about remedying both the
14 inability of the company to get adequate rate
15 increases and the widely divergent rates that
16 were in place and were continuing to be
17 exacerbated with each rate increase
18 application.

19 We also knew, of course, they had a
20 large deficit and we knew as well that it had
21 operating costs that were high. We worked
22 immediately on the operating costs so that
23 didn't become an issue for the rehabilitation
24 plan.

25 But the first really intense



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



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



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.



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



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



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,



1 could not be described that way.

2 Q. Mr. Cantilo, you used the term
3 "feasible." Can you explain what you meant
4 when you said feasible?

5 A. Yes. I meant a plan that would be
6 practical to enrollment and would have a
7 material impact on the reduction of the
8 company's deficit, obviously, while addressing
9 the other goals that were already described.

10 Q. How did you come to that
11 understanding of the word "feasible"?

12 A. Well, the Pennsylvania statute does
13 not provide specific requirements for the
14 components of the rehabilitation plan, but I
15 think if you read the statute on when you
16 should go from rehabilitation to liquidation,
17 it compels that conclusion, because if a plan
18 is futile, then that is one of the routes to
19 going to liquidation.

20 We wanted a plan that would not be
21 futile, and I converted that to feasible.

22 Q. If the plan does not eliminate the
23 deficit, what impact will it have on the
24 deficit for SHIP?

25 A. So it will not eliminate the deficit



1 really simple. So as I get into it, Your
2 Honor, I will also explain some of the
3 strategies we are going to use to try to make
4 the process simpler for policyholders.

5 Q. Mr. Cantilo, will policyholders'
6 premiums go up under the plan?

7 A. They will for some policyholders.
8 We estimate that something around a third of
9 our policyholders today are paying If Knew
10 premium. Those policyholders will not face an
11 involuntary rate increase, although they could
12 select an option that is a rate we simply
13 prefer for some reason, and I will come back to
14 that. But that aside, those policyholders will
15 not face a rate increase.

16 The remaining two thirds, there are
17 a number of options available to each, some of
18 which do entail rate increases and some of
19 which do not. The most significant rate
20 increase will be the ones faced by those
21 policyholders who are not paying a new premium
22 today but want to hold on to their current
23 policies, the so-called Cadillac policies.

24 Those rich in benefits policies are
25 very expensive, they are the most underpriced,



1 and one element of the plan is if you really
2 want to hold onto those benefits, you are going
3 to have to go pay your own freight for that.
4 So they could see fairly material rate
5 increases.

6 For the population that doesn't have
7 those very rich policies, the rate increases
8 will be much more moderate, and I will be
9 specific in numbers as we get further into the
10 details.

11 Q. To what extent does the plan's
12 success depend on large rate increases?

13 A. It does not. In fact, Your Honor,
14 if the only thing we could do was raise rates,
15 we could not rehabilitate SHIP. The kinds of
16 rate increases that would have to be
17 implemented to eliminate a 1.2 million deficit
18 would be unsustainable. We're talking about
19 thousands of percent of rate increases for new
20 policyholders. So we couldn't do that.

21 But the combination of rate
22 increases and benefit modifications or
23 liability reduction resulting from those
24 modifications, that can make a big difference
25 in the deficit.



1 BY MR. BROADBENT:

2 Q. Mr. Cantilo, you mentioned the
3 policyholders have several options available to
4 them under the plan.

5 A. Right. And if we could put up --
6 there we go. So on this slide, I have
7 summarized the options, and I will say again
8 that options will be the same in Phase One and
9 Phase Two, although the premium methodology
10 will differ.

11 So the first option, which we
12 conveniently call Option 1, is to downgrade
13 your current policy so you can continue paying
14 the premium you're paying now. As I said a
15 little bit earlier, one of the things we wanted
16 to do is to make it more able to retain their
17 current premium level.

18 So the staff and our consulting
19 experts have worked very hard to develop a
20 pretty complicated model and showed algorithms
21 and they are more detailed, not the elements of
22 that, but which allow us to take a given
23 policy, take the current premium that that
24 policy is paying, and determine how we would
25 have to adjust that policy so that dollar



1 amount is adequate on an If Knew basis.

2 So, say a policy is paying a
3 thousand dollars a year in annual premium, but
4 for the benefits that policy offers, we
5 calculate the If Knew premium would be \$1,500,
6 we have a program that would reduce those
7 benefits to a thousand dollars on an If Knew
8 basis, so that now every policyholder is on the
9 same basis. That's like we are all paying the
10 same rate for each pound of potatoes.

11 The second option is what we call
12 the basic policy endorsement. We have selected
13 what we think are the key components of
14 long-term care that people want to have, if
15 they can't afford everything, these are the
16 things they want to have.

17 And we created an array of those
18 that we think will generate affordable
19 premiums. And so there are some limits on what
20 we're going to do with those options. We're
21 going to have a maximum benefit period that is
22 no greater than 80 percent of the current
23 premium or four years. For most people, we
24 think four years of benefit period is a basic
25 long-term care insurance policy. Sure, if you



1 have the money and you would like to have a
2 longer period, but four years is a pretty
3 reasonable benefit period.

4 We are doing the same thing with the
5 daily benefit. We're going to take 80 percent
6 of the current daily benefit or \$300 and use
7 the lower to -- as a basic daily benefit for
8 that policy.

9 There will be an inflation component
10 if there is one in the policy already, but it
11 would be capped at one and a half percent, not
12 five percent. There is a variation on the
13 policy that we, again, very creatively call 2A,
14 and the differences are that you can take a
15 benefit period out to five years and the
16 inflation to two percent, and you'll pay a
17 little more premium for that variation.

18 Q. Mr. Cantilo --

19 A. One very important aspect of the
20 basic policy is if you select this option, you
21 will not be affected by Phase Two. It is what
22 we call a one and done option, which makes it,
23 we think, very attractive to policyholders.

24 Q. How did you and the other team
25 members working on the plan identify what



1 should be included in the basic policy?

2 A. So we are lucky because there are
3 several members of our team that have a lot of
4 industry experience, and I and others also have
5 a lot of experience where we did a lot of
6 policyholder outreach.

7 So we are basing those judgments on
8 what we interpret to be the opinions expressed
9 by policyholders throughout the country about
10 what they find valuable in their long-term care
11 insurance policies and which are the things
12 they are willing to give up.

13 Now, it's not a perfect world. So
14 some of the things they find valuable are the
15 most expensive and we're not necessarily going
16 to retain them in the policy, but I think the
17 fundamental coverage responds to those
18 policyholders around the country.

19 The next option, Option 3, is a
20 paid-up policy or a non-forfeiture option. But
21 unlike the one I described earlier that is
22 common in the industry that just takes
23 accumulated premium less claims, here we are
24 putting a floor on that policy of two and a
25 half years of benefit period, unless your



1 policy already has less than that. We are not
2 going to lengthen your benefit period. But if
3 you have a five-year policy, even if you take
4 an NFO, you have to have at least 30 months of
5 coverage. That makes that option, Option 3,
6 very attractive, because unlike the typical NFO
7 that gives you at most months of coverage, here
8 you have two and a half years, which is a
9 pretty reasonable period of coverage.

10 We also floored the maximum daily
11 benefit at 80 percent of the current level of
12 \$300, which, again, is a reasonable maximum
13 daily benefit. So not a luxurious policy,
14 certainly not what anyone would call a Cadillac
15 policy, but I think this is a solid Chevy
16 policy that we're offering as an alternative.
17 And I don't mean to be pejorative about Chevys
18 when I say that.

19 And then the last option is the
20 option that we hope the fewest policyholders
21 will select, but it's out there, and that is
22 pay whatever it takes to keep your current
23 policy.

24 Q. A policyholder electing Option 1,
25 does he or she get to decide which benefits to



1 depressed asset. Probably should not have done
2 so, but that is water under the bridge, so.

3 JUDGE LEAVITT: Okay.

4 BY MR. BROADBENT:

5 Q. When will these changes take effect?

6 A. For TransAmerica, it took effect in
7 the year end. With the Court's permission, for
8 American Health & Life and for Primerica, it
9 would become effective with the effective date
10 of the plan.

11 Q. Moving to the concerns of the state
12 insurance regulators, I think one of the
13 concerns to which you testified was the
14 Rehabilitator and the Court approving SHIP's
15 rates throughout the country.

16 Can you elaborate on what your
17 understanding is of that concern?

18 A. Certainly. There is a tradition
19 that has been codified in most of the states of
20 having the state of issue of an insurance
21 policy be the principal regulator for the rates
22 for those policies.

23 So even though an insurer might be
24 down in Tennessee, for the policies and issues
25 in Pennsylvania, it is the Pennsylvania



1 department that scrutinizes the rates and
2 eventually approves or rejects rate increases.
3 And that is so regardless of where the
4 policyholder resides.

5 So the policy may have been issued
6 by a Tennessee domiciled insurer to a
7 Pennsylvania resident who then moved to
8 Nebraska, and after that, moved to California
9 and eventually moved to Illinois.
10 Notwithstanding, it's going to be a
11 Pennsylvania department that regulates the
12 rates of that policy all the way through the
13 life of the policy, because that's the state in
14 which the policy was issued.

15 My own view is that that arrangement
16 is a matter of convenience allocating
17 responsibility for rate approval to one rather
18 than each state of issue rather than having
19 them all owned by the state of domicile. Doing
20 them by state of residence, obviously, would be
21 complicated because you would have several
22 departments passing on the same rate over
23 different periods of time.

24 Based on that tradition, the, what I
25 understand the Maine, Massachusetts and



1 Washington regulators to be suggesting is that
2 they, and not this Court or this Rehabilitator,
3 ought to be approving rate increases for the
4 policies issued by SHIP or its predecessors in
5 those three states.

6 And -- but we disagree with that
7 notion because we believe that the
8 Rehabilitator and this Court have the power to
9 just modify rates and benefits under the
10 policies of the rehabilitation plan.

11 But that's my understanding of that
12 principal objection.

13 Q. Do you understand the regulators to
14 assert that they can -- they are the only party
15 that can approve rate increases for residents
16 in their states?

17 A. No. Their position, consistent with
18 the statutes, is that they are the only ones
19 who can approve rate increases from policies
20 issued in those states, regardless of whether
21 -- which, of course, creates some ironic
22 consequences. So on my Slide 97, I explained
23 that just for these three states, we have 34
24 residents of Maine issued policies in other
25 states. So if Maine set the rates for all of



1 the policies issued in that state, it would do
2 so for 34 residents of other states. It would
3 be 84 for the policies issued in Massachusetts,
4 and 89 for the policies issued in Washington.

5 So all together, for this group of
6 regulators, they would be setting rates for 207
7 policies issued in those states, but the
8 holders reside in other states, so they
9 wouldn't be protecting their own residents.

10 Conversely, if you look at the next
11 slide, there are 21 Maine residents who hold
12 policies issued in other states and 83
13 Massachusetts and 87 Washington residents who
14 hold policies issued in other states, which is
15 to say, if these three regulators set the
16 rates, they will not be doing so for these 191
17 residents of their state because those policies
18 were issued in other states.

19 So all together, having -- giving
20 effect to their rules, so to speak, that the
21 issued state sets the rate, means that 400
22 policyholders will have their rates set by
23 states in which they don't reside because of
24 this rule.

25 Q. In a receivership, why wouldn't you



1 follow the standard rule of having the issued
2 state control the rate process?

3 A. Well, I guess my first opinion is
4 that's how we got here. One of the biggest
5 problems SHIP faces is uneven response to rate
6 approvals, as we described earlier today in
7 great detail.

8 But, more importantly, I don't think
9 you can rehabilitate or liquidate a large
10 insurance company with little pieces being
11 addressed by each of the 50 states.

12 The tradition in this country has
13 been that a multistate troubled insurer is
14 managed by its domiciliary regulator through
15 the entire policy over the rehabilitation
16 process.

17 And the notion that that rule should
18 apply with respect to contract modifications
19 but not with respect to rate modifications does
20 not make common sense to me. I don't see a
21 qualitative difference between the two.

22 Q. Does the plan address the issued
23 state rate?

24 A. Yes. After we received these
25 objections, following the original plan which



1 was filed in April of last year, we added to
2 the plan what we called the issue state rate
3 approval section, and that's a fairly
4 complicated section aimed exactly at addressing
5 this concern.

6 So under this section, what would
7 happen is every state will be given the option,
8 if this Court approves the plan, to opt out of
9 the rate approval section. If they do, in an
10 opt out state, the Rehabilitator will file an
11 application for rate increases for the policies
12 issued in that state to the If Knew level. The
13 regulator will do whatever he or she thinks is
14 appropriate with that application, but if that
15 application is not completely approved, say
16 it's only half approved, as it happens so
17 often, we will then adjust the benefits under
18 those policies to what that regulator has
19 approved.

20 That is essential. If we don't have
21 that, we will continue having the other
22 policyholders subsidize the policies. So we
23 will stop the subsidy, but we will let the opt
24 out states set their own rates. Each opt out
25 policyholder will still have four options.



1 They are not exactly the same as the plan but
2 they are similar. So they will be able to keep
3 -- even though the regulator may not have
4 approved a full rate increase, one of the
5 options we will give them is a voluntary paid
6 in full rate to keep your current policy. So
7 we are not going to punish those policyholders
8 because their states opted out and they're not
9 letting them keep their current policy. If
10 they really want to keep their current policy,
11 they can voluntarily pay the premium.

12 But if they don't, if they want to
13 pay the premium approved by the opt out state,
14 then the benefits of the policy will be
15 adjusted to that level.

16 Or if they don't want to pay any
17 premium increase, just like the opt-in
18 policyholders, they will have a downgrade
19 option so that they don't have to pay any rate
20 increase. And they also have a non-forfeiture
21 option, but there will be no requirement by
22 that state or that policy, it will not be
23 enhanced by that plan option.

24 Q. Mr. Cantilo, under ordinary
25 circumstances, that is, outside of the



1 statute.

2 We won't be approving that, but
3 we're not going to block policyholders from
4 doing it voluntarily. I thought that was a
5 persuasive argument, so we included that as an
6 Option B in the program.

7 Q. Do policyholders governed by the opt
8 out states have Phase Two of the plan?

9 A. Yes. And, again, just as for
10 opt-ins, Phase Two will be very similar for opt
11 out states. Again, we will file rate increase
12 applications in each of the opt out states, but
13 on a self-sustaining basis, individually,
14 Seriatim again, and again, they will have the
15 ability to approve them individually or in
16 groups.

17 Q. Have you received a reaction from
18 state regulators, generally, to the issue state
19 rate approval option?

20 A. The only formal reaction has been
21 the filing by the state regulators in this case
22 that that doesn't satisfy them. I think there
23 was a passing comment on this in the Louisiana
24 case but really not germane to any of the
25 issues in that case.



1 Other than that, I had informal
2 conversations with a number of regulators who
3 think this is creative and a good way of
4 slashing the cat, so to speak, or whatever the
5 expression would be.

6 A lot of people are not going to
7 come out in public and say that because it
8 would mean surrendering to the Pennsylvania
9 Insurance Commissioner the ability to set
10 rates, and that has become a very contentious
11 issue.

12 But in terms of harmonizing their
13 concerns with the exigencies of SHIP's
14 circumstances, they think this would create an
15 effective solution.

16 Q. Is all of this explained in the
17 plan?

18 A. Yes.

19 Q. Will states opting out hurt the
20 plan?

21 A. No. Ironically, we anticipate, we
22 can be surprised, but we anticipate that the
23 results of states opting out will be a deeper
24 reduction in benefits because of more rate
25 approvals.



1 So in terms of the company, states
2 opting out will probably be helpful. In terms
3 of policyholders, we think it will be harmful.
4 So although it will not hurt the plan in terms
5 of reducing the deficit, it is likely to hurt
6 the plan in terms of providing policyholders
7 the best options.

8 Q. To be clear, what options do opt out
9 policyholders not have?

10 A. Well, one of the most important ones
11 that they won't have is the enhanced
12 non-forfeiture option and the basic policies.
13 Those are not forms approved in the opt out
14 states, so we are not going to use them. Those
15 would be part of the participation in the plan.

16 MR. BROADBENT: Your Honor, I
17 will pause again momentarily to let you know we
18 are moving to the question of rehabilitation
19 and liquidation, and I wanted to make sure Your
20 Honor had sufficient time to ask the questions
21 that Your Honor may have had on this issue at
22 this time.

23 JUDGE LEAVITT: No, I'm fine.

24 MR. BROADBENT: Thank you.

25 BY MR. BROADBENT:



1 300,000 --

2 JUDGE LEAVITT: Okay.

3 THE WITNESS: And so for this
4 policyholder, Your Honor, I would not recommend
5 Option 4 because Option 4 is a higher premium,
6 and I think that's the whole point about the
7 benefit of choice under the plan.

8 JUDGE LEAVITT: So the column
9 labeled current shows the annual premium of
10 \$2,760.

11 THE WITNESS: Right, Your
12 Honor. That would be one of those ones I
13 mentioned earlier that is vastly underpriced.

14 JUDGE LEAVITT: Right. I see.
15 Okay. I got it.

16 THE WITNESS: Well, apart from
17 this aspect of their measure that I think is a
18 little bit oversimplified in their analysis,
19 there are other ways of measuring the value of
20 each of these options. On Slide 104, I know
21 some of them are obvious ones.

22 So one they suggest is the present
23 value future benefits less the present value
24 future premiums. You could also take the
25 present value future benefits over annual



1 premium, what some people call the bang for the
2 buck measure, how much insurance are you
3 getting for each dollar.

4 But with respect to both of these
5 measures, Your Honor, what you are looking at
6 are projections. We don't know those numbers.
7 And if I gave you the numbers today, they would
8 be wrong tomorrow. Every day, those
9 projections are going to change.

10 The third option that I have up
11 there is not susceptible to that problem. That
12 is a maximum policy value. That is not going
13 to change. That is the product of that
14 policy's maximum benefit period times its
15 maximum daily benefit. Unless you modify the
16 policy, that's a static number and it will be
17 that way until the policy ends.

18 The other part of that formula is
19 annual premium which, again, does not change.
20 That's not a projection. So if you are going
21 to give policyholders guidance, I think you
22 should give them guidance at a static, not that
23 you know it was wrong the day after you give it
24 to them.

25 The fourth measure is another bang



1 for the buck approach, not one that we are
2 particularly recommending, but if you are going
3 to use the bang for the buck approach, at least
4 use policy value rather than present value
5 future benefits because, as I said earlier,
6 again, it's a known number. It's not going to
7 change.

8 And then the last measure, which I
9 think is the obvious one, is the actual policy
10 coverage. You know, when I buy life insurance,
11 I buy a million dollars worth of life
12 insurance. That's my policy. I don't buy a
13 policy that some actuary has projected will
14 cost my insurance company \$187,000 compared to
15 Mr. Robinson's \$176,000 for the same million
16 dollars.

17 That is how people buy insurance.
18 They buy the policy amount and that amount is
19 in their policy forms. Many of SHIP's forms
20 use a term "benefit account value" or "lifetime
21 maximum," but it's, basically, this formula.
22 If you're going to use any formula to suggest
23 to policyholders what relative values are, I
24 think that is a more meaningful one.

25 Just for the sake of illustration of



1 how all of these things fall out, Oliver Wyman
2 calculated, beginning on Slide 105, how
3 policyholders fare with each of these measures.
4 So this first slide, 105, is the one about
5 which the intervening state regulators have
6 written.

7 In this case, which is their
8 measure, in Phase One, 85 percent of
9 policyholders have at least one option, which
10 is at least as good as liquidation.

11 The other 15 percent arguably do
12 better using this measure than liquidation, or
13 other than liquidation.

14 Your Honor, even if you stop there,
15 even if this is all the information you had, I
16 would submit to you that because in
17 Pennsylvania we evaluate the better off
18 standard for policyholders as a group, not
19 every last one of them, that a plan that's
20 better for 85 percent is good enough.

21 But let me go on. We then looked at
22 the second measure I described to you, the bang
23 for the buck actuarial measure. In that one,
24 only 79 percent of policyholders do better. 21
25 percent would do better with liquidation.



1 Then in the next slide, Your Honor,
2 we analyzed the first maximum policy value
3 option and you can see that with that one, 89
4 percent of policyholders are better off and 11
5 percent do not have a better rehab option than
6 liquidation.

7 And then if you use my simple
8 approach of maximum policy value -- sorry, I
9 skipped over it. This is an actual policy less
10 premium, and that one is 96 percent in favor,
11 four percent do better in liquidation.

12 And then if you use simple policy
13 value, every policyholder has at least one
14 option in a plan that offers the same policy
15 values on liquidation.

16 Now, these are actuarial techniques.
17 So I can't sit here, Your Honor, and tell you
18 this one is right and this one is wrong. This
19 is the exercise of professional judgment.

20 I can tell you that no policyholder
21 ever knows what the present value future
22 benefits of his or her policy is or the present
23 value future premium or what the difference
24 between those two numbers is. But most
25 policyholders will be able to tell you, I have



1 half a million in insurance or three-quarters
2 of a million dollars in insurance or \$100,000
3 of insurance, I think that's what policyholders
4 look at. If you're going to give them
5 guidance, Your Honor, I think you ought to give
6 them guidance that is familiar to them.

7 We did put, on Slide 110, a table
8 that shows all the results I just summarized.
9 So no matter which measure you pick, Your
10 Honor, you see in Phase One, this plan offers
11 the majority of policyholders at least one
12 option to liquidation.

13 Now, the intervening state
14 regulators will tell you, that may be true, but
15 you are ignoring Phase Two. Well, that's
16 right. This doesn't have Phase Two in it
17 because I don't know what Phase Two will look
18 like. But I will make two suggestions to Your
19 Honor.

20 The first is, assume for a moment
21 that the world turns upside down and Phase Two
22 reverses these columns. That's not going to
23 happen. But let's just assume that. Even if
24 that were the case, Your Honor, just in Phase
25 One, we will have accomplished a lot of good.



1 And if we have to go into liquidation at the
2 time of Phase Two, so be it. But we will have
3 right sized the policy so that we have everyone
4 on a level playing field and we will have
5 chopped that deficit by half or more.

6 B, I'm not sure that they do worse
7 in Phase Two. We just can't tell yet how Phase
8 Two will be. But if most of our policyholders
9 choose Options 2 or 3 rather than Option 4 in
10 Phase One, it's not so bad in Phase Two. They
11 don't even get hit in Phase Two. So there is a
12 lot of speculation when we consider how is this
13 going to look in Phase Two.

14 BY MR. BROADBENT:

15 Q. Mr. Cantilo, I want to make sure --

16 A. You want me to stop talking?

17 Q. I want to make sure the record is
18 clear about this measure No. 5. Does the plan
19 provide every policyholder the opportunity to
20 buy coverage as valuable as they could have in
21 liquidation?

22 A. Yes.

23 Q. Do these computational measures
24 account for all of the factors on which a
25 policyholder might base a decision?



1 into account but incredibly important. Sorry.

2 Q. I notice that the rehab plan does
3 not offer a cashout option. Why is that?

4 A. So there are some states that permit
5 them. Most states or many states do not.

6 In our view, and by "our," I mean
7 mine and Commissioner Altman, as well as our
8 advisory team, cashout options are pretty
9 cynical. They offer policyholders some sum of
10 money, typically less than \$50,000, to give up
11 their long-term care coverage forever and ever.

12 If a policyholder really can't pay
13 anymore, the non-forfeiture option is a much
14 better course. That at least preserves some
15 coverage. These policies were sold as policies
16 without a cash value for a reason, and to now
17 manufacture an artificial cash value to induce
18 them to give up their coverage, as I say, I
19 think is pretty cynical. And there are a lot
20 of insurance regulators around the country that
21 feel strongly that way and will not approve
22 cashout options.

23 Q. Throughout your testimony,
24 Mr. Cantilo, you referred to the likelihood of
25 success of the plan. Do you know whether the



1 plan will reduce SHIP's deficit?

2 A. If a plan is implemented, it will
3 reduce SHIP's deficit. What I can't tell you
4 is whether it will eliminate it.

5 In all likelihood, it will not
6 eliminate it. In all likelihood, it will just
7 reduce it materially.

8 We have actually done some modelling
9 of that very important issue, and so if you
10 look at Slide 113, here are 11 scenarios. I
11 will be clear, Your Honor, that these are
12 artificial. We cannot pick what policyholders
13 will actually do, but each of these columns
14 represents a particular hypothetical take rate
15 for each option under the plan, and those take
16 rates are in the yellow boxes below that.

17 So, for example, Your Honor, in
18 Scenario 1, we assume that seven percent of the
19 policyholders will take Option 1, four percent
20 Option 2 and so on, and that the vast majority,
21 81 percent, will take Option 4, pay whatever it
22 takes to keep my policy.

23 If that were the scenario that
24 occurs, Your Honor, we will reduce the deficit
25 by \$525 million as shown above the bar there,



1 which is a little bit less than half of the
2 deficit.

3 Scenario 2 moves more people away
4 from Option 4 to the other options and
5 increases the reduction of the deficit and so
6 on. If you go all the way to the right, Your
7 Honor, to Scenario 11, where a very small
8 number of policyholders elect to pay the high
9 premium and keep their policy and the rest are
10 spread evenly among the other options, that
11 wipes out the deficit.

12 Now, I hasten to add, Your Honor, we
13 are not predicting Scenario 11. This is a
14 demonstration that the policyholders will be
15 the masters of the fate of the company here,
16 and if they stubbornly decide to stick to their
17 expensive policies, probably the most we can
18 hope to accomplish is cut the deficit in half.

19 But we worked hard in making the
20 other options attractive and hope fervently
21 that policyholders will select the other boxes.

22 The next graph will show why that is
23 so important. On this chart, Your Honor, we
24 show how effective each individual option is in
25 reducing the deficit. So on the left side is



1 zero, meaning zero percent of policyholders
2 take that option, and on the right side is a
3 hundred.

4 If a hundred percent of the
5 policyholders chose Option 4, which is the
6 bottom of the curve here, the one that ends at
7 227, if every policyholder says, I will pay
8 whatever it takes, don't mess with my policy,
9 we're only going to eliminate \$227 million of
10 the deficit.

11 On the other hand, Your Honor, if
12 100 percent of the policyholders decide to take
13 Option 3, we would create a \$136 million
14 surplus. And you can see in between where the
15 other options fall on this analysis.

16 Again, no one of these options is
17 going to get a hundred percent take rate. So
18 if you wanted to predict, you would move your
19 marker to the portion of the line for each
20 graph and add them up, and that's what we did
21 in the prior slide.

22 We attempted one more way to try to
23 figure out which way things would work out with
24 the plan, and that is Slide 115, which makes
25 the assumption that every policyholder will



1 select the economically rational policy. That
2 is an assumption that is much more sympathetic
3 to the U.S. policy by the state regulators.
4 It's probably not realistic because I think,
5 Your Honor, they ignore subjective factors.

6 But if you did that, you can see
7 that those take rates would produce deficit
8 reductions in the \$750 million range. And the
9 exact assumptions are spelled out in that blue
10 box just to the right.

11 Q. Mr. Cantilo, do any of these
12 scenarios take into account for Phase Two?

13 A. They do not. We, as I said, we have
14 not projected Phase Two yet. But as I also
15 suggested, if we do Phase One, chop \$700
16 million off the deficit and then decide we have
17 to liquidate, we're in better shape, especially
18 with right sizing the policies, than we are
19 today.

20 Q. I'm going to change topics here and
21 ask, Mr. Cantilo, why does the plan propose to
22 suspend payments on accrued commissions to stop
23 the accrual on the policyholder election date?

24 A. The basic reason is we don't think
25 the plan should put agents in a better position



1 me to sit here. Hopefully my voice will carry
2 throughout the room and not too much of a
3 volume.

4 Secondly, in demonstration of the
5 comity that regulators can show one another,
6 the Rehabilitators' counsel has graciously
7 agreed to project various documents onto the
8 screen when I get there so everyone can see
9 those. So, thank you.

10 CROSS-EXAMINATION

11 BY MR. LESLIE:

12 Q. Mr. Cantilo, were the approximately
13 39,000 long-term care policies you testified to
14 yesterday as in force on the date the
15 rehabilitation order entered, were they
16 enforceable contracts as against SHIP?

17 A. I have not analyzed each one
18 individually, but I have no reason to believe
19 that they were not enforceable contracts.

20 Q. So you don't contend that they were
21 unlawful contracts that were fraudulent or
22 lacked consideration or in some other way were
23 not suitable to be enforced?

24 A. I do not.

25 Q. Were the premium rates charged on

1 those policies the rates that were approved by
2 insurance regulators across the United States
3 and at that point in time the date that the
4 rehabilitation order entered?

5 A. Again, I have not evaluated each one
6 individually, but I have no reason to believe
7 that they were not all approved by the
8 regulators when issued.

9 Q. So on the date that the
10 rehabilitation order entered, were there any
11 outstanding litigation over rates, SHIP rates
12 with any regulator, were there any
13 administrative proceedings pending over rate
14 reviews?

15 A. There was no litigation pending of
16 which I am aware. There may still have been
17 pending at that time action by state insurance
18 regulators on previously filed rate increase
19 approvals or, rather, requests.

20 Q. But you don't know; you're saying
21 they may, but you don't know?

22 A. I don't remember precisely. I know
23 that there were some before the plan was filed
24 in April. I don't know whether all of them had
25 been resolved by the time the plan was filed in

1 April.

2 I do know that eventually we
3 withdrew the ones that had not been resolved
4 after the plan was filed.

5 Q. But you don't contend that the
6 premium rates that were being charged by SHIP
7 at that point in time were unlawful, they were
8 the approved rates; is that correct?

9 A. I do not contend they were unlawful.

10 Q. Okay. How many of those 39,000
11 policies are eligible for one of the options
12 under the proposed plan?

13 A. Assuming that the plan is approved,
14 all of the policies would be entitled to select
15 any of the options, although -- let me correct
16 that. All of the policies that have not
17 already taken non-forfeiture option status
18 would be able to select one of the four
19 options, although for a number of them, Options
20 1 and 4 would be meaningless.

21 Q. Do you recall how many of those
22 39,000 policyholders had already elected a
23 non-forfeiture option?

24 A. That would be 9,000.

25 Q. So is it correct that of the 39,000

1 Q. So under Scenario 1, 81 percent of
2 the policyholders would be expected to select
3 Option 4?

4 A. Right, as I mentioned yesterday.

5 Q. And does Option 4, of the five
6 options, does it have the best or the worst
7 effect in reducing the funding gap?

8 A. In general, Option 4 is the least
9 effective at reducing the funding gap.

10 Q. So if 81 percent of the
11 policyholders selected Option 4, after Phase
12 One, the funding gap would be the largest as
13 distinct from policyholders selecting Options 2
14 or 2A or 3?

15 A. Yes. I believe I addressed that
16 yesterday.

17 Q. Yes, you did.

18 A. I think the scenario you described
19 would result in about a \$525 million reduction
20 in the funding gap.

21 Q. Yes. Yesterday you testified, I
22 believe, about the -- that policyholders had an
23 option, had a least one option equal to what
24 would be the case in liquidation; is that
25 correct?

1 mistake in not approving them?

2 A. That was not the question you asked
3 me.

4 Q. Okay. So no rate filings were filed
5 for those years, but your If Knew Premium
6 illustration includes the If Knew Premium for
7 those years, notwithstanding the fact the rate
8 filings weren't submitted?

9 A. That's true.

10 Q. You think that's a fair portrayal of
11 the situation?

12 A. Yes.

13 Q. All right. Were the rates, as they
14 stood on the day the rehabilitation order
15 entered, were they lawful rates; had they been
16 lawfully approved?

17 A. I assume they were, yes.

18 Q. So does the rehabilitation plan seek
19 to modify rates that were lawfully approved or
20 disapproved?

21 A. The plan will modify the rates as
22 described in the plan, and I am assuming that
23 some or all of the rates that will be modified
24 were roughly approved.

25 Q. You, yesterday you showed us a chart

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

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?

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

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.

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.

1 Another is that in the case of SHIP,
2 there are many policyholders who are paying far
3 less for the coverage they are receiving than
4 they would be had the premiums been set
5 appropriately, which is in a sense to say that
6 they are underpaying for their coverages. That
7 is not a criticism of the policyholders, they
8 are paying everything they were asked to pay,
9 but they weren't asked to pay enough.

10 So shifting that burden, the burden
11 of underpriced policies to the taxpayers or to
12 other insureds in the State of California seems
13 unjustified under the circumstances.

14 Q. That sounds like a policy judgment;
15 do you agree?

16 A. You could call it that.

17 Q. Are the guaranty funds created by
18 statute?

19 A. Yes.

20 Q. So legislators who make policy
21 enacted those statutes across the United
22 States. Are you aware of any state that
23 doesn't have a life and health guaranty fund?

24 A. Not anymore, no.

25 Q. But the Pennsylvania Commissioner

1 Q. That would be an example of a
2 policyholder voluntarily choosing to give up
3 some coverage in exchange for the benefit of
4 lower premium and a lower benefit because of
5 their financial circumstances at that time?

6 A. That is possible, yes.

7 Q. Now, these adjustments in Phase One
8 are permanent; isn't that correct?

9 A. The adjustment resulting from
10 selecting Options 2, 2A or 3 under the plan are
11 intended to be permanent under the plan.

12 Q. Yeah.

13 A. Obviously, if the plan is
14 unsuccessful in keeping the company out of
15 liquidation, then other changes might result in
16 liquidation.

17 Q. So a policyholder, your hypothetical
18 policyholder that makes the decision you just
19 described, could their circumstances change in
20 Phase Two?

21 A. Yes.

22 Q. Okay. So that policyholder is
23 making a choice in Phase One which has a
24 permanent effect on that policyholder?

25 A. In the sense I just described, yes.

1 Q. Well, in the sense that guaranty
2 association coverage may be given up?

3 A. Yes.

4 Q. And so in Phase Two, I believe the
5 plan says premium could be materially increased
6 for those selecting Option 4; is that correct?

7 A. That is correct.

8 Q. And benefits could be materially
9 reduced for those selecting Option 1; is that
10 correct?

11 A. That is correct.

12 Q. So our hypothetical policyholder who
13 gives up a certain level of guaranty fund
14 protection in Phase One may find a result in
15 Phase Two that looks very different than what
16 that policyholder thought the circumstances
17 were in Phase One?

18 A. That is possible, yes.

19 Q. So why do policyholders have to give
20 up guaranty association benefits in Phase One
21 permanently; why do they have to do that?

22 A. I'm not sure what you mean by "have
23 to."

24 Q. Well, the plan requires them to give
25 those benefits up permanently, it specifies

1 One.

2 Q. So do you see Phase Two as the phase
3 at which a funding gap that remains at the end
4 of Phase One is addressed and resolved?

5 A. Yes.

6 Q. So at the end of Phase Two, is it
7 your view there will be no funding gap?

8 A. That would be ideal, but as I think
9 I also said yesterday, we can't guarantee that
10 that will be the result.

11 Q. Yes. Yesterday you testified that
12 it was unlikely, I think highly unlikely, that
13 the plan could eliminate the funding gap.

14 Did you mean Phase One or did you
15 mean Phase One and Phase Two?

16 A. I meant Phase One and Phase Two.
17 Certainly Phase One but, as I said yesterday in
18 candor, given the magnitude of the funding, it
19 is possible that for Phase Two to eliminate the
20 remaining gap depending on what happens in
21 Phase One would put such a burden on
22 policyholders, that a different alternative
23 might be preferable.

24 Q. Could that be because the number of
25 policyholders that remain after Phase One whose

1 between the Rehabilitator and the Court.

2 Q. So you are envisioning that order
3 will be modified on this point?

4 A. No, no. That's something different.

5 Q. So will the Court review this and
6 approve this, if you need to have it,
7 alternative methodology?

8 A. Yes.

9 Q. But that's -- how does that arise?
10 It's not in the order. The order gives the
11 Rehabilitator the power to implement the plan.

12 A. Well, I haven't seen the order. You
13 obviously have a crystal ball that I don't
14 have, but I would envision that whatever order
15 the Court enters with respect to the plan would
16 be subject to the further orders of the Court,
17 as is typically the case.

18 Q. So you would be comfortable with the
19 Court approving the plan subject to approving
20 any Phase Two self-sustaining premium or
21 alternative adjustments?

22 A. Of course I would be comfortable
23 with that, yes.

24 Q. You would. Okay. That is great.

25 So would you -- then why, if the

1 Court would be asked to do that, why did the
2 modifications in Phase One have to be
3 permanent? Why couldn't they be voluntary
4 elections, after which everyone looks at the
5 situation and decides how it looks like it will
6 work? Why does Phase One have to be mandatory?

7 A. They are described that way in the
8 plan in fairness to the policyholders so that
9 they recognize the possibility that whatever
10 elections they make in Phase One will be
11 permanent to them. There is no guarantee about
12 anything about this plan going forward, and it
13 is certainly possible that the Court will want
14 to review aspects of the plan after Phase One.

15 Q. Okay. I mean, we are here to deal
16 with the plan as it is, to deal with it as the
17 order stands, and that order doesn't provide
18 for any judicial review.

19 It also doesn't provide for any
20 judicial review of disclosure to the
21 policyholders. Yesterday you testified about
22 trend-setting disclosure, I believe. Do you
23 envision the Court approving that disclosure?

24 A. We had not contemplated coming back
25 to the Court separately for that, no.

1 the same and a lot of cases all the work is the
2 same. So you would develop one model and you
3 would derive output from it that would be
4 needed for each of the ten states. But, in
5 general, it's the same information.

6 Q. In your experience, let me ask it
7 differently, do you have a sense of how long on
8 average it took from the time of submitting the
9 application to receiving an approval or denial
10 from the various states?

11 A. It really varies. Some states are
12 fairly quick. You might get an approval within
13 90 days. Others can take years.

14 Q. So, in other words, can you clarify
15 what you mean by "years"?

16 A. Yeah. There is at least one state
17 that, I think, the industry would consider it,
18 you know, positive if you received an approval
19 within two years.

20 Q. Now, in the plan, I believe
21 Mr. Cantilo testified the rates were calculated
22 on a seriatim basis.

23 Do you recall that?

24 A. Yes.

25 Q. How does that compare to what

1 ordinarily happens in the rate application
2 process?

3 A. So in a more traditional, you know,
4 application process, the company is requesting,
5 although their models might be developed on a
6 seriatim basis, they are requesting a premium
7 rate increase that might only be an aggregate
8 either for that specific state or even
9 nationwide. So just one average premium rate
10 increase.

11 It's becoming more common to be a
12 little more, I would say, I guess more, you
13 know, fine-tuned than that. I do see premium
14 rate increases varying by certain benefit
15 features, like do you have an inflation option
16 or not, do you have unlimited benefits or not.
17 But in general, it's some broader class of
18 policies that will get one average premium rate
19 increase.

20 In the case of a plan, every
21 individual policyholder is going to receive a
22 -- is going to have a premium rate increase
23 calculated based on his or her individual
24 policyholder characteristics, so the specific
25 features of the policy and the policyholder's

1 characteristics. So their individual claim
2 experience themselves won't be considered, but,
3 you know, all the various variants that make up
4 a given assumption, risk factor or risk class
5 will be considered.

6 And so whatever that policy's
7 specific combination of characteristics, you
8 know, creates, whatever assumptions that
9 derives -- or drives from that unique
10 combination will determine that policy rate
11 increase or premium rate.

12 Q. In the ordinary course, in your
13 experience, if a state approves an aggregate
14 rate increase, what impact will that have on
15 the policyholders who may be already paying If
16 Knew Premium?

17 A. Well, so if -- at any -- it will
18 just increase the amounts of subsidies that are
19 occurring if there are any. Generally there
20 aren't in today's blocks levels of subsidy
21 going on.

22 Even within a state, we tend to see
23 that policies issued to older people with less
24 rich benefits tend to be paying more, you know,
25 than I would say relative to an If Knew Premium

1 rate than younger people with more rich
2 benefits.

3 And so just applying or just
4 applying an aggregate rate increase, it doesn't
5 solve that. It just perpetuates it.

6 Q. You may have just done this, sir,
7 but you used the term "subsidies." Can you
8 just define that term as you use it?

9 A. Yeah. I think in this context, it's
10 just the fact that some policies are paying,
11 you know, if there is an actuarially
12 appropriate premium rate for -- on a seriatim
13 basis, then there are at any time quite a few
14 people paying a lot more than that and then
15 there's quite a few people that are paying a
16 lot less than that, so just the fact that there
17 are subsidies going on.

18 Q. In the ordinary course, if a company
19 submits rate applications to a number of
20 states, is it unusual to receive differing
21 responses from those states as to whether the
22 rates are approved or disapproved?

23 A. Yes. It is quite common, and often
24 not very well explained. So you can apply --
25 you can prepare all of the same materials

1 provided to, you know, all the states and, you
2 know, you will get a mixed reaction.

3 Every state has its own -- it
4 changes quite frequently, too, even within a
5 state. Every state has its own approach to
6 reviewing the rates. They, you know, they have
7 different requirements, their own internal
8 rules, statutory rules for what they will
9 approve and not approve, and the measuring
10 sticks they have for determining what is
11 actuarially justified.

12 Q. So what impact on the policyholders
13 does that varying response for the rate from
14 the regulators have?

15 A. It means that, depending on what
16 state your policy was issued in, you can
17 receive a different premium rate. You could be
18 paying a vastly different premium rate if you
19 live in one state compared to another, not live
20 in, but where the policy was issued.

21 Q. Just to clarify that last point, if
22 a policy was issued in state A and you now
23 reside in state B, in the ordinary course, who
24 determines the rate that would apply?

25 A. State A, the issuing state.

1 A. I prefer the word "projected."

2 Q. Yes. So the projected benefits, is
3 that where projection goes, into the projection
4 of the benefits, or does it go into all the
5 elements?

6 A. I'm sorry, could you repeat your
7 original question?

8 Q. I apologize. I'm trying to
9 understand where your word -- you suggested
10 "projection" is a better word, and I'm trying
11 to understand what projection, what it applies
12 to; could you help me with that?

13 A. When you used the word "prediction,"
14 I prefer the word "projection."

15 Q. Okay. In the computation of the
16 present value of benefits, is maximum policy
17 value a classic actuarial consideration?

18 A. In a long-term care policy, yes.
19 You need to know when a benefits -- a policy's
20 benefits might expire because it's reached its
21 maximum value.

22 Q. Sure. But when you predict -- I
23 think "predict" is your word, or "project,"
24 when you project the present value of benefits,
25 do you project the present value of benefits



1 based on the maximum policy value as an
2 actuary?

3 A. That is a -- yes. That is a pretty
4 important consideration. Yes.

5 Q. So the present value of benefits is
6 predicated or based upon the maximum policy
7 value?

8 A. The maximum policy value is taken
9 into consideration in developing a projection
10 of benefits, yes.

11 Q. Sure. Because it's the outer
12 boundary?

13 A. Yes.

14 Q. As other elements like elimination
15 periods, others factors that would bound the
16 coverage equivalent in understanding the
17 coverage for which you are predicting the
18 benefit, is that the nature of the maximum
19 policy value?

20 A. That is correct.

21 Q. Okay. When you project the present
22 value of a long-term care policy, do you look
23 at, in addition to the policy design, do you
24 look at past experience, do you look at the
25 assumptions that were utilized in setting the

1 can't remember what we were thinking at the
2 time.

3 Q. Okay.

4 A. We, you know --

5 Q. Okay.

6 MR. BROADBENT: I don't know
7 that the witness was finished with his answer,
8 please.

9 THE WITNESS: Yeah. I don't
10 know if I would characterize our thinking that
11 way. I just don't recall that at all.

12 BY MR. LESLIE:

13 Q. Okay. I will draw your attention to
14 -- I will draw your attention to Option 4,
15 please. Option 4 in Scenario 1, which is
16 derived in part from Penn Treaty, seems to be
17 an attractive option for active and disabled
18 policyholders, with 81 percent selecting it; is
19 that right?

20 A. Well, in these scenarios we are
21 showing 81 percent electing it, so in that
22 scenario, it would be.

23 Q. Let's go back to RP 17, please. I'm
24 sorry, RP 7. I apologize.

25 So this is the comparison



1 illustration that shows the relative benefits
2 in Phase One of the rehabilitation options
3 compared to liquidation; is that correct?

4 A. This shows -- I believe we looked at
5 this exhibit a few times. I would continue to
6 characterize it as comparing present value
7 benefits minus present value premiums under
8 liquidation and rehabilitation.

9 Q. Is this the comparison upon which
10 the assertion is made -- that you assert that
11 policyholders have at least one option equal to
12 or greater than liquidation?

13 A. For the purposes of this comparison.

14 Q. Isn't this the comparison that's in
15 the comparison file?

16 A. It is, yes.

17 Q. Isn't this the comparison the
18 Rehabilitator is relying upon for asserting
19 that over 80 percent of policyholders are
20 better off with a rehab option, at least one
21 option than they would be in liquidation?

22 A. I don't believe that is the case,
23 no.

24 Q. Well, okay. 85 percent, is the 85
25 percent, to get to the 85 percent, is that



1 materially influenced by the high percentage of
2 policyholders that the group guessed would
3 select Option 4?

4 A. I don't think this has anything to
5 do with selecting anything. This is showing
6 that 85 percent of the people would have one
7 option available to them in which PV benefits
8 minus PV premiums is greater than it would be
9 in liquidation.

10 Q. And which of those options is going
11 to have -- had the most significant effect in
12 generating this 85 percent?

13 A. My recollection is that Option 4.

14 Q. Would it be the 81 percent shown on
15 the earlier chart we just looked at or
16 illustration we just looked at?

17 A. That 81 percent -- I don't think
18 they are the same. They are not one and the
19 same.

20 Q. So where did -- what is the
21 underlying, where are the underlying numbers
22 that you used for purposes of coming up with
23 this 85 percent, what is it based on?

24 A. This is a mathematical exercise
25 comparing these measurements on a seriatim



1 basis.

2 Q. Do you believe that is a fair and
3 reasonable way to look at the relative benefits
4 of the proposed rehabilitation options to
5 liquidation?

6 MR. BROADBENT: Your Honor, I
7 am going to object again. We are now
8 revisiting territory I think we covered two or
9 three times and continuing to go on at length.
10 And if Your Honor is inclined to continue, I
11 will withdraw the objection, but I do think we
12 are now doubling and tripling the testimony
13 that Mr. Bodnar has already given as to these
14 documents.

15 MR. LESLIE: Your Honor, the
16 amount of time we have taken during this case
17 is a fraction of the Rehabilitator's time.
18 This witness has been very precise in his
19 answers. It has been important to build to
20 this point which is critical to a comparison of
21 rehab versus liquidation and the underlying
22 reasons for that.

23 So I apologize for having to repeat,
24 but I feel I am being required to do that by
25 the witness.



1 JUDGE LEAVITT: I think the
2 witness is being very cooperative. We have
3 spent a good amount of time on this particular
4 exhibit. It is -- I understand your point,
5 it's a good one. If you can finish up.

6 As I understand it, you're trying to
7 establish for the record that the liquidator's
8 argument that 85 percent of the SHIP
9 policyholders have one option that is superior
10 to, and I hate to use the term "superior," but
11 they will fare better than in a liquidation,
12 that's Option 4? Is that what you're trying to
13 get the witness to identify?

14 MR. LESLIE: Yes.

15 JUDGE LEAVITT: Do you know
16 the answer to the question?

17 THE WITNESS: Yes, Your Honor.
18 Using this measurement of present value
19 benefits minus present value premiums, 85
20 percent of the policyholders will have one
21 choice under the plan, at least one choice
22 under the plan, in which that value, that
23 metric is greater than or equal to what they
24 would receive in liquidation. That is using
25 this metric.



1 JUDGE LEAVITT: But what
2 option of the five options?

3 THE WITNESS: Oh, generally,
4 it's Option 4.

5 JUDGE LEAVITT: Okay.

6 BY MR. LESLIE:

7 Q. Which, Mr. Bodnar, is the option
8 that has the least effect on reducing the
9 funding gap; is that correct?

10 A. Yes. That is also true, yes.

11 MR. LESLIE: I am done, Your
12 Honor.

13 JUDGE LEAVITT: Thank you.
14 Just, we will break for lunch and then resume
15 cross examination. The Court would like a
16 clarification, Mr. Bodnar. You said you based
17 this exhibit on the Penn Treaty liquidation or
18 -- maybe not this one, but the comparison where
19 you are showing the various options and the
20 percentage of choices per option.

21 THE WITNESS: Yes. So the
22 exhibit that is on your screen now, Your Honor,
23 the very left-hand.

24 JUDGE LEAVITT: Option 1.

25 THE WITNESS: Scenario 1,



1 MR. SMITH: Before I begin the
2 examination of Mr. Edwards, I just wanted to
3 address the state insurance regulators'
4 exhibits along --

5 THE COURT REPORTER: I'm
6 sorry, excuse me. Thank you.

7 MR. SMITH: Before we begin,
8 if I may just offer the exhibits. We have
9 consulted with counsel for Rehabilitator, for
10 the agents, for the health insurers and for
11 NOLHGA, and they have no objections to the
12 admissibility of the exhibits, so I just would
13 like to identify them for the record.

14 JUDGE LEAVITT: All right.

15 MR. SMITH: I have hard
16 copies. The first exhibit is Exhibit SIR-1.
17 It is an Oliver Wyman 11/20/20 Phase One
18 rehabilitation plan results as of 6/30/2020
19 exhibit with a summary of rehabilitation plan
20 results (Phase One). I note for the record it
21 has also been previously identified as Exhibit
22 RP 21.

23 The second exhibit, SIR-2, is an
24 Oliver Wyman 1/26/21 actuarial report
25 supporting the rehabilitation plan, except



1 excerpt -- it is the cover page, Page 11 and
2 Page 77. And I note for the record this is an
3 excerpt of what has been previously marked as
4 RP-16.

5 The next exhibit is SIR-3, which is
6 Oliver Wyman 3/2/21 Phase One rehabilitation
7 plan funding gap exhibits as of 6/30/2020 with
8 Phase One funding gap reduction by plan option
9 and Phase One funding gap reduction by election
10 rate scenario. And I note for the record that
11 has been previously marked as Exhibit RP 19.

12 Exhibit SIR 4 is a SHIP 12/31/20
13 income statement and balance sheet. I believe
14 that was previously marked as RP 12.

15 The next five -- the next exhibits
16 are all under Exhibit 5. 5-1, SIR 1 -- excuse
17 me, SIR 5-1 is a page entitled Impacts of
18 Liquidation on Policyholders and Guaranty
19 Associations.

20 The next exhibit, SIR 5-2, is a
21 sheet entitled Policyholder Comparison For Each
22 Phase One Option Versus Liquidation.

23 The next exhibit, SIR 5-3, entitled
24 Effect of Phase One Scenarios on Funding Gap.

25 The next exhibit, SIR 5-4, is a



1 sheet entitled Best Interest Scenario
2 Calculation.

3 The next exhibit, SIR 5-5, is a
4 sheet entitled Rehabilitation Versus
5 Liquidation Calculations Reflecting "Best
6 Interest" Scenario in Phase Two Premium
7 Increases.

8 Next exhibit, SIR 5-6, is a sheet
9 entitled Rehabilitator's Calculation of Plan
10 Benefits (Option 2) Versus Rehabilitator's
11 Calculation of Guaranty Association Benefits.

12 The next exhibit, SIR 6, is a
13 3/12/21 letter from Eric A. Smith and Michael
14 J. Broadbent called Actuarial Advisors.

15 And Exhibit SIR 7 is a 3/30/21
16 letter from Michael J. Broadbent to J. David
17 Leslie and Eric Smith responding to Exhibit SIR
18 6. And we would ask that those exhibits be
19 admitted into evidence.

20 JUDGE LEAVITT: They are
21 admitted. There is no objection?

22 MR. HAMILTON: Dexter Hamilton
23 for the Rehabilitator, no objection, Your
24 Honor.

25 MR. DONLEY: No objection,



1 Your Honor.

2 COUNSEL: No objection.

3 JUDGE LEAVITT: Ms. Glawe?

4 MS. GLAWE: No objection, Your
5 Honor.

6 (Exhibits SIR 1 through SIR 7
7 were marked for identification and admitted
8 into evidence.)

9 MR. SMITH: If I may approach
10 the witness, we are going to be using hard copy
11 exhibits, if I may give SIR 1 through SIR 5-6
12 to the witness so he has them before him.

13 JUDGE LEAVITT: Yes.

14 BY MR. SMITH:

15 Q. Would you please state your name?

16 A. Frank Edwards.

17 Q. Mr. Edwards, do you have any
18 professional credentials?

19 A. I am an associate of the Society of
20 Actuaries and a member of the American Academy
21 of Actuaries.

22 Q. Thank you. Are you employed?

23 A. As consultant, vice president, chief
24 actuary.

25 THE COURT REPORTER: I'm



1 Q. Does the comparison file provide for
2 comparisons based on maximum policy values?

3 A. There is no mention of maximum
4 policy value in the comparison file.

5 Q. Mr. Edwards, do the materials
6 provided by the Rehabilitator on the box site
7 provide the size of the funding gap?

8 A. Yes. \$1.224 billion.

9 Q. And were you asked by the Intervenor
10 state insurance regulators to calculate the
11 amount of the funding gap that would be borne
12 by policyholders in a liquidation?

13 A. Yes.

14 Q. And is your calculation set forth on
15 an exhibit?

16 A. Exhibit 1.

17 Q. Are you referring to exhibit SIR
18 5-1?

19 A. I think so. Yes.

20 Q. What was the source of the data for
21 the calculations set forth on Exhibit 1?

22 A. All the information came from the
23 comparison files in that first liquidation.

24 Q. Looking at the top of the exhibit,
25 there is a chart headed baseline and the second

1 section liquidation. Can you describe what is
2 in that chart?

3 A. Soon as I can find it.

4 JUDGE LEAVITT: We're on SIR
5 1?

6 MR. SMITH: Yes, SIR 1 -- 5-1.

7 BY MR. SMITH:

8 Q. The one-page exhibit?

9 A. Yeah.

10 Q. Looking at the top of exhibit SIR
11 5-1, there is a chart. What does that chart
12 contain?

13 A. It shows the baseline information
14 compared to liquidation.

15 Q. And what is baseline?

16 A. Baseline, the current assumption
17 used by Oliver Wyman as the comparison file,
18 which I believe is 6/30/2020, showing the
19 present value benefits, present value premiums
20 and the net benefit values in Column 3.

21 Q. And what does the section entitled
22 liquidation contain?

23 A. They have another column showing the
24 adjustment of present value future benefits by
25 including the guaranty association limits shown



1 in Column 4, and then the present value
2 benefits is adjusted based on that limit and
3 the premiums are also adjusted based on what
4 the premiums would be charged by the liquidator
5 and that present value.

6 MR. HAMILTON: Excuse me, Your
7 Honor, I don't know if I have the same -- is
8 that this document?

9 MR. SMITH: I created some
10 confusion earlier. It is Exhibit SIR-5-1.

11 BY MR. SMITH:

12 Q. Mr. Edwards, looking at the line
13 beginning total in the top, what does that line
14 contain?

15 A. Those are the values summing all the
16 policy information total for each of the items
17 in the column. So that information is the sum
18 from the comparison file rehabilitation versus
19 liquidation of the 33,261 policyholders.

20 Q. So you mentioned the file is a
21 seriatim file containing individual policy
22 information, and this is the sum of those terms
23 for each policy?

24 A. Correct.

25 Q. And were you asked to calculate the



1 impact of liquidation on policyholders?

2 A. Yes.

3 Q. And does Table 1 reflect your
4 calculation?

5 A. Yes, it does.

6 Q. Table 1 on Exhibit SIR 5-1, excuse
7 me.

8 A. Yes. It shows the baseline
9 benefits, it reduces -- compares that to the
10 present value benefits, so you have the total
11 from Column 1, you subtract off the values in
12 Column 5 to get the change in the present value
13 of benefits.

14 Q. So what is the sum of contract
15 benefits lost in liquidation compared to the
16 baseline?

17 A. Say that again.

18 Q. What is the benefits lost by
19 policyholders?

20 A. The loss by policyholders is the
21 difference to the 827 million.

22 Q. I'm sorry, I'm jumping ahead. Can I
23 ask you, first of all, what is the 303,490,655
24 number?

25 A. That is the difference in present



1 value of benefits between the baseline and
2 liquidation.

3 Q. And then what --

4 A. The next row shows a difference in
5 the premiums that would be from the present
6 value basis paid by the policyholders. So you
7 take -- the benefits are reduced, premiums are
8 increased, and then get the net difference.

9 MR. HAMILTON: If I may, Your
10 Honor, I would like to interpose an objection
11 to this testimony. Based on Mr. Leslie's
12 proffer, Mr. Edwards is a fact witness, and for
13 him to testify about things like liquidation
14 impact on policyholders, premium interest borne
15 by policyholders, I would, on behalf of the
16 Rehabilitator, we take the position that those
17 are really expert determinations, and this fact
18 witness, there is no foundation been laid and
19 this fact witness does not really have the
20 grounding to make those expert determinations.

21 So we would object to these
22 questions along with this testimony.

23 JUDGE LEAVITT: Well, I will
24 sustain the objection to the extent there is
25 any actuarial value being given, but I look at



1 Table 1 as being nothing more than a series of
2 mathematical exercises, so --

3 THE WITNESS: That is correct,
4 Your Honor.

5 JUDGE LEAVITT: So I will
6 allow the testimony. Try to limit your
7 characterizations.

8 MR. SMITH: Thank you, Your
9 Honor. This is all based, of course, on the
10 Rehabilitator's comparison file.

11 JUDGE LEAVITT: Right.

12 BY MR. SMITH:

13 Q. So let me go back. What is the
14 total impact on policyholders calculated from
15 the comparison file, and just give me the
16 dollar number?

17 A. 827 -- or the 396,969,559.

18 Q. Did you compare that number to the
19 funding gap borne by policyholders in
20 rehabilitation?

21 A. Yes.

22 Q. And where is that shown on the
23 chart?

24 A. That is shown at the bottom of
25 Table 1, subtracting that off the 1.224 billion



1 to get a difference of 827,030,441.

2 Q. So approximately -- okay. Skip
3 that.

4 Did you also calculate the amount of
5 support provided by guaranty associations?

6 A. Yes.

7 Q. And how did you do that?

8 A. Table 2 using the values of the
9 comparison file, compare the present value
10 benefits in Column 4 based on the GA and the
11 present value premium to get the difference of
12 1.641281443, and then in the file there is a 49
13 percent liquidation dividend that was
14 determined by Oliver Wyman using that amount to
15 get to adjust that difference when you get the
16 804,227,907 to get the net guaranty association
17 support of 837,053,536.

18 Q. So just to clarify, the first line
19 PV of benefits GA limit, is that the amount
20 that guaranty funds would pay based upon the
21 calculations in the comparison file?

22 A. Yes.

23 Q. And the next line, PV of premiums,
24 is that the amount that guaranty funds perceive
25 as premiums?



1 A. Yes.

2 Q. So the net guaranty fund payments in
3 the course of the liquidation as calculated in
4 the comparison file would be the \$1.6 billion
5 number?

6 A. Yes.

7 Q. And then you multiplied that by the
8 49 percent liquidation dividend to get the
9 amount that would presumably be paid in this
10 situation by the estate to the guaranty
11 association?

12 A. Correct, which is also provided by
13 Oliver Wyman.

14 Q. So the net guaranty fund association
15 would be the 837 million?

16 A. Correct.

17 MR. HAMILTON: Your Honor, may
18 I have a continuing objection to this
19 testimony? I still have the same concern.
20 This witness is testifying about things that
21 would happen if the receivership were to go
22 into liquidation and the guaranty associations
23 would take certain actions.

24 There are certain numbers, but this
25 witness, to put it in this chart that he



1 witness who is doing mathematical calculations
2 to testify about a document and present to the
3 Court and put in this record a conclusion of
4 policyholders being better off.

5 That is an expert opinion.

6 JUDGE LEAVITT: I agree that
7 it is opinion and this witness has not been
8 qualified as an expert. Nevertheless, with
9 those qualifications. But I would ask,
10 Mr. Smith, that you, when you -- as you
11 question Mr. Edwards about these exhibits, you
12 have been very helpful in identifying where the
13 numbers come from in the Oliver Wyman work, but
14 I think what you need to do is define what you
15 mean by "better off" or anything that has -- is
16 in the nature of what most people would say is
17 expressing a value judgment.

18 MR. SMITH: Your Honor, I
19 stand admonished. I would only add that this
20 exhibit was prepared in the context of
21 responding to the comparison file which
22 permitted this particular comparison.

23 JUDGE LEAVITT: All right.

24 BY MR. SMITH:

25 Q. Looking at the next couple of lines



1 down, the -- just let me complete the analysis;
2 the first column under Option 1, what is the
3 61.97 percent number, Mr. Edwards?

4 A. Could you repeat that?

5 Q. Looking in the Option 1 column,
6 going down to the line which contains the
7 number 61.97 percent --

8 A. Correct.

9 Q. Can you just tell me what that
10 percentage means?

11 A. That is the percentage of the 61 is
12 better off, as we have used that name, for
13 liquidation 61.97, it's just a simple ratio of
14 the 20,611 over the 33,261.

15 Q. Okay. So for Option 1, 61.97
16 percent of the policyholders have a net present
17 value in liquidation that exceeds that in any
18 of the rehabilitation options; is that correct?

19 A. Correct.

20 Q. Excuse me. Moving quickly over to
21 the Option 4 column, what is the 83.04 percent
22 number?

23 A. That represents the percentage of
24 policyholders' net present value is greater in
25 rehabilitation versus liquidation.



IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

**STATE INSURANCE REGULATORS’
 APPLICATION FOR STAY PENDING APPEAL**

Pursuant to Pa. R.A.P. 123 and 1732(a), the Intervenor Superintendents of Insurance of the State of Maine, Commissioner of Insurance of the Commonwealth of Massachusetts, and Insurance Commissioner of the State of Washington (“State Insurance Regulators”), move for a stay pending appeal of the August 24, 2021 Order granting the application of the Insurance Commissioner of the Commonwealth of Pennsylvania as Rehabilitator (“Rehabilitator”) of Senior Health Insurance Company of Pennsylvania (“SHIP”) for approval of the Second Amended Plan of Rehabilitation (“Plan”), as well as the May 21, 2021 ruling granting the Rehabilitator’s motion in the nature of a directed verdict regarding issue state rate approval and the August 25, 2021 Order denying reconsideration. The State Insurance Regulators filed their appeal on September 21, 2021.

Introduction

This case involves an unprecedented plan of rehabilitation for an insolvent insurance company. The Plan places the entire \$1.2 billion burden of the

insolvency on 30,000 of SHIP's remaining policyholders through benefit cuts and premium increases even though, in a liquidation, based on the Rehabilitator's comparison analysis, the policyholders would only bear a loss of \$400 million, as guaranty associations would provide over \$800 million of additional support. The Plan also supersedes the authority of insurance regulators in other states to review rates for policies issued in their States.

The Court approved the Plan over the objections of the Intervenor State Insurance Regulators. It expressed fundamental disagreement with the Intervenor's position that the policyholders' best financial interest must be protected in an insolvency and that state regulators control rates in their states. The Court instead took the view that (a) SHIP's policies were historically "underpriced" so that policyholders should bear the burden of insolvency instead of the guaranty associations and those who fund them, and (b) the state-based rate review system historically resulted in "discriminatory" rates so that rates should be set nationwide by the Rehabilitator and the Court.

In their appeal, the State Insurance Regulators contend that the Rehabilitator was required as a matter of law to protect the financial interest of policyholders in their contracts, rather than pursuing other goals, and that the Rehabilitator and Court must take the policies as they find them. Deeming policyholders unworthy of guaranty association protection and deciding instead to protect those who fund

the guaranty associations is contrary to the purpose of the guaranty association statutes. The Plan was constitutionally required, but fails, to provide all policyholders an option with a value at least equal to the value they would receive in liquidation. Finally, the Plan exceeds statutory authority and violates the Full Faith & Credit Clause by displacing insurance regulators from their statutory role in reviewing rates applicable to policies issued in their States.¹

These novel and important issues should be resolved by the Supreme Court before the Plan is implemented and the rights of policyholders and insurance regulators permanently impaired. The Plan will not correct SHIP's insolvency. However, implementation of the Plan will alter the *status quo* and permanently reduce the contract rights of policyholders so that they will have less protection from insurance guaranty associations when SHIP is inevitably liquidated. It will also require insurance regulators to decide whether to "opt-out" of the Plan to the detriment of policyholders in their States.

The Rehabilitator is now moving to implement the Plan. In the "Approved SHIP Rehabilitation Plan" as corrected September 30, 2021, the Rehabilitator advised that:

¹ The appeal also involves additional and more specific issues. This relatively brief application does not address all grounds for the appeal. The State Insurance Regulators reserve and do not waive any grounds not discussed herein.

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.

Praeipie to Substitute Approved Plan of Rehabilitation, Exhibit A, p. 19 (September 30, 2021). This is consistent with the testimony at the hearing. *See* Memorandum Opinion dated August 24, 2021 ("Mem. Op.") at 6, 47, 77. Insurance regulators will need to make "opt-out" decisions following approximately November 15, 2021. *See* Rehabilitator's Email to Commissioners dated September 20, 2021 (attached as Exhibit A hereto).

If the Plan is implemented before the appeal is heard and decided, the Rehabilitator may contend that the appeal is equitably moot and that the policyholders' and regulators' rights have been permanently altered despite the pending appeal. The Court should accordingly grant this application and stay its Orders pending appeal.

Standard for Stay Pending Appeal and Summary

The standard governing this application for stay is well-established.

On an application for stay pending appeal the movant is required to make a substantial case on the merits and to show that without the stay, irreparable injury will be suffered. Additionally, before granting a request for a stay, the court must be satisfied the issuance of the stay will not substantially harm other interested parties in the proceedings and will not adversely affect the public interest.

Maritrans G.P., Inc. v. Pepper, Hamilton & Scheetz, 573 A.2d 1001, 1003 (Pa. 1990) (decision of Nix, C.J.) (citing *Pa. Pub. Util. Comm'n v. Process Gas Consumers Grp.*, 467 A.2d 805, 808-809 (Pa. 1983)). A stay pending appeal should be granted here.

First, the State Insurance Regulators have a strong case on the merits of their arguments that the Plan should not be approved. As discussed below, the Plan is not feasible as required by law; constitutes an abuse of discretion and error of law because it does not serve the best financial interest of policyholders and ignores guaranty associations; fails to place policyholders in at least as good a position as in a liquidation as required by *Neblett v. Carpenter*, 305 U.S. 297 (1938); and exceeds statutory authority and violates the Full Faith and Credit Clause in superseding the regulatory authority of other States over rates.

Second, the policyholders of SHIP and the State Insurance Regulators will suffer irreparable injury if the Plan is implemented during the appeal. The Plan will permanently reduce policyholders' contract rights and displace state insurance regulators from their statutory role in reviewing rates. If the Plan is implemented before the appeal is decided, the Rehabilitator may contend that the appeal is equitably moot. If so, this would leave policyholders with reduced coverage and reduced guaranty association protection in the inevitable liquidation, and regulators with no role in determining rates in their States.

Third, issuance of a stay pending appeal will not harm other interested persons. It will preserve the *status quo*. Policyholders will continue to pay premiums at the lawfully approved rates as before, and those on claim will continue to receive claim payments as they have during the pendency of the Rehabilitator's application for approval of the Plan. The intervenor agents and brokers have settled their issues. *See* Memorandum Opinion dated September 13, 2021. Finally, so long as the appeal is pending, SHIP will not be liquidated and the intervenor health insurers will not need to pay guaranty association assessments.

Fourth, a stay will not adversely affect the public interest. This appeal protects the financial interests of policyholders that are intended to be protected by the insurer receivership statutes and the guaranty association system and protects the state-based rate regulatory system. The Rehabilitator may contend that delaying benefit cuts and premium increases under the Plan will ultimately increase the size of SHIP's insolvency and the burden on the guaranty associations, their member insurers and, in many States, on taxpayers when SHIP is liquidated. That is not cognizable "harm" because the guaranty associations were created specifically to protect policyholders in the event of an insolvency, and the legislatures have determined how to allocate the burden of that protection.

Factual Background

While most of the basic facts on which the State Insurance Regulators rely are referred to in the Court's Memorandum Opinion, some are omitted, understated or only noted in passing. The essential facts are set forth below.

1. SHIP's policies are enforceable contracts, and the premiums charged on the policies historically and on the rehabilitation date were lawfully approved rates. Tr. 227-229, 282.

2. SHIP is insolvent, with a deficit or "funding gap" of approximately \$1.2 billion. Ex. RP-55 (the Plan) at 87.

3. Under the Plan, the burden of reducing or eliminating the \$1.2 billion funding gap will rest on the 30,000 remaining SHIP policyholders who have not taken non-forfeiture options. Tr. 290-292; Ex. RP-55 at 102-103. The Plan seeks to reduce the funding gap by reducing policy benefits and increasing premiums. Ex. RP-55 at 10, 102-103.

4. The Plan requires policyholders to select among options, only one of which (Option 4) retains the policyholders' full benefits in Phase One. The other options (Options 1, 2, 2a, and 3) all reduce benefits in Phase One. Ex. RP-55 at 23-24; Tr. 113-117. Policyholders who choose Options 1 or 4 in Phase One face the possibility of additional substantial rate increases or benefit reductions in Phase Two. Ex. RP-55 at 15, 58.

5. In a liquidation, virtually all of SHIP's policies would be covered by one of the guaranty associations created by statute in each state, subject to the individual state statutory limits on guaranty association coverage. Ex. RP-55 at 93.

6. If SHIP were liquidated now so that guaranty associations are triggered, policyholders will absorb only approximately \$397 million of the funding gap, based on the Rehabilitator's comparison file. Ex. SIR 5-1, Table 1; Tr. 564. This is because guaranty associations would provide approximately \$837 million in additional support to benefit policyholders, also based on the Rehabilitator's comparison file. Ex. SIR 5-1, Table 2; Tr. 565-66. The Plan does not trigger the guaranty associations, Ex. RP-55 at 92, so these additional funds will not be available to benefit policyholders under the Plan.

7. The policyholder elections under the Plan will be permanent in that guaranty association coverage may be given up. If SHIP is placed in liquidation after the Plan is implemented, the policies to which guaranty association coverage will apply will be the policies as modified as a result of the elections. EX. RP-55 at 14, 92; Tr. 300-301, 313.

8. The Plan is highly unlikely to eliminate the funding gap and restore SHIP to solvency, even considering both Phase One and Phase Two. Tr. 80, 306. In all likelihood, the Plan will not eliminate the deficit, just reduce it materially. Tr. 189-190.

9. The Plan will not provide all policyholders with an option with a net present value (present value of future benefits less present value of future premiums) at least as great as the net present value in liquidation. Only 85% of policyholders will have at least one Phase One option with a net present value equal to or greater than liquidation. Ex. RP-7; Tr. 183, 185, 510, 512. This 85% rests principally on Option 4. Tr. 510, 512-513, 572; Ex. SIR 5-2. Option 4 has the least impact on the funding gap, and it is subject to further adjustment in Phase Two. Tr. 259, 513; Ex. RP-55 at 14.

10. Under state statutes, long term care insurance rates are reviewed and approved by the insurance regulatory official of the state in which the policy is issued. Tr. 155, 157. Each state has its own approach to reviewing rates. Tr. 413-414. The Plan does not follow this issue state rate approval process. Ex. RP-55 at 33-34, 96; Tr. 158-159. It removes state insurance regulators from their role in reviewing rates, which is “unprecedented.” Ex. RP-55 at 33-34; Tr. 82. Under the Plan, the Rehabilitator will not seek approval of rates from state regulators under their statutes but instead from the Commonwealth Court. Ex. RP-55 at 33-34, 96.

11. The Plan has an “issue state rate approval” section under which state regulators purportedly may “opt-out” of having the Commonwealth Court approve rates. Ex. RP-55 at 108. The section provides that, unless the “opt-out” state approves the Rehabilitator’s rate application, in full, within 60 days, it is deemed

denied. Ex. RP-55 at 111. In that case, the options available to policyholders in that state will be more limited than the options available in other states, and the state's policyholders will be disadvantaged. Ex. RP-55 at 109, 116; Tr. 169-170.

ARGUMENT

I. THE STATE INSURANCE REGULATORS HAVE A STRONG CASE ON APPEAL.

The State Insurance Regulators have substantial arguments that the Court's approval of the Plan should be reversed because the Plan is based on errors of law. To warrant approval under 40 P.S. § 221.16, the Plan must be free from any abuse of the Rehabilitator's discretion. *Foster v. Mutual Fire, Marine and Inland Ins. Co.*, 614 A.2d 1086, 1091 (Pa. 1992) ("*Mutual Fire II*"), *cert. denied* 506 U.S. 1080 and 1087 (1993). "It is a paradigmatic abuse of discretion for a court [or the Rehabilitator] to base its judgment upon an erroneous view of the law." *Commonwealth v. Taylor*, 230 A.3d 1050, 1072 (Pa. 2020).

A. The Court Erred In Holding That There Is No Feasibility Requirement And That The Plan Was Feasible Where It Is Highly Unlikely To Restore SHIP To Solvency.

The goal of the Plan as originally presented to the Court was to restore SHIP to solvency – "to restore SHIP to a financially self-sustaining long-term care insurance company." Rehabilitator's Application for Approval of the Plan of Rehabilitation ¶ 2 (April 22, 2020). At the hearing, however, the Special Deputy Rehabilitator conceded that "it is not likely that we will magically restore SHIP to

solvency.” Tr. 80. The Court seemed to acknowledge this (Mem. Op. 14, 24-25), but it later said that the Plan “will reduce or eliminate” the funding gap (Mem. Op. 78) as if elimination were a reasonable possibility. The Special Deputy Rehabilitator made clear it was not. He testified that: “In all likelihood [the Plan] will not eliminate [the deficit]. In all likelihood, it will just reduce it materially.”

Tr. 190. Further:

Q. . . . Yesterday you testified that it was unlikely, I think highly unlikely, that the plan could eliminate the funding gap. Did you mean Phase One or did you mean Phase One and Phase Two?

A. I meant Phase One and Phase Two. . . .

Tr. 306. The most that can be said is that the Plan will “materially reduce” the funding gap. Mem. Op. 67; Tr. 90. But if the Plan only materially reduces the funding gap, SHIP will still need to be liquidated.

The Court held that feasibility is not required, and that it is sufficient if the Plan reduces the funding gap because it also pursues other goals. This was error.

1. A Rehabilitation Plan Must Be Feasible.

To be approved, a rehabilitation plan for an insolvent insurer must be reasonably likely to restore the insurer to solvency. This commonsense requirement reflects the fact that if the insurer continues to be insolvent after the plan, it will still need to be liquidated. It is not enough that the “ultimate goal” of a plan is to restore the company to solvency if the plan is not likely to actually do so.

Feasibility is a well-recognized requirement. *See 1 Couch on Ins.* § 5:24 (3d ed. 2021) (“Above all, the rehabilitation plan must be feasible . . .”). Contrary to the opinion (Mem. Op. 65), feasibility has been recognized as a requirement in Pennsylvania decisions. For instance, in an earlier case in which the insurer opposed liquidation, the Supreme Court held that “[i]t is clear that [the company] has the burden of showing that rehabilitation is feasible.” *Sheppard v. Old Heritage Mut. Ins. Co.*, 425 A.2d 304, 310 (Pa. 1980) (citing *Comm. Ins. Dep’t v. Safeguard Ins. Co.*, 336 A.2d 674, 680) (Pa. Commw. 1975)). In *Mutual Fire II*, the Supreme Court detailed the history of the rehabilitator’s and trial court’s consideration of feasibility. 614 A.2d at 1090. While feasibility was not an issue on appeal, the discussion shows that a rehabilitation plan that is not feasible should not be approved. *See also Grode v. Mutual Fire, Marine & Inland Ins. Co.*, 688 A.2d 233, 234 (Pa. Commw. 1996) (noting that court had required the rehabilitator to report on feasibility and that the initial plan did not proceed because it was not feasible). The feasibility requirement also rests on the statutory standard for conversion to a liquidation. Tr. 90. Where rehabilitation is “futile,” it should not proceed. *See* 40 P.S. § 221.18.

Feasibility is particularly important here because the Plan is expressly intended to permanently reduce policyholders’ benefits and increase their premiums. Ex. RP-55 at 14, 92. If SHIP is liquidated after the Plan is

implemented, the guaranty associations and liquidation estate will only cover contractual obligations as reduced under the Plan. The amount by which SHIP's liabilities are reduced will not be covered in a subsequent liquidation.

2. The Court's Redefinition of Feasibility is Unlikely to be Upheld.

The Court refashioned the concept of feasibility, holding that it just means "properly conserving and equitably administering the assets of the involved insurer." Mem. Op. 66. This deprives feasibility of any meaning. That language from *Mutual Fire II* did not describe the purpose of rehabilitation but only that a plan need not restore the company "to its exact original condition." 614 A.2d at 1094.

"The goal of rehabilitation is to manage the affairs of an insolvent insurer with the intended result of restoring the entity to sound fiscal status." *Mutual Fire II* at 1096 (emphasis added). See *Kueckelhan v. Fed. Old Line Ins. Co.*, 444 P.2d 667, 674 (Wash. 1968) (*en banc*) (rehabilitation aims to "restore the company to a viable status for the benefit of the policyholders"). The Plan's feasibility must be measured against the goal of restoring SHIP to solvency.²

² The State Insurance Regulators have not contended that feasibility requires SHIP to resume operation as an insurer writing insurance in the market, only that the Plan (assuming it were otherwise proper) must be reasonably likely to restore SHIP to solvency so that it can run off its obligations paying them in accordance with the options selected pursuant to the Plan.

Where the insurer is insolvent, measuring feasibility against goals other than financial viability is improper. Whatever the merits of the other goals, liquidation will follow if the insurer remains insolvent. Rehabilitation must be reasonably likely to avoid liquidation, and not – as here – just serve as a means to reduce policyholders’ contract rights on the way to inevitable liquidation.

B. The Plan Constitutes An Abuse Of Discretion, Exceeds The Rehabilitator’s Authority And Is Contrary To Law By Disregarding The Financial Interest Of Policyholders And The Guaranty Association System.

The Court’s approval of the Plan is an unprecedented departure from the fundamental goal of insurer rehabilitations – to protect to the maximum extent possible the contractual rights of policyholders. Instead of seeking to protect those contract rights, the Court approved reductions in those rights on the unprecedented theory that the policies were historically “underpriced.” Mem. Op. 43, 51, 63-64. The Court explicitly rejected triggering the insurance guaranty associations established to protect policyholders’ contract rights because that would impose a burden on the association’s insurer members and, ultimately, upon taxpayers. Mem. Op. 45, 63, 81. The Court also relied on its view that the state-based rate approval system has resulted in “discriminatory” rates contrary to the public good. Mem. Op. 45, 68-69, 80-81.

The Court’s approval of the Plan on these policy grounds (*see* Tr. 295) is contrary to the purpose of the rehabilitation statute to protect policyholders to the

maximum extent possible and frustrates the legislative judgment that the policyholders of insolvent insurers warrant guaranty association coverage. “[T]he power of courts to formulate pronouncements of public policy is sharply restricted. . . . Generally speaking, the Legislature is the body to declare the public policy of a state and to ordain changes therein.” *Conway v. Cutler Grp., Inc.*, 99 A.3d 67, 72 (Pa. 2014) (quoting *Mamlin v. Genoe (City of Phila. Police Beneficiary Ass’n)*, 17 A.2d 407, 409 (Pa. 1941)). The Court’s disregard of the statutory mandates to advance its policy views, at the expense of policyholders, is impermissible.

1. The Plan Is Adverse to the Best Financial Interest of Policyholders.

SHIP is massively insolvent, with a deficit of \$1.2 billion. Accordingly, it could be placed in liquidation on grounds of insolvency, *see* 40 P.S. § 221.19, § 221.14(1), which would trigger guaranty association coverage. The undisputed evidence, based on the Rehabilitator’s own Comparison File, is that in a liquidation the guaranty associations would provide over \$800 million in additional support, so that in liquidation the policyholders would bear a loss of only \$397 million from SHIP’s insolvency. While the Court acknowledges this (Mem. Op. 31-32), its decision disregards this undisputed adverse financial impact on policyholders.

Under the Plan, the entire \$1.2 billion burden of SHIP’s insolvency rests on SHIP’s 30,000 remaining non-NFO policyholders through benefit cuts and premium increases – even though those policyholders only contributed to part of

the Funding Gap. The benefits foregone under the Plan will be given up permanently, and they cannot form the basis for a claim to guaranty association benefits or a liquidation dividend in any subsequent liquidation. In a present liquidation, by contrast, the policyholders stand to receive the benefit of guaranty association coverage based on their original policies plus potentially a liquidation dividend on the excess. The Rehabilitator and Court thus chose to place the entire burden of the insolvency on the remaining policyholders and to forgo over \$800 million in guaranty association support that in a liquidation would fill much of the funding gap, spread the loss, and reduce the burden of insolvency on policyholders.

2. Placing the Burden of Insolvency on Policyholders is Contrary to the Purpose of the Rehabilitation Statute.

This disregards the fundamental purpose of the rehabilitation statute – to protect policyholders by preserving their contract rights to the maximum extent possible. A rehabilitator’s “first duty [is] to the ‘grave and important public interest’ in not depriving the . . . policyholders of the protection of their policies.” *In re Exec. Life Ins. Co.*, 38 Cal. Rptr. 2d 453, 465 (Cal. Ct. App. 1995) (emphasis added) (quoting *Carpenter v. Pacific Mut. Life Ins. Co. of Cal.*, 74 P.2d 761, 775 (Cal. 1937) (“*Carpenter*”), *aff’d sub nom. Neblett v. Carpenter*, 305 U.S. 297 (1938) (brackets omitted)). The goal of rehabilitation is not just to restore the company to solvency, but to do so in a way that benefits policyholders. *See*

Kueckelhan, 444 P.2d at 674 (rehabilitation aims to “restore the company to a viable status for the benefit of the policyholders”) (emphasis added). A rehabilitation plan must minimize harm to policyholders, as the statutes aim to protect them. *See* 40 P.S. § 221.16.

To support its efforts to “correct” historical underpricing and rates and avoid burdening those who fund the guaranty associations, the Court relied on general statements in *Mutual Fire II* that rehabilitation is intended to protect “the public good.” *See* Mem. Op. 42-43 (quoting *Mutual Fire II*, 614 A.2d at 1094 & n. 4). *See* 40 P.S. § 221.1. Those generalized statements, however, do not address the question here: whether a plan can advantage other persons to the detriment of policyholders. That issue was not presented in *Mutual Fire II*. Indeed, the Supreme Court recognized the primacy of policyholder interests elsewhere in the decision. *See Mutual Fire II*, 614 A.2d at 1100 (“If, after all, insurance is to perform its function of risk assumption and distribution of loss, then those statutes which govern it must first protect the insuring public.”) (quoting *Mutual Fire I*, 572 A.2d at 807) (emphasis added); *id.* at 1102 (referring to “the ultimate goal of this process, the overall good of the general public and the insurer’s policyholders”) (emphasis added); *id.* at 1104 (referring to “the statutorily charged duty of the Rehabilitator to protect the interests of Mutual Fire insureds”) (emphasis added). The Supreme Court’s initial, general statements do not provide

the Rehabilitator with a roving commission to adjust contract rights and refuse guaranty association support as she chooses.

The rehabilitation statute is limited. It provides for a rehabilitator to “correct” the conditions that constituted the ground for the rehabilitation order (here, insolvency), not to require the policyholders to exclusively bear the consequences. 40 P.S. § 221.16(b), (d). A rehabilitator is to honor policies to the extent possible and treat policyholders equally. *See* 40 P.S. § 221.15(d) (rehabilitation order “shall not constitute an anticipatory breach of any contracts of the insurer”); 40 P.S. § 221.44 (preferring policy obligations by giving them priority and prohibiting subclasses within a priority class). The statutes do not contemplate that a rehabilitator will decide that policyholders have been “underpaying” for “Cadillac” policies and should have their benefits cut. Tr. 78, 102. This may leave SHIP as an entity in “better shape” (Mem. Op. 25), but its policyholders are worse off. A plan that only attempts to materially reduce the size of the insolvency at the sole expense of policyholders, but still leaves the company insolvent, is not a proper rehabilitation plan.

3. The Court Improperly Rejected Guaranty Association Protection for Policyholders.

The Court approved the Plan because, in its view, SHIP’s policyholders should have paid more for their coverage so that it is “unjustified” to seek to trigger the guaranty associations because that would burden others through the

assessment mechanism. Mem. Op. 43, 45, 63, 81. This rationale is legally erroneous. The Court's view that it "serves the public good" (Mem. Op. 43) to avoid triggering guaranty associations is contrary to the very purpose of having such associations. The legislatures in Pennsylvania and other states have chosen to protect policyholders of insolvent insurers by establishing guaranty associations to provide coverage (subject to certain limits), and they have chosen how to spread the burden of those protections through the assessment mechanism. It is not within the Rehabilitator's or Court's discretion to reject these statutory protections because they deem the policyholders unworthy of guaranty association support. *See Weaver v. Harpster*, 975 A.2d 555, 563 (Pa. 2009) ("[I]t is for the legislature to formulate the public policies of the Commonwealth.")

Guaranty associations were established to protect policyholders by fulfilling the insolvent insurer's contractual obligations (subject to statutory limits). For instance, the Pennsylvania statute provides:

The purpose of this article is to protect, subject to certain limitations, [policyholders] against failure in the performance of contractual obligations, under life, health and annuity policies, plans or contracts . . . because of the impairment or insolvency of the member insurer that issued the policies, plans or contracts.

40 P.S. § 991.1701. The statutes do not limit guaranty association coverage based upon the insufficiency of premiums that the policyholders paid in the past. They

seek to honor the insurer's contractual obligations, subject to specific limits. *E.g.*, 40 P.S. § 991.1703, § 991.1706(b).

The legislatures also chose how to allocate the burden of honoring the insurer's contractual obligations. The guaranty association statutes generally fund the associations through assessments on member insurers. *See, e.g.*, 40 P.S. § 991.1707. They typically permit the member insurers to offset the assessments against their premium tax obligations or to recoup assessments by a surcharge on premiums. *See, e.g.*, 40 P.S. § 991.1711. The legislatures chose to spread the burden of an insurer's insolvency broadly, including on taxpayers, not to focus it exclusively on the insurer's policyholders.

The Court improperly overrode these legislative judgments.

C. The Court Misapplied *Neblett v. Carpenter*.

The State Insurance Regulators also have substantial arguments that the Plan fails to satisfy the requirement of *Neblett v. Carpenter*, 305 U.S. 297 (1938), that the Plan must place policyholders in no worse off a position than they would face in a liquidation of SHIP. Contrary to the decision (Mem. Op. 62), this fundamental standard was recognized by the Supreme Court in *Mutual Fire II*. *See Mutual Fire II*, 614 A.2d at 1093-94 (“Under *Neblett*, creditors must fare at least as well under a rehabilitation plan as they would under a liquidation . . .”), at 1096 (plan provision “ensures that the creditors herein, at a minimum, will fare at least

as well under the rehabilitation as they would in a liquidation proceeding as mandated by the holding of *Neblett*”), and at 1096 n. 6 (noting “the fundamental right of the creditors to be treated, at a minimum, as well under the rehabilitation as they would in a liquidation”).³

Under this standard, the Plan must provide policyholders with an option that provides at least the value of the policyholder’s policy in liquidation. *See Neblett*, 305 U.S. at 305 (policyholders were not forced to accept policy modifications “but are given the option of a liquidation which on this record appears as favorable to them as that which would result from the sale of the assets and pro rata distribution in solution of all resulting claims for breach of outstanding policies.”). The Supreme Court in *Mutual Fire II* did not replace the *Neblett* standard with the three-part test of *Energy Reserves Grp., Inc. v. Kan. Power and Light*, 459 U.S. 400 (1983). It treated them as two separate issues.

Neblett established a floor of liquidation value that each policyholder should be able to obtain if desired. It is undisputed that the Plan fails to provide every

³ The Commonwealth Court has previously shared this understanding of *Neblett*. In the decision leading to *Mutual Fire II*, the Commonwealth Court said “[T]he Rehabilitator agrees that *Neblett* requires claimants be treated the same or better than in liquidation. We shall not belabor this point except to agree with the parties that the Plan must also be viewed in the light of this principle.” *Mutual Fire I*, 572 A.2d at 804. *See also Koken v. Fidelity Mut. Life Ins. Co.*, 907 A.2d 1149, 1155 (Pa. Commw. Ct. 2006) (“Under the Plan, [creditors] have received or will receive at least as much as they would receive in a forced liquidation, as is required if a rehabilitation plan is to be deemed fair and equitable,” citing *Mutual Fire II*).

policyholder with such an option based on the “Carpenter value” of net present value (present value of benefits less present value of premiums). Based on the Rehabilitator’s own Comparison File, only 85% of policyholders have such an option in Phase One. Mem. Op. 65. Moreover, this percentage falls sharply if Phase Two is considered. The Court cited evidence showing that the 85% figure principally reflects the availability of Option 4 in Phase One, that Option 4 is subject to benefit reductions and premium increases, and that premium increases alone can bring the percentage of policyholders with net present value in excess of liquidation value below 50%. Mem. Op. 31-32. However, the Court did not address the significance of these points.

The Court instead rejected the net present value Carpenter value relied on by the State Insurance Regulators (and, initially, by the Rehabilitator) in favor of the Rehabilitator’s new “maximum policy value” approach. Mem. Op. 64-65. This does not comport with *Neblett*. The Supreme Court set the constitutional floor as the value that would result “from the sale of the assets and pro rata distribution in solution of all resulting claims for breach of outstanding policies.” *Neblett*, 305 U.S. at 305. That is the net present value. *See 1 Couch on Ins. 3d* § 6:1 (2021). The “maximum policy value” of a policy is not the value of a claim for breach of the policy. It is just the maximum amount that a policy could pay. *See* Ex. RP-55 at 126 (defining “Maximum Policy Value” as the Maximum Daily Benefit times

the Maximum Benefit Period). It is an “outer boundary” (Tr. 468) that does not consider the likely amount (projected value) of a claim or the cost (projected premiums) of the policy. RP-55 at 126. Maximum policy value is not economic value, and it is not a proper measure for the constitutional standard under *Neblett*.

D. The Court Erred In Overriding The States’ Regulatory Authority Over Rates.

The State Insurance Regulators also have strong grounds to contend that the Court’s approval of the Plan should be overturned because the Plan’s rate provisions exceed the authority granted to the Rehabilitator by the Pennsylvania statutes and violate the Full Faith & Credit Clause. Rate regulation has long been committed to the individual States. See 1 *Couch on Ins.* 3d § 2:31 (2021); *German All. Ins. Co. v. Lewis*, 233 U.S. 389 (1914); *Ins. Dep’t v. City of Phila.*, 173 A.2d 811, 813 (Pa. Super. Ct. 1961). The states regulate rates for long-term care insurance by providing for review by the insurance regulator of the State in which the policyholder resided when the policy was issued and judicial review in the courts of that State. See, e.g., 24-A Me. Rev. Stat. § 2736; Mass. Gen. Laws ch. 175, § 108; Wash. Rev. Code § 48.19.010(2), §§ 48.83, 48.84, § 48.18.110. The Court improperly overrode these statutes.

1. The Rehabilitation Statute Does Not Authorize Displacement of State Regulatory Authority.

The Court’s expansive view of the Rehabilitator’s powers (Mem. Op. 49-50) is not consistent with the statutory language. “A creature of statute, such as the

Insurance Commissioner acting as rehabilitator, can only exercise those powers which have been conferred by the Legislature in clear and unmistakable language.” *Koken v. Legion Ins. Co.*, 831 A.2d 1196, 1227 (Pa. Commw. Ct. 2003). The statutes do not authorize the Rehabilitator and Court to impose rates in disregard of the long-standing state-based system for review and approval of insurance rates. The rehabilitation statutes provide the Rehabilitator with control over assets and the business of the insurer. They do not oust state regulation of the insurer.

An order to rehabilitate an insurer “shall appoint the commissioner . . . rehabilitator and shall direct the rehabilitator forthwith 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). Nothing in this language provides the rehabilitator with authority beyond the insurer itself. Its limited scope is confirmed by the sentences that follow, which specify that the rehabilitator “shall have all the powers of the directors, officers and managers” and “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). The statutes

authorize the Rehabilitator to manage SHIP. *See Koken*, 831 A.2d at 1227-1228. They do not authorize her to disregard State regulation.⁴

Nor does the provision for rehabilitation plans exempt insurers in rehabilitation from State regulation. A rehabilitator may “prepare a plan for the reorganization, consolidation, conversion, reinsurance, merger or other transformation of the insurer.” 40 P.S. § 221.16(d). This does not authorize a rehabilitator to change contracts and rates without required regulatory approvals. Nothing in the text allows the Rehabilitator or Court to supplant otherwise applicable regulatory authority over the business of the insurer in other States.

A domiciliary state has an interest in rehabilitation, but it is not “overriding” (Mem. Op. 52). The rehabilitation statutes recognize that a rehabilitator must seek relief from courts in other jurisdictions as to litigation in other states. 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.”); 40 P.S. § 221.17(a). Article V also specifies that it “shall not be interpreted to limit the powers granted the commissioner by other provisions of the law.” 40 P.S. § 221.1(a). Where the Article expressly does not

⁴ The language describing Article V’s purpose further demonstrates the intent to authorize displacement of private, not public actors: “The 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 insurers . . .” 40 P.S. § 221.1(c) (emphasis added). *See also* 40 P.S. § 221.6 (requiring cooperation by officers and employees).

limit the Pennsylvania Commissioner's regulatory authority, it cannot reasonably be interpreted to limit the regulatory authority of other States.

The purpose of rehabilitation is "to rehabilitate the business of an insurer," 40 P.S. § 221.15(b), not to supersede regulation of the insurer. *Cf. Koken v. Fidelity Mut. Life Ins. Co.*, 803 A.2d 807, 826-827 (Pa. Commw. 2002). (rehabilitation plan provided that "FLIC obtain all necessary regulatory approvals to do business in the respective states"). The Plan's displacement of other states' regulatory authority exceeds statutory authority and is likely to be reversed.

2. The Full Faith & Credit Clause Protects Other State's Regulation Over Rates Within Their Boundaries.

Finally, the State Insurance Regulators have compelling arguments that the Court's ruling concerning the Full Faith and Credit Clause is erroneous. The purpose of the clause "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 ex rel. Thomas v. General Motors Corp.*, 522 U.S. 222, 232 (1998) (quoting *Milwaukee Cnty. v. M.E. White Co.*, 296 U.S. 268, 277 (1935)). The Court's view that it can set rates in other states and supersede their statutes requiring review by their own regulatory officials violates this command.

Insurance rates are a matter of particularly local concern and regulation, and the States have placed responsibility for rates on their own insurance officials. The cases cited by the Court do not support extraterritorial jurisdiction to set rates in other states. The Plan works more than a “change[] in forum” (Mem. Op. 58), and the Court’s assertion that the rate setting statutes are all essentially alike (Mem. Opp. 57) ignores the evidence that rates have historically varied across states, and that state rate setting practices differ. See Ex. RP-55 at 88; Tr. 413-414. See Mem. Op. 14, 28. A Pennsylvania court cannot dictate to other States what rates are to be applied to policies issued in their jurisdictions, nor can it require that they “surrender[]” (Tr. 169) their authority and unilaterally substitute itself (or the Pennsylvania Commissioner) for the officials designated to review rates.

The Court’s decision plainly reflects hostility to state-based rate setting and the different rates that may result from it. See Mem. Op. 14-15 (describing rate structure resulting from different responses of state regulators to SHIP’s requested rate increases as “discriminatory” and “inequitable”), 43, 60, 80. Indeed, the Court expressly states an intent to use the Full Faith and Credit Clause as a sword to compel other states to respect its judgment to disregard their statutes and arrogate to itself the power to set rates. Mem. Op. 61. It thus seeks 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.” See

Franchise Tax Bd. Of Cal. v. Hyatt, 136 S. Ct. 1277, 1281 (2016) (quoting *Carroll v. Lanza*, 349 U.S. 408, 412 (1955)).

The Court also erred in holding that the Plan’s “issue state rate approval” section cured the constitutional violation by allowing state insurance regulators to “opt-out” of the Plan’s rate-setting mechanism. That provision does not allow state regulators to apply their statutes and meaningfully review rates. The undisputed evidence is that it imposes requirements as to timing and methodology for the various states to follow, and penalties if they do not. Ex. RP-55 at 111; Tr. 410-414. It requires that “opt-out” states approve the Rehabilitator’s seriatim rate application in full within 60 days, absent which their policyholders will face different options from policyholders in other states. The Court downplays the differences by allowing only that the options under the provision “are not exactly the same” (Mem. Op. 58). This disregards the evidence. The Plan itself acknowledges that the options are likely to be worse, Ex. RP-55 at 109, and the Special Deputy Rehabilitator testified that “[i]n terms of policyholders, we think that [states opting out] will be harmful.” Tr. 170. Indeed, the Rehabilitator has recently advised regulators that in her view opting out “may not be in the best interest of the affected policyholders.” See Rehabilitator’s Letter to Commissioners dated August 26, 2021 at 1 (attached as Exhibit B hereto). This is coercive. The Plan seeks to present the appearance of deference to State rate

review while in fact requiring the States to approve the Rehabilitator's rates, in full, on pain of punishing policyholders in the State.

II. Absent A Stay, Policyholders And Regulators Will Suffer Irreparable Injury.

The Rehabilitator is moving to implement the Plan. *See* Praeipice to Substitute Approved Plan, Ex. A at 19 (September 30, 2021); Rehabilitator's Email (Exhibit A hereto). This is likely to irreparably harm both policyholders and regulators because both will be forced to make decisions that may not be reversible even if the Court's decision is reversed on appeal. SHIP's policyholders will be required to select options under the Plan that will permanently reduce their contract benefits. *See* Ex. RP-55 at 14, 92. This will reduce their rights as against SHIP and against guaranty associations in the liquidation that will inevitably follow, potentially by hundreds of millions of dollars. *Id.* The State Insurance Regulators and other regulators across the country will be required to decide whether or not to "opt-out" of the Plan. A regulator can only "opt-out" before the opt-out deadline; otherwise he or she is deemed to have "opted" into the Plan. Ex. RP-55 at 109-110. As noted above, if a regulator does anything other than approve the Rehabilitator's rate proposal in full within 60 days, the policyholders in the State will be left with options that are worse than those available in other states.

Thus, absent a stay, the Plan will impair the contract rights of the 30,000 affected policyholders and require regulators to take steps that may be detrimental

to policyholders in their states. The required elections and “opt-outs” under the Plan will fix contractual rights, and they are intended to be permanent. They will also occur relatively quickly. Regulators will be required to make opt-out decisions that will determine the options available in their States around mid-November 2021. *See* Exhibit A hereto. Around year-end, policyholders will be presented with election packages requiring them to make decisions by around mid-March 2022. Most critically, sometime around April 2022, the elections will be “effective,” and the policyholders will begin paying revised premiums and receiving reduced benefits in accordance with the Plan. *See* Praeceptum to Substitute Approved Plan, Ex. A at 19. These steps could potentially be undone by deeming the policyholder elections and regulator opt-outs nullities in the event the Court’s approval is reversed. However, it will be administratively difficult and confusing to policyholders and regulators to undo those steps. A stay preserving the *status quo* would prevent such problems.

Not granting a stay could result in policyholders and regulators being deprived of the benefit of appeal. The practical realities suggest that at some point the Rehabilitator may contend that the Plan has been “substantially consummated” so that the appeal should be dismissed under the doctrine of equitable mootness. *See, e.g., In re Tribune Media Co.*, 799 F.3d 272, 277 (3d Cir. 2015) (equitable mootness is “a narrow doctrine by which an appellate court deems it prudent for

practical reasons to forbear deciding an appeal when to grant the relief requested will undermine the finality and reliability of consummated plans of reorganization.”).

The State Insurance Regulators believe that the equitable mootness doctrine should not apply. There is a “strong presumption that appeals from confirmation orders of reorganization plans . . . need to be decided,” *Tribune Media*, 799 F.3d at 278. Further, “third parties with interests protected by equitable mootness generally rely on the emergence of a reorganized entity from court supervision,” *Id.* at 280, and that will not happen here for a long time if ever. The implementation of the Plan is subject to the continuing jurisdiction of the Court. However, given the significant contractual interests at stake for the policyholders and the important regulatory interests at stake for the regulators, the possibility that review could be denied if the Plan goes forward warrants a stay.

III. Issuance Of A Stay Will Not Harm Other Interested Persons.

Issuance of a stay pending appeal will not harm other interested persons. It will preserve the *status quo*. SHIP’s policyholders have paid the lawfully approved rates for their coverage, and they will continue to do so. Policyholders who are on claim will continue to receive claim payments as they have during the pendency of the Rehabilitator’s application for approval of the Plan. The

intervenor agents and brokers have settled. The intervenor health insurers will not need to pay guaranty association assessments.

The Rehabilitator may contend that the size of SHIP's insolvency will increase during the appeal, and that over time this will reduce amounts that can be paid to policyholders. However, this reflects the intended working of the Plan, which places the entire burden of SHIP's insolvency on policyholders through benefits cuts and premiums increases and specifically avoids triggering guaranty associations. *See* Mem. Op. 45, 63. The State Insurance Regulators' appeal, by contrast, seeks to protect policyholders by triggering guaranty associations. If the State Insurance Regulators are correct and guaranty associations must be triggered, then an additional \$800 million in support for policyholders will be available. *See* Mem. Op. 31-32. The balance of a somewhat deeper insolvency against the benefit of reversal weighs in favor of a stay. Under the Plan, the policyholders will bear the full existing \$1.2 billion deficit, while a successful appeal will bring \$800 million in guaranty association support and reduce the burden of insolvency on policyholders to approximately \$400 million.

IV. Issuance Of A Stay Will Not Harm The Public Interest.

Nor will a stay adversely affect the public interest. The State Insurance Regulators pursue this appeal to protect the financial interests of policyholders that are intended to be protected by the rehabilitation statutes and the guaranty

association system, and also the interests of regulators in their statutory role in reviewing the rates charged for policies issued in their states.

The Rehabilitator may contend that delaying benefit cuts and premium increases under the Plan will increase SHIP's insolvency and the burden on the guaranty associations, their member insurers and, in many States, on taxpayers when SHIP is liquidated. That is not cognizable "harm" to the public interest. As described above, the guaranty associations were created specifically to protect policyholders in the event of an insolvency (*see, e.g.*, 40 P.S. § 991.1701) by honoring the insurer's contractual obligations, subject to specific limits. *E.g.*, 40 P.S. § 991.1703, § 991.1706(b). The legislatures determined how to allocate the burden of that protection. *See, e.g.*, 40 P.S. § 991.1707, § 991.1711. Where the legislatures have chosen to provide protection to policyholders and how to fund that protection, allowing that process to work is not contrary to the public interest. Similarly, the legislatures have chosen to place rate review with their regulatory officials, and protecting that statutory choice and the application of the States' rate approval statutes is not contrary to the public interest.

Conclusion

For the above reasons, the State Insurance Regulators request that the Court stay its Orders approving the Plan pending appeal.

Dated: October 1, 2021

Respectfully submitted,

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PUBLIC ACCESS POLICY CERTIFICATE OF COMPLIANCE

It is hereby certified by the undersigned that this filing complies with the provisions of the *Public Access Policy of the Unified Judicial System of Pennsylvania: Case Records of the Appellate and Trial Courts* that require filing confidential information and documents differently than non-confidential information and documents.

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PROOF OF SERVICE

I, Stephen G. Harvey, hereby certify that on October 1, 2021, I served the foregoing document on all parties appearing on the Master Service List via PACFile, except the following, who have been served by U.S. Mail:

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IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

ORDER

AND NOW, THIS _____ day of _____, 2021, upon consideration of the Intervenor State Insurance Regulators' Application for Stay Pending Appeal, and the Rehabilitator's response thereto, IT IS ORDERED that the Application is DENIED.

MARY HANNAH LEAVITT
PRESIDENT JUDGE EMERITA

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

REHABILITATOR'S ANSWER AND BRIEF IN OPPOSITION TO
THE INTERVENOR STATE INSURANCE REGULATORS'
APPLICATION FOR STAY PENDING APPEAL

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Filed October 15, 2021

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INTRODUCTION

Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as the Statutory Rehabilitator (“Rehabilitator”) of Senior Health Insurance Company of Pennsylvania (“SHIP”), hereby submits this Answer and Brief in Opposition to the Intervenor State Insurance Regulators’ (“Intervening Regulators”) Application for Stay Pending Appeal (“Stay Application”). This Court should deny the Stay Application because it fails to meet every criterion necessary for a stay. The Intervening Regulators fail entirely to show irreparable harm to themselves in the absence of a stay; they fail entirely to negate harm to the Rehabilitator and policyholders if a stay is imposed; they fail entirely to show a strong likelihood of success on the merits of their appeal; and they fail entirely to show that public policy supports a stay.¹

¹ The Stay Application does not comply with Pa. R.A.P. 123 and Pa. R.A.P. 1732, because an application must stand alone even if accompanied by a brief. The rules require an application to “state with particularity the grounds on which it is based, and . . . set forth the order or relief sought.” Pa. R.A.P. 123. The Stay Application includes an introduction, eleven numbered paragraphs stating the “essential facts” but without an assertion of authority or request for relief, and the text of a brief. The Intervening Regulators also suggest that “most of the basic facts” necessary to the Stay Application were referenced in the Court’s Approval Opinion approving the Plan but others were “omitted, understated or only noted in passing.” (Stay Application at 7.) There is no explanation of which facts fall into these latter categories, and there is no verification attached to the Stay Application despite the Intervening Regulators’ admission that it relies on facts outside of the record and the inclusion of two documents that post-date the hearing and are not authenticated by any party. These defects are procedural, yet they implicate substantive problems with the Stay Application which this Court should consider in ruling on its merits.

ANSWER TO STAY APPLICATION

APPLICATION:

1. SHIP's policies are enforceable contracts, and the premiums charged on the policies historically and on the rehabilitation date were lawfully approved rates. Tr. 227-229, 282.

RESPONSE:

Denied. The statements in Paragraph 1 are legal conclusions to which no response is required. To the extent a response is required, the statements are denied, as they are immaterial to the merits of the Stay Application. Moreover, the record cited by the Intervening Regulators does not affirmatively support these statements. The cited testimony from Mr. Cantilo states only that he has no reason to believe that the policies are not enforceable contracts and no reason to believe that the policies were not approved. Mr. Cantilo further explained in the cited testimony that he is not contending that the policies are unlawful and he assumes the rates were lawfully approved.

APPLICATION:

2. SHIP is insolvent, with a deficit or "funding gap" of approximately \$1.2 billion. Ex. RP-55 (the Plan) at 87.

RESPONSE:

Admitted in part, denied in part. It is admitted that SHIP had a funding gap of approximately \$1.2 billion at the time of the rehabilitation proceedings. The

statement in Paragraph 2 that SHIP is insolvent is a legal conclusion to which no response is required. To the extent a response is required, neither the Second Amended Plan cited by the Intervening Regulators nor the Approved Plan filed October 3, 2021 state that SHIP is insolvent. No finding of insolvency has been made by any court.

APPLICATION:

3. Under the Plan, the burden of reducing or eliminating the \$1.2 billion funding gap will rest on the 30,000 remaining SHIP policyholders who have not taken non-forfeiture options. Tr. 290-292; Ex. RP-55 at 102-103. The Plan seeks to reduce the funding gap by reducing policy benefits and increasing premiums. Ex. RP-55 at 10, 102-103.

RESPONSE:

Denied as stated. The statements in Paragraph 3 are characterizations of the Approved Plan, which is in writing, and thus the characterizations in this paragraph are denied. The Plan attempts to reduce the funding gap using a variety of mechanisms, including by offering policyholders options through which they can decide for themselves how to allocate the relationship between premiums and benefits under their SHIP policies.

APPLICATION:

4. The Plan requires policyholders to select among options, only one of which (Option 4) retains the policyholders' full benefits in Phase One. The other options (Options 1, 2, 2a, and 3) all reduce benefits in Phase One. Ex. RP-55 at 23-24; Tr. 113-117. Policyholders who choose Options 1 or 4 in Phase One face the possibility of additional substantial rate increases or benefit reductions in Phase Two. Ex. RP-55 at 15, 58.

RESPONSE:

Admitted in part, denied in part. It is admitted that the Plan requires policyholders to elect one of the offered options; any remaining characterization of the Plan options is denied. Option 1 will retain a policyholder's full benefits if that policyholder is currently paying the If Knew premium. Depending on a policyholder's election, Options 2 and 2a involve a reduction of benefits to match the future premiums, and Option 3 will provide a set amount of benefits without requiring any future premiums. Not all policyholders electing Option 1 or Option 4 in Phase One will face additional rate increases or benefit reductions in Phase Two; the scope and impact of Phase Two has not yet been decided, and, as explained in the Plan, no adjustments will be made to Option 1 or Option 4 policies unless those policies exceed guaranty association limits and are not already at a self-sustaining premium level.

APPLICATION:

5. In a liquidation, virtually all of SHIP's policies would be covered by one of the guaranty associations created by statute in each state, subject to the individual state statutory limits on guaranty association coverage. Ex. RP-55 at 93.

RESPONSE:

Admitted.

APPLICATION:

6. If SHIP were liquidated now so that guaranty associations are triggered, policyholders will absorb only approximately \$397 million of the funding gap, based on the Rehabilitator's comparison file. Ex. SIR 5-1, Table 1; Tr. 564. This is because guaranty associations would provide approximately \$837 million in additional support to benefit policyholders, also based on the Rehabilitator's comparison file. Ex. SIR 5-1, Table 2; Tr. 565-66. The Plan does not trigger the guaranty associations, Ex. RP-55 at 92, so these additional funds will not be available to benefit policyholders under the Plan.

RESPONSE:

Admitted in part, denied in part. The first phrase in the third sentence of Paragraph 6 is admitted, and the remaining statements in Paragraph 6 are legal conclusions and characterizations of evidence, all of which are denied. To the extent a response is required, the first and second sentences cite to documents prepared by the Intervening Regulators' expert which were not accepted by the Court. The

second phrase of the third sentence is denied because, while guaranty association funds are not available in rehabilitation, they remain available to policyholders in the event liquidation is later ordered.

APPLICATION:

7. The policyholder elections under the Plan will be permanent in that guaranty association coverage may be given up. If SHIP is placed in liquidation after the Plan is implemented, the policies to which guaranty association coverage will apply will be the policies as modified as a result of the elections. Ex. RP-55 at 14, 92; Tr. 300-301, 313.

RESPONSE:

Admitted in part, denied in part. It is admitted that the Plan calls for permanent changes to policies based on the elections made during the process and that policies may be modified based on those elections. The remaining statements in Paragraph 7 are denied. Policyholder elections will not cause any policyholders to give up guaranty association coverage because state guaranty associations have not yet been triggered. Instead, the options offered to policyholders will allow them to retain their existing policies by paying the appropriate premium or voluntarily give up their benefit-rich policies in favor of a more affordable option that better suits their needs. Whether policies modified as a result of elections in Phase One

will remain effective and in force at the time of any potential liquidation order will not be known until a liquidation order is entered, assuming one is entered at all.

APPLICATION:

8. The Plan is highly unlikely to eliminate the funding gap and restore SHIP to solvency, even considering both Phase One and Phase Two. Tr. 80, 306. In all likelihood, the Plan will not eliminate the deficit, just reduce it materially. Tr. 189-190.

RESPONSE:

Denied as stated. The statements in the first sentence of Paragraph 8 mischaracterize the cited record. The Special Deputy Rehabilitator testified that “it is not likely that we will magically restore SHIP to solvency, but it is likely that the plan that we were trying to design would substantially reduce the deficit and substantially improve the inequitable rate structure for the company.” (Tr. 80:6-12.) Later, the Special Deputy Rehabilitator testified that Phase Two would seek to eliminate any remaining funding gap, and while it “would be ideal” if the funding gap was eliminated after Phase Two, the Rehabilitator could not “guarantee that will be the result.” (Tr. 306:6-19.) The Intervening Regulators’ counsel, not the Special Deputy Rehabilitator, used the term “highly unlikely.” (Tr. 306:11-14.) The second sentence of Paragraph 8 accurately characterizes the cited portion of the Special Deputy Rehabilitator’s testimony, but it is not the only testimony on this issue.

APPLICATION:

9. The Plan will not provide all policyholders with an option with a net present value (present value of future benefits less present value of future premiums) at least as great as the net present value in liquidation. Only 85% of policyholders will have at least one Phase One option with a net present value equal to or greater than liquidation. Ex. RP-7; Tr. 183, 185, 510, 512. This 85% rests principally on Option 4. Tr. 510, 512-513, 572; Ex. SIR 5-2. Option 4 has the least impact on the funding gap, and it is subject to further adjustment in Phase Two. Tr. 259, 513; Ex. RP-55 at 14.

RESPONSE:

Admitted in part, denied in part. The Rehabilitator denies that any of the statements in Paragraph 9 are material to the Stay Application, and she further denies that any of the statements in Paragraph 9 are decisive on the question of whether Plan approval was properly entered. As the Rehabilitator established during the hearing, net present value is only one possible metric, and it is one that has no meaning for policyholders—making it very unlikely or perhaps impossible that an individual policyholder would care whether the policies offered have an equal, greater, or lower net present value than the policy that might be offered in liquidation. (*See* Ex. RP-43 through Ex. RP-47 (multiple metrics); Tr. 347:1-348:12 (Cantilo), 437:13-438:9 (Bodnar).) The Rehabilitator showed that 100% of

policyholders have the option to elect a policy which matches their existing maximum policy value, and Option 1 allows policyholders to elect a policy which matches their existing premiums even if a benefit reduction is applied. (*See* Ex. RP-47 (MPV analysis); Ex. RP-56, Cantilo Slides at 109, 110; Tr. 184:12-15 (Cantilo Testimony).) These are the data points on which policyholders will assess the options. Moreover, even if net present value were the only test, an 85% equivalence rate would be more than enough to pass any required comparison to liquidation. Notwithstanding these denials, it is admitted that approximately 85% of policyholders will be presented with a Phase One option carrying a net present value equal to or greater than the net present value of their theoretical liquidation policy. It is also admitted that Option 4 is, in most cases, the option through which policyholders would obtain a policy with net present value equal to their theoretical liquidation policy, and that an Option 4 election, standing alone, has the least impact on the funding gap. It is denied that Option 4 elections are subject to further adjustment in Phase 2; rather, Option 4 elections are eligible for further adjustment in Phase 2, but only if the policy as elected exceeds guaranty association limits and the policy as elected is not self-sustaining with respect to premiums and benefits. Additionally, policyholders electing Option 4 in Phase One are not necessarily subject to further adjustment in Phase Two even if they meet the eligibility criteria, because such policyholders will have the opportunity to elect a different policy.

APPLICATION:

10. Under state statutes, long term care insurance rates are reviewed and approved by the insurance regulatory official of the state in which the policy is issued. Tr. 155, 157. Each state has its own approach to reviewing rates. Tr. 413-414. The Plan does not follow this issue state rate approval process. Ex. RP-55 at 33-34, 96; Tr. 158-159. It removes state insurance regulators from their role in reviewing rates, which is “unprecedented.” Ex. RP-55 at 33-34; Tr. 82. Under the Plan, the Rehabilitator will not seek approval of rates from state regulators under their statutes but instead from the Commonwealth Court. Ex. RP-55 at 33-34, 96.

RESPONSE:

Denied as stated. The first sentence of Paragraph 10 is not supported by the record, because it cites to testimony of the Special Deputy Rehabilitator and not any specific state statute. Moreover, the first sentence of Paragraph 10 overstates the meaning of the Special Deputy Rehabilitator’s cited testimony, in which the Special Deputy Rehabilitator was describing and summarizing the Intervening Regulators’ arguments, including that they arise out of “a tradition that has been codified in most of the states of having the state of issue of an insurance policy be the principal regulator for the rates for those policies.” (Tr. 155:11-158:24.) The second sentence of Paragraph 10 accurately summarizes the cited testimony of the Rehabilitator’s actuarial expert Vincent Bodnar, but it is incomplete and thus inaccurate, as Mr. Bodnar also testified that a lifetime loss ratio of at least 60%—*i.e.*, the ratio resulting

from the Rehabilitator’s proposed use of If Knew premium—is generally used across the country and is treated as a benchmark by regulators in determining what is actuarially justified. (Tr. 455:5-22.) It is true that, as stated in the third sentence of Paragraph 10, the Plan rightfully does not follow exactly the standard approval process, but the Plan has not removed regulators from their role in reviewing rates, as the Intervening Regulators and other state regulators have the opportunity to assert their authority over the rate review process by opting-out. The fourth sentence of Paragraph 10 is incomplete; the Rehabilitator will obtain approval for rates within the Plan pursuant to the procedure described in the Memorandum Opinion and Order, but, as described in the Issue-State Rate Approval Option, the Rehabilitator also intends to seek rate approval from the regulators of states opting-out of the Plan.

APPLICATION:

11. The Plan has an “issue state rate approval” section under which state regulators purportedly may “opt-out” of having the Commonwealth Court approve rates. Ex. RP-55 at 108. The section provides that, unless the “opt-out” state approves the Rehabilitator’s rate application, in full, within 60 days, it is deemed denied. Ex. RP-55 at 111. In that case, the options available to policyholders in that state will be more limited than the options available in other states, and the state’s policyholders will be disadvantaged. Ex. RP-55 at 109, 116; Tr. 169-170.

RESPONSE:

Admitted in part, denied in part. It is admitted that the Plan provides state regulators with an opportunity to opt-out of the Plan and review rates for policies issued in their state, but it is denied that such option is “purported[],” because regulators—including the Intervening Regulators—will have the actual opportunity to opt-out. Indeed, the Intervening Regulators rely on the opt-out process as proof that the Rehabilitator is implementing the Plan and as (a misguided attempt at) proof of the potential harm of implementation. It is admitted that a regulator who elects to opt-out has sixty days to approve or deny the application, but Paragraph 11 mischaracterizes the impact of that decision. A regulator who approves in full the requested rate increases shall be treated as if his or her state did not opt-out, while a regulator who does not approve in full the requested rate increases shall be treated as having opted-out, exactly as requested. Policyholders in an opt-out state are not disadvantaged by the decision to opt-out. Consistent with the state-based system for which the Intervening Regulators advocated, residents of an opt-out state that own policies issued in a state that did not opt-out will have the full range of options available. Policyholders who own policies issued in an opt-out state that does not approve the Rehabilitator’s rate application are likely to have rates set on a group basis and receive fewer options than under the Plan, outcomes which may be disadvantageous to some of those policyholders regardless of where they reside.

BRIEF IN OPPOSITION TO THE STAY APPLICATION

A. INTRODUCTION

SHIP is currently in dire financial condition requiring immediate action. On August 25, 2021, this Court filed herein its Memorandum Opinion and Order (“Approval Opinion”) approving the Rehabilitation Plan proposed by the Rehabilitator (“Approved Rehabilitation Plan” or “Approved Plan”). As this Court recognized, it is imperative that the Rehabilitator move expeditiously and take the necessary steps to begin to implement SHIP’s Approved Plan to address the causes of SHIP’s financial distress and adequately preserve its assets. Notwithstanding, the Intervening Regulators now request that the Court stay implementation of the Approved Plan pending appeal, completely ignoring the significant harm this delay will cause to SHIP, its policyholders and creditors, and the public.

At the outset, the Intervening Regulators’ Stay Application is fundamentally flawed and should be rejected. The vast majority of the Intervening Regulators’ contentions are focused on purported policyholders’ interests. This is true with respect to both the underlying merits of the appeal (*e.g.*, Stay Application at 5 (contending that the Plan “does not serve the best financial interest of policyholders”)), as well as the purported harm that will occur absent a stay (*id.* at 29). But the Intervening Regulators do not speak for or represent **any** of SHIP’s policyholders. Indeed, the Intervening Regulators have expressly disavowed that

they are acting in a representative capacity for ***even the policyholders in their own respective states***, which in any event comprise only a small fraction of SHIP's overall policyholders. (Tr. 543:9-18.) Thus, the Stay Application's entire discussion of purported harm to interests the Intervening Regulators do not represent is irrelevant. Notably absent from the Stay Application is any discussion of some actual harm to the Intervening Regulators themselves that would result from not staying implementation of the Approved Plan. This alone is fatal to the Intervening Regulators' Stay Application.

Even setting aside this critical defect, the Intervening Regulators utterly fail to satisfy their burden for a stay. *First*, the Intervening Regulators fail to show that they are likely to prevail on the merits—let alone make a *strong* showing that they are likely to prevail, as required for a stay. The parties extensively briefed all of the issues raised on appeal, in both pre-hearing and post-hearing submissions. The Court carefully considered—and rejected—the Intervening Regulators' arguments on three separate occasions: first, on a motion for a directed verdict on the Issue-State Rate Approval Option; then, in denying the Intervening Regulators' application for reconsideration; and finally, in a detailed eighty-one page memorandum opinion addressing each and every one of the contentions they now raise on appeal. Nor was this a close call. As the Court recognized, the Intervening Regulators failed to present any evidence supporting their challenge to the Issue-

State Rate Approval Option, failed to offer any evidence disputing any material fact that the Rehabilitator set forth in support of the Plan, and lacked standing to assert claims on behalf of policyholders. (Opinion at 68, 77, 79.) Moreover, the Intervening Regulators’ legal arguments essentially boiled down to the proposition that they would have exercised their discretion differently—hardly a basis for finding that the Rehabilitator abused her broad discretion in formulating a plan that balances the competing interests of policyholders, general creditors, other stakeholders, and public policy. The Stay Application’s rehashing of the very same arguments that the Court has already thoroughly rejected fails to make a strong showing that the Intervening Regulators are likely to prevail on appeal.

Second, the Intervening Regulators fail to demonstrate that they will suffer any harm, let alone irreparable injury, without a stay. As noted above, the Stay Application does not identify how the Intervening Regulators themselves will be harmed in any way. Instead, they point to supposed harm to policyholders and others. Of course, they do not, and cannot, speak for policyholders or other state regulators not a party to these proceedings. But even setting that aside, their argument that policyholders will suffer if the Plan is implemented and the policies “right-sized” is similarly without merit. There is no irreparable harm in SHIP’s policyholders paying actuarially justified rates for their insurance coverage during the pendency of this action or in discontinuing the involuntary subsidies of some

policyholders by others. Nor is there irreparable harm based on the mere possibility of policyholder “confusion” should the process be reversed after appeal. In short, implementation of the Approved Plan will not cause irreparable harm to the Intervening Regulators or to any other interested party.

Moreover, even the purported harm to policyholders (not the Intervening Regulators themselves) of which the Stay Application complains is speculative on its face and factually unsupported. At its core, the supposed harm arises from taking away from some policyholders the ability to continue buying long-term care coverage at inadequate premium rates at the expense of other policyholders. The Intervening Regulators, however, have introduced no evidence or authority in this proceeding supporting the proposition that any policyholders have an inviolate right to subsidization of their long-term care insurance. Neither is any supporting evidence or authority identified in the Stay Application, because there is no such right. In the absence of any record on this issue, this baseless argument cannot now constitute the requisite showing of irreparable injury.

Finally, a stay will significantly harm SHIP, its policyholders, creditors, and the public. Tellingly, the Stay Application hardly discusses these factors (Stay Application at 31–33) because any delay obviously causes significant harm to SHIP’s financial health. Delay in implementation of the Plan will allow for one of the primary conditions that led to SHIP’s poor financial condition to continue

unabated—that is, underpriced policies that are far from actuarially justified. It is critical that the Rehabilitator move quickly to implement the Plan, and a stay pending appeal imperils the prospects for a successful rehabilitation of SHIP.

Perhaps inadvertently signaling the little confidence they have in their Stay Application, the Intervening Regulators also fail entirely to address the issue of a supersedeas bond. Even if the Court were inclined to consider granting a stay (for which the Rehabilitator submits there is no basis), it would also have to consider what bond to require of the Intervening Regulators to insulate the Rehabilitator and SHIP's policyholders and creditors from the harm resulting from delay in implementation of the Plan. The Rehabilitator believes that even a conservative estimate of the cost of a one-year delay is in the range of \$55 to \$70 million. The Rehabilitator does not seek here to make the case for a specific bond amount, as the Court can address the amount of a bond in a subsequent hearing in the event it is inclined to permit a stay. Instead, the Rehabilitator's argument seeks only to highlight that this critical element of an application for stay has been wholly ignored as well, and the Stay Application should be denied for this additional reason.

B. THE STAY APPLICATION IS PREMISED ON PURPORTED POLICYHOLDER INTERESTS THAT THE INTERVENING REGULATORS LACK STANDING TO ASSERT.

The Intervening Regulators implicitly concede that they cannot satisfy the requisite showing for a stay based on any alleged harm to them or any other interest that they have in SHIP's rehabilitation. Instead, the Intervening Regulators attempt

to substitute the purported interests of SHIP's policyholders nationwide for their own, when they do not speak for or represent *any* of SHIP's policyholders in these proceedings—not even with respect to the relatively small fraction of policies issued in their own respective states. The Intervening Regulators' misguided attempt to shift the focus of the Stay Application to the merits of arguments that they lack standing to assert and purported harms to parties they do not represent is defective on its face. The Stay Application may be denied on that basis alone.

This Court should not impose the requested stay unless the Intervening Regulators can demonstrate a strong likelihood of success on appeal. Insofar as their asserted harm is what they allege will be adverse effects for policyholders, their complete failure to adduce supporting evidence of such harm in the underlying proceeding vitiates entirely any likelihood of success, let alone a strong likelihood, on appeal.

The Intervening Regulators' position in SHIP's rehabilitation proceedings is uncontroverted: they do not—and cannot—speak on behalf of any policyholders, *including* any policyholders in their own respective states. The Court granted the Intervening Regulators' request for limited intervention in these rehabilitation proceedings based on their own purported interests as regulators, and not in any *parens patriae* or other representative capacity for policyholders. Indeed, the Intervening Regulators have expressly disavowed that they are acting in any “sort of

parens patriae capacity on behalf of . . . policyholders [from their respective states] who have chosen not to intervene.” (Tr. 543:9-18; *accord* Intervening Regulators’ Pre-hearing Memorandum at 50 (conceding that the Intervening Regulators are not acting “as some sort of agent for the policyholders in their States”).) As a result, the Court held that the Intervening Regulators lacked standing to assert claims on behalf of policyholders that they do not purport to represent. (Opinion at 68.)

Notwithstanding, the Stay Application is focused almost *exclusively* on the interests of policyholders. That is, the Intervening Regulators’ arguments regarding the merits of the appeal are focused on purported financial interests of and burdens on policyholders through rehabilitation. (*E.g.*, Stay Application at 5 (arguing that the Plan “does not serve the best interests of policyholders” and “fails to place policyholders in at least as good a position as in liquidation”) and at 14–22.) Similarly, the Stay Application focuses on purported harm to policyholders absent a stay. (*Id.* at 29–30 (arguing that the Plan will affect “the contractual rights of the 30,000 affected policyholders”); (*id.* at 30 (policyholder “confusion”); *id.* (asserting benefit of appeal to policyholders).)

To be clear, the Intervening Regulators do not have standing to assert any alleged harm to policyholders or any basis to argue what is in the best interests of policyholders. Again, they do not represent the interests of any policyholders—unlike the Rehabilitator, who by statute is expressly charged with protecting the

interests of SHIP's policyholders. *See* 40 Pa. Stat. § 221.1(c).² The Intervening Regulators have no basis for requesting a stay based on their own interests, and cannot mask that deficiency by now invoking the interests of others whom they do not represent. *See Dep't of Env'tl. Res. v. Jubelirer*, 614 A.2d 199, 203 (Pa. 1989) (party failed to demonstrate a substantial case on the merits where it "had a serious standing problem"). The Intervening Regulators lack of standing to raise policyholders' interests is fatal to the Stay Application.

C. THE STAY APPLICATION FAILS TO MAKE A STRONG SHOWING THAT THE INTERVENING REGULATORS ARE LIKELY TO SUCCEED ON THE MERITS.

The Court's eighty-one page Memorandum Opinion addresses at length—and rejects—each of the Intervening Regulators' arguments that they repeat in their Stay Application. Regurgitating the same flawed arguments that this Court has already

² The Intervening Regulators' attempt to assert the interests of SHIP's policyholders against the Rehabilitator is particularly egregious here because collectively, fewer than 6% of SHIP's remaining 39,000 policies were issued in the Intervening Regulators' respective states. (*See* Joint Application for Intervention of Maine and Massachusetts (July 31, 2020) at ¶¶ 8, 13 (identifying 388 Maine policies and 345 Massachusetts policies subject to the Rehabilitation Plan as of November 30, 2019) and Joinder of Washington in the Joint Application for Intervention (Sep. 15, 2020) at ¶ 8 (identifying 1,509 Washington policies subject to the Rehabilitation Plan as of November 30, 2019).) Importantly, the Intervening Regulators do not speak for or represent even that limited number of SHIP's policyholders in their own states. Notwithstanding the Intervening Regulators' small share of the total policies, the Stay Application improperly attempts to focus on the alleged interests of SHIP's policyholders *nationwide*.

rejected does not satisfy the Intervening Regulators' burden of making a strong showing of likelihood of success on the merits.

The Intervening Regulators' arguments should be rejected on their face for several reasons. *First*, as explained above, the Intervening Regulators lack standing to assert claims on behalf of policyholders, and thus necessarily cannot prevail on the merits of those flawed arguments. Moreover, there is no evidence in the record supporting the Intervening Regulators' contentions whatsoever. The Stay Application overlooks that the Intervening Regulators failed to present *any* evidence supporting their challenge to the Issue-State Rate Approval Option (Opinion at 77)—which necessitated the Court's directed verdict on this issue—and failed to submit evidence disputing any material fact that the Rehabilitator set forth in support of the Plan (*id.* at 79). There is simply no evidentiary basis which would support allowing the Intervening Regulators to assert the harms purportedly suffered by policyholders or which would demonstrate that such harm exists in the first place.

Certainly, both in the underlying proceeding and now with the Stay Application, the Intervening Regulators have failed entirely to identify, let alone support with evidence and legal authority, any harm that they would suffer *as regulators* upon the Plan's implementation and in the absence of a stay.

Moreover, the substance of the Intervening Regulators' arguments regarding plan approval lack merit for the reasons this Court has already addressed in its

Approval Opinion. *First*, the Stay Application continues to assert that the Plan is not “feasible.” (Stay Application at 10–14.) But as the Court explained, “Article V does not require [the approved] Plan be ‘feasible’ in order to be approved.” (Opinion at 67.) In any event, the Court also held that the Plan *is* feasible to the extent such a requirement exists, because the Plan will materially reduce the Funding Gap, significantly improve SHIP’s financial condition, and if successful, will restore SHIP to its pre-receivership condition of an insurer winding down its long-term care insurance business. (*Id.* at 65–66.) The Intervening Regulators have not offered any evidence in support of a different conclusion, nor have they shown any likelihood of success as to their attack on the public policy findings reached by the Court or on the feasibility of the Plan in satisfying the Rehabilitator’s goals.

Second, the Stay Application broadly asserts (again without evidence) that the Plan is not in the best financial interests of policyholders. (Stay Application at 14–20.) Setting aside that the Intervening Regulators lack standing to assert whether the Plan is in the best financial interests of policyholders, the Intervening Regulators argument amounts to little more than suggesting that “they would have exercised their discretion differently,” which the Court correctly held “is not a basis for the Court to disapprove the Plan.” (Opinion at 79.) Nothing in the Stay Application or in any other filing offers a reason to believe the Intervening Regulators will succeed on appeal in convincing the Supreme Court that their judgment is entitled to the same

degree of deference—indeed, more—than that of the Statutory Rehabilitator. The Stay Application also ignores that the Plan is designed around “the core principle of policyholder choice,” and the Intervening Regulators completely and wrongfully discount the value of that choice simply because they disagree with the Rehabilitator’s exercise of her discretion in making that determination. (*See id.* at 9, 43, 47–48.)³ Instead, what the Stay Application again argues is that liquidation should be favored over rehabilitation because of the availability of guaranty association coverage. As the Court recognized, however, the Intervening Regulators’ views on this issue are contrary to Pennsylvania public policy favoring rehabilitation of an insurer where possible. (*Id.* at 67.) And independent of the existing Pennsylvania law favoring rehabilitation, there were numerous reasons for the Rehabilitator to exercise her discretion in choosing rehabilitation over liquidation. (*Id.* at 44–47.) The Intervening Regulators cannot make a strong showing that they are likely to prevail on the merits simply because they disagree with Pennsylvania public policy and disagree with how the Rehabilitator exercised her discretion.

³ On this point, the Intervening Regulators cannot avoid contradicting themselves, asserting that policyholder choice is unimportant while at the same time claiming that policyholders governed by opt-out state regulators will be injured if those policyholders receive fewer choices in rehabilitation than policyholders whose premiums and benefits are set by the Plan, an implicit acknowledgement that even the Intervening Regulators believe in the value of choice.

Third, the Stay Application continues to misconstrue *Neblett v. Carpenter*, 305 U.S. 297 (1938). (Stay Application at 20–23.) As the Court found, the Intervening Regulators’ interpretation of *Carpenter*—on which they double down in the Stay Application—is flawed. (Opinion at 64–65.) But even under the Intervening Regulators’ flawed metric, 85% of SHIP’s policyholders will be offered at least one option with a value equal to or higher than the value of the policy that they might have in liquidation. (*Id.* at 65.) As such, the Court correctly explained that even if the Plan substantially impairs policies, it meets any test created by *Carpenter* because “it serves a legitimate and significant public purpose, and the policy modifications are reasonable and appropriate to that purpose.” (*Id.* at 63.) The Stay Application offers no basis for overturning the Court’s findings.

Finally, as with the Intervening Regulators prior filings, the Stay Application baldly asserts that the Plan “exceed[s] the authority granted to the Rehabilitator by the Pennsylvania statutes and violate[s] the Full Faith & Credit Clause.” (Stay Application at 23.) Tellingly, the Stay Application cannot identify any specific statutory provision that the Plan would purport to violate—just as the Intervening Regulators failed to identify such a provision prior to the Court’s approval of the Plan.

As this Court explained, the Plan’s provisions fully comport with Pennsylvania law. (Opinion at 48–53.) Moreover, “[t]he 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.” (*Id.* at 60.) To the contrary, such a requirement “would fracture Pennsylvania’s ‘own legitimate public policy’ in the rehabilitation of SHIP,” in contravention of the Full Faith and Credit Clause. (*Id.*) The Intervening Regulators cannot satisfy their burden on the Stay Application by simply repeating these failed arguments.

D. THE INTERVENING REGULATORS FAIL TO PROVE THEY WOULD SUFFER IRREPARABLE HARM ABSENT A STAY.

This Court can deny the Stay Application solely because the Intervening Regulators cannot show a substantial likelihood of success on the merits. *See Maritrans G.P., Inc. v. Pepper, Hamilton & Scheetz*, 573 A.2d 1001, 1004 (Pa. 1990) (“In view of [the] failure [to show a substantial likelihood of success on the merits, the court] need not scrutinize compliance with the remaining three criteria.”). Should the Court proceed to analyze the remaining elements, however, the Court will reach the same conclusion: the Stay Application should be denied.

Under the standard set forth in *Pennsylvania Public Utility Commission v. Process Gas Consumers Group*, 467 A.2d 805 (Pa. 1983), a stay cannot be entered unless the Intervening Regulators establish that “without the requested relief, [they] will suffer irreparable injury.” 467 A.2d at 809; *see also* Pa. R.A.P. 1732 (rule governing application for stay noting that *Process Gas* determines “the criteria for the issuance of a stay pending appeal.”) Irreparable injury is present only when the

movant demonstrates some imminent harm which cannot be avoided, unwound, or redressed. *See, e.g., Maritrans*, 573 A.2d at 1004-05 (no irreparable harm related to disclosure of confidential information where there was no evidence of any actual or imminent disclosure); *Commonwealth Bd. of Fin. v. Rosetta Oil, Inc.*, 635 A.2d 139, 142 (Pa. 1993) (irreparable injury would arise if a lien was imposed during appeal because the lien would likely place the moving party in default with its lender, driving the moving party out of business); *Process Gas*, 467 A.2d at 809-10 (irreparable harm where plaintiff-consumers would lose benefit of lower gas rates and state agency was barred by law from using mechanisms to make up the difference in the future).

The Intervening Regulators cannot carry their burden on this issue. As set forth herein, the Intervening Regulators have no direct interest in the Plan; they gain no benefit and suffer no burden from its implementation, and the policy modifications proposed by the Plan have no impact on the Intervening Regulators. In ruling on the directed verdict and on the Rehabilitator's application for approval, this Court rightfully recognized that the Intervening Regulators lacked an interest in the proceedings sufficient to warrant disapproval of the Plan. (*See Opinion at 74.*) Absent any record evidence of any harm to the Intervening Regulators arising out of or related to the Plan as proposed, the Intervening Regulators cannot now assert an irreparable harm arising out of implementation of that same Plan once approved.

The Stay Application also fails to identify any irreparable harm warranting a stay independent of this fatal lack of interest in the Plan. The Intervening Regulators allege that a stay is necessary to prevent “harm [to] both policyholders and regulators because both will be forced to make decisions that may not be reversible even if the Court’s decision is reversed on appeal.” (Stay Application at 29.) This argument fails for three reasons.

First, the Intervening Regulators have no right to seek a stay based on potential irreparable harm to third parties—here, policyholders and “other regulators across the country.” (Stay Application at 29.) To satisfy the second *Process Gas* factor, Pennsylvania law clearly requires a showing of irreparable harm to the movant—*i.e.*, the Intervening Regulators—rather than any other party or non-party. In *Process Gas*, adopting the existing federal law on supersedeas, the Supreme Court of Pennsylvania defined the second factor as requiring ““the petitioner [to] show[] that without the requested relief, **he** will suffer irreparable injury.”” *Process Gas*, 467 A.2d at 808-809 (quoting *Virginia Petroleum Jobbers Ass’n v. Fed. Power Comm’n*, 259 F.2d 921 (D.C. Cir. 1958)) (emphasis added). In granting the stay, the Court found a “sufficient showing of irreparable harm **likely to result to the [movants]**,” a group of industrial gas consumers directly impacted by the surcharge allocation at issue. *Process Gas*, 467 A.2d at 809. Thus, a stay can only be entered upon a showing of irreparable harm to the Intervening Regulators—not anyone else.

To the extent the Intervening Regulators invoke injuries allegedly suffered by other regulators or policyholders, those harms are simply immaterial to the irreparable injury analysis. The Intervening Regulators cannot speak for the regulators of more than forty other states, each of whom rejected the opportunity to intervene in these proceedings, and who may in fact support the Plan. With respect to policyholders, the Intervening Regulators explicitly disclaimed that they participated in the proceedings in a representative capacity such as *parens patriae*, and instead affirmed that they appeared on their own behalf to challenge the Plan based on their judgment as regulators. (Tr. at 541-547.)⁴ Even if the Intervening Regulators could speak in a representative capacity, however, their judgment as to whether policyholders or others are harmed absent a stay is merely one opinion among many possible opinions—including the Rehabilitator’s—and is not entitled to any weight. *See Jubilerer*, 614 A.2d at 204 (no irreparable harm to appellant state environmental agency claiming it could not act for protection of that state’s citizens where, *inter alia*, the agency’s “judgment” was not “the sole indication of the public

⁴ The Stay Application also confusingly references the impact of the Plan on policyholders “in” the opt-out state—*i.e.*, residents of the opt-out state. This is incorrect. A state insurance regulator who opts out of the Plan retains his or her authority to approve or reject rates for policies issued in that state, regardless of where that policyholder lives now. During the hearing, the Rehabilitator showed that 207 of the residents of the Intervening Regulators’ states had policies issued in other states, placing these policyholders beyond the regulatory authority of the Intervening Regulators. (Tr. 157:17-158-24.)

interest when there are other agencies equally responsible for protecting this interest”).

Second, the single alleged harm to the Intervening Regulators is no harm at all, and certainly not an irreparable harm. According to the Stay Application, the Intervening Regulators will be injured if they are required to decide now whether to allow the Rehabilitator and the Court to set rates and benefits or to opt-out of the Plan and exercise their regulatory authority over policies issued in their states. Indeed, the Intervening Regulators argued in these proceedings that the Plan harmed them by pre-empting their rate review process. Notably, they failed then and fail again now to explain *how* this injured them in any way. Their presentation appears limited to dubious legal argument that they—and only they—can approve premium rates in their states. Even if that legal proposition were accepted (though the Rehabilitator has shown that there is little reason to do so in this rehabilitation), the Intervening Regulators have never identified even a scintilla of harm to them from its purported violation despite intervening in these proceedings more than a year ago. Furthermore, early on, the Rehabilitator included in the Plan the Issue-State Rate Approval Option, thus giving the Intervening Regulators the ability to opt-out of the Plan in favor of their own review and approval processes. Nowhere do the Intervening Regulators show that any hypothetical harm is not wholly avoided by this provision. And, in addition, the Stay Application fails to establish any difference

between making that rate decision now and making that decision following an appeal, let alone any harm to the Intervening Regulators.

The Intervening Regulators have complained that opting-out deprives policyholders whose policies were issued in Maine, Massachusetts, and Washington of the full range of Plan options. This alleged “harm” belongs to policyholders if it exists at all; the Intervening Regulators themselves suffer no injury if policyholders whose policies were issued in their states have fewer options in rehabilitation than policyholders of policies issued in other states. Moreover, the Intervening Regulators have disagreed from the beginning with the Rehabilitator’s effort to level the playing field by eliminating subsidies and right-sizing the policies in receivership because it presents a fundamentally different set of circumstances than business in the ordinary course. Any state-to-state variation in premiums and benefits during receivership is the natural consequence of the checker-board state-based process for which the Intervening Regulators have advocated—just as it would be if SHIP were not in receivership. The Intervening Regulators should not be allowed to demand the right to ensure that policies issued in different states are treated differently even in receivership, then turn around and complain that treating policies differently negatively impacts those policyholders.

Third, even ignoring these critical defects in the Stay Application, the harms cited by the Intervening Regulators are not irreparable or imminent. The only

alleged injury to the Intervening Regulators themselves—the decision to participate in the Plan or opt-out—is plainly reparable because if Plan approval is reversed then the decision to participate or opt-out is rendered moot because there is no plan being implemented. The same is true of other regulators and policyholders, assuming *arguendo* this Court permits the Intervening Regulators to rely on the alleged harms of others in satisfying the second *Process Gas* factor. In fact, after describing the opt-out and election processes, the Intervening Regulators make a revealing and fatal admission: “[t]hese steps could potentially be undone by deeming the policyholder elections and regulator opt-outs nullities in the event the Court’s approval is reversed.” (Stay Application at 30.) Thus, accepting the Intervening Regulators’ arguments as true, their proposed stay would not prevent *irreparable* harm, only the unidentified “problems” that could arise because it could be “administratively difficult and confusing . . . to undo” implementation. (*Id.*) Assuming these claims are true—and the Intervening Regulators have not shown that they are—“difficult and confusing” is not the test under *Process Gas*.

The Intervening Regulators also argue that a stay should be entered because the Rehabilitator “may contend” that the “the appeal should be dismissed under the doctrine of equitable mootness,” citing *In re Tribune Media Co.*, 799 F.3d 272 (3d Cir. 2015). (*See* Stay Application at 30.) But the Rehabilitator notes that the question of mootness is not before the Court at this time, and the mere possibility that the

Rehabilitator may raise an argument in the future is not an imminent harm. Even if the Rehabilitator were certain to make such an argument, however, “[t]he possibility that an appeal may become moot does not alone constitute irreparable harm for purposes of obtaining a stay.” *In re Nuverra Env'tl. Solutions, Inc.*, No. 17-10949, 2017 WL 3326453, at *4 (D. Del. Aug. 3, 2017). In contrast, a stay has been entered on equitable mootness grounds where, for example, a party has consistently and convincingly argued that “equitable mootness was a near certainty” if a stay was not entered. *See, e.g., In re Adelphia Commc'ns Corp.*, 367 B.R. 84 (S.D.N.Y. 2007) (finding appellant was judicially estopped from arguing against equitable mootness after affirmatively using equitable mootness to seek stay). Here, the Intervening Regulators take no position as to whether Plan implementation will render the appeal moot.⁵ The Intervening Regulators cannot rely on equitable mootness as an imminent and irreparable harm while refusing to say affirmatively that it will occur in this case absent a stay.

E. THE INTERVENING REGULATORS IGNORE THE HARM CAUSED BY A STAY AND THE CLEAR PUBLIC INTEREST IN MOVING QUICKLY TO IMPLEMENT THE PLAN.

The Intervening Regulators are the *only* party in these proceedings without a financial, equitable, or legal interest impacted by the Plan, and yet they are also the

⁵ As its name implies, equitable mootness involves a weighing of numerous factors, many of which cannot be known at this time. The Intervening Regulators do not even attempt to address any of these factors, and neither the Court nor the Rehabilitator can or should address such a theoretical and incomplete argument.

only party insisting on a stay of implementation, with no regard for the impact of that stay on other parties. Having failed to prove the first two *Process Gas* requirements, the Intervening Regulators are again unconvincing in their arguments addressed to the final two factors: harm to other parties and the public interest. With respect to other parties before the Court, the Intervening Regulators assert that a stay will not cause injury to other interested persons because it retains the *status quo*—policyholders continue to receive coverage, the agents and brokers have settled, and the guaranty associations have not been triggered. With respect to the public interest, the Intervening Regulators claim their appeal is designed to benefit policyholders and other regulators, and that the requested stay supports that mission.

Both arguments are plainly without merit. The record before this Court is clear in showing that delay itself is damaging to the rehabilitation and thus to policyholders. As the Court found, rehabilitation is preferable to liquidation in part because it avoids delay: “a plan can be implemented quickly, thereby addressing the causes of SHIP’s financial distress, preserving assets, and reserving flexibility.” (Opinion at 47.) In reaching that conclusion, the Court noted that the Rehabilitator could learn the impact of Phase One and the potential scope of Phase Two within a year of approval—a favorable timeline over liquidation, where rate approvals could take as long as two years, and in which there would be little certainty as to the impact on policyholders for some time. (*Id.*) Unlike the opt-out and election processes

acknowledged by the Intervening Regulators to be reversible, delay in implementation is absolutely irreparable. In fact, if there were a hearing on the amount of a bond, the Rehabilitator would be prepared to demonstrate that the irreparable damage from a one-year delay, even using a conservative measure, would be at least \$55 to \$70 million. The Rehabilitator would demonstrate as well that such damage equates to a year of the most costly long-term care services for approximately 500 policyholders. The Rehabilitator cannot ever recover those assets through other means, and those policyholders will be left unable to make up the difference.

The Intervening Regulators first blame the Rehabilitator for any deepening of the deficit during delay, saying it “reflects the intended working of the Plan, which places the entire burden of SHIP’s insolvency on policyholders through benefit cuts and premium increases.” (Stay Application at 32.) But the Plan is designed to be implemented as quickly as possible, not after a delay, so that policyholders can minimize any potential loss or burden from SHIP’s receivership by allocating the premiums and coverages available to best suit their individual needs. It is disappointing that the Intervening Regulators continue to misunderstand the Plan and the benefit provided to policyholders in making these elections. The Intervening Regulators also claim that any deepening of SHIP’s deficit is immaterial because \$800 million will be available in liquidation if the Intervening Regulators succeed.

But even assuming as the Intervening Regulators do that liquidation is inevitable, the alleged \$800 million will be available independent of the stay. In contrast, if a stay is not entered and the Court's order is upheld, policyholders will benefit by having made the prompt election of policy options and through the accompanying use of SHIP's assets to pay claims during the rehabilitation.

The Intervening Regulators make similarly unpersuasive arguments with respect to the public interest. The Intervening Regulators point to the various state legislatures' allocation of the burden of policyholder losses through the guaranty association system, claiming that a deeper deficit cannot harm the public because using guaranty association funds to cover SHIP's deficit—however big or small—is simply the system functioning as intended. But SHIP is not yet in liquidation, and the Pennsylvania legislature, like that of many other states, also enacted laws reflecting a public policy favoring meaningful efforts at rehabilitation over immediate liquidation. As this Court found, “[t]he legislatively stated purpose of Article V is the protection of the interests of insureds, creditors, and the public generally [as well as] the equitable apportionment of any unavoidable loss through, *inter alia*, improved methods for rehabilitating insurers. . . .” (Opinion at 41 (citation and internal quotation marks omitted).) Similarly, “[t]he benefits of rehabilitation—its flexibility and avoidance of inherent delays—are preferable to the static and cumbersome procedures of statutory liquidation.” *Grode v. Mutual Fire, Marine*

and Inland Ins. Co., 572 A.2d 798, 803 (Pa. Commw. Ct. 1990). Thus, recognizing the legislative interest in effective and meaningful efforts at rehabilitation, allowing estate assets to be depleted during an appeal can only harm the public interest by making the rehabilitation process more difficult.

F. THE INTERVENING REGULATORS FAIL TO ADDRESS THE NECESSITY OF A BOND.

The Intervening Regulators cannot make out a case on the merits for a stay, and thus the Court need not consider now whether a bond is appropriate to maintain the *status quo* as requested in the Stay Application. *See* Pa. R.A.P. 1732, 1733 (related to appeals and security). The Intervening Regulators' decision to omit any argument on the question of whether a bond is needed—and if so, in what amount—offers an additional reason to deny the motion. If the Court is inclined to grant a stay despite the numerous defects in the Stay Application, however, the Court will be required to address the bond issue at some point. Given that the Intervening Regulators made no reference at all to a bond, they have arguably waived the right to oppose the imposition of security here, and indeed the Court could find that a bond representing the Intervening Regulators' own projection of the outcome in rehabilitation—a deficit reduction exceeding \$300 million—is appropriate. Alternatively, the Court may conclude that a bond representing the \$55 million or more of deepening deficit during an appeal is sufficient. These are difficult fact-based questions, and thus the Rehabilitator submits that the question of appropriate

security—whether required and in what amount if so—should be considered in a separate hearing during which the parties can present evidence and argument on this specific issue.

G. CONCLUSION

For the reasons set forth herein, and for the reasons addressed in this Court’s Memorandum Opinion and Order, the Rehabilitator respectfully asks that this Court deny the Application for Stay.

Dated: October 15, 2021

Respectfully submitted,

/s/ Michael J. Broadbent

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CERTIFICATE OF SERVICE

I, Michael J. Broadbent, hereby certify that on October 15, 2021, I caused to be served the foregoing REHABILITATOR'S ANSWER AND BRIEF IN OPPOSITION TO THE INTERVENOR STATE INSURANCE REGULATORS' APPLICATION FOR STAY PENDING APPEAL through the Court's PACFile system and on all parties listed on the Master Service List. In addition, I hereby certify that an electronic copy of the foregoing document will be posted on SHIP's website at <https://www.shipltc.com/court-documents>.

/s/ Michael J. Broadbent

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

In re: Senior Health Insurance
Company of Pennsylvania (In
Rehabilitation)

No. 1 SHP 2020

**THE HEALTH INSURERS' RESPONSE TO THE INTERVENING
REGULATORS' APPLICATION FOR STAY PENDING APPEAL**

The 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, the “Health Insurers”), through their undersigned counsel, hereby submit this Response to the application filed by the Intervenors Superintendent of Insurance of the State of Maine, Commissioner of Insurance of the Commonwealth of Massachusetts, and Insurance Commissioner of the State of Washington (collectively, the “Intervening Regulators”) for a stay pending appeal of the August 24, 2021 Order (the “Confirmation Order”) granting the application of the Insurance Commissioner of the Commonwealth of Pennsylvania as Rehabilitator (the “Rehabilitator”) of Senior Health Insurance Company of Pennsylvania (“SHIP”) for approval of the Second Amended Plan of Rehabilitation (the “Plan”), the May 21, 2021 ruling granting the Rehabilitator’s motion in the nature of a directed verdict regarding issue state rate approval and the

August 25, 2021 Order denying reconsideration (the “Application”).¹ For the reasons set forth below, the Application should be denied because the Intervening Regulators have failed to meet the requirements for a stay pending appeal.

ARGUMENT

I. The Standards for the Issuance of a Stay Pending Appeal

The criteria for issuing a stay or supersedeas pending appeal are derived from the Pennsylvania Supreme Court’s decision in *Penn. Public Util. Comm’n v. Process Gas Consumers Group*, 467 A.2d 805 (Pa. 1983). *See also* Pa.R.A.P. 1732, Official Note (citing *Process Gas* for the criteria for the issuance of a stay). Under that case, a stay or supersedeas is warranted if:

- (1) The petitioner makes a strong showing that he is likely to prevail on the merits. (2) The petitioner has shown that without the requested relief, he will suffer irreparable injury. (3) The issuance of a stay will not substantially harm other interested parties in the proceedings. (4) The issuance of a stay will not adversely affect the public interest.

Process Gas, 467 A.2d at 808–09. “[I]t is essential that the unsuccessful party, who seeks a stay of a final order pending appellate review, make a strong showing under the[se] criteria in order to justify the issuance of a stay.” *Id.* at 809.

In establishing the criteria for the grant of a stay or supersedeas pending appeal, the Pennsylvania Supreme Court expressly adopted the standards set forth in *Virginia Petroleum Jobbers Ass’n v. Federal Power Comm’n*, 259 F.2d 921 (D.C.

¹ Capitalized terms used but not defined herein have the meanings ascribed to them in the Plan.

Cir. 1958), as refined in *Washington Metro. Area Transit Comm'n v. Holiday Tours, Inc.*, 559 F.2d 841 (D.C. Cir. 1977). The Court in *Virginia Petroleum* elaborated on the stay criteria as follows:

(1) Has the petitioner made a strong showing that it is likely to prevail on the merits of the appeal? **Without such a substantial indication of probable success, there would be no justification for the court's intrusion into the ordinary processes of administrative and judicial review.**

(2) Has the petitioner shown that without such relief, it will be irreparably injured? **The key word in this consideration is irreparable.** Mere injuries, however substantial, in terms of money, time and energy necessarily expended in the absence of a stay, are not enough. **The possibility that adequate compensatory or other corrective action will be available at a later date, in the ordinary course of litigation, weighs heavily against a claim of irreparable harm.** But injury held insufficient to justify a stay in one case may be sufficient to justify it in another, where the applicant has demonstrated a higher probability of success on the merits.

(3) Would the issuance of a stay substantially harm other parties interested in the proceedings? **On this side of the coin, we must determine whether, despite showings of probable success and irreparable injury on the part of the petitioner, the issuance of a stay would have a serious adverse effect on other interested persons.** Relief saving one claimant from irreparable injury, at the expense of similar harm caused another, might not qualify as the equitable judgment that a stay represents.

(4) Where lies the public interest? **In litigation involving the administration of regulatory statutes designed to promote the public interest, this factor necessarily becomes crucial.** The interest of private litigants must give way to the realization of public purposes. The public interest may, of course, have many faces—favoring at once both the rapid expansion of utilities and the prevention of wasteful and repetitive proceedings at the taxpayer's or consumer's expense; both fostering competition and preserving the economic viability of existing

public services; both expediting administrative or judicial action and preserving orderly procedure. We must determine, these many facets considered, how the court's action serves the public interest.

Virginia Petroleum, 259 F.2d at 925 (emphasis added). *Washington Metro. Area Transit Comm'n* clarified that the necessary level of “possibility of success” to warrant a stay or supersedeas “will vary according to the court’s assessment of the other factors.” 559 F.2d at 843. “In essence, *Process Gas* requires that a court balance the equities without necessarily giving any one element more weight than another.” G. Ronald Darlington et al., 20A West’s Pa. Prac., Appellate Practice § 1732:6. *See also Reading Anthracite Co. v. Rich*, 577 A.2d 881, 884 (Pa. 1990) (“As a rule, we assume that a party will establish the existence of each criterion and that a court will assess the movant’s chances for success on appeal and weigh the equities as they affect the parties and the public and, thereby, exercise its discretion to grant or deny a stay so that injustice will not follow from the court’s decision.”).

The Intervening Regulators have not made a strong showing on any of these elements, and the issuance of a stay in this case will cause significant harm to the interests of the Rehabilitator, SHIP’s estate and other interested parties. As a result, the Application should be denied. Each element is considered below as well as the need for a bond as security in the event a stay were to be issued (a requirement the Intervening Regulators failed to address at all in the Application).

II. The Intervening Regulators Have Failed to Demonstrate a Strong Showing that They Are Likely to Prevail on the Merits of the Appeal

The Plan involves nothing more than the application of doctrines already well established under Pennsylvania Supreme Court authority. Its building blocks are these:

- The Pennsylvania Insurance Commissioner as rehabilitator has broad discretion to structure a plan of rehabilitation for an insurer. *Vickodil v. Commw. of Pa. Ins. Dep't*, 559 A.2d 1010, 1013 (Pa. Commw. Ct. 1989). The Rehabilitator is granted the authority under Article V 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 [SHIP].” 40 P.S. § 221.16(b). The Court reviews those decisions for an abuse of discretion only. *Grode v. Mutual Fire, Marine and Inland Ins. Co.*, 572 A.2d 798, 803 (Pa. Commw. 1990) (“*Mutual Fire I*”); *Foster v. Mutual Fire, Marine and Inland Ins. Co.*, 614 A.2d 1086, 1091 (Pa. 1992) (“*Mutual Fire II*”); *see also Koken v. Fidelity Mutual Life Ins. Co.*, 803 A.2d 807, 826 (Pa. Commw. Ct. 2002) (“The decision to rehabilitate the business of an insurer is within the sound discretion of a rehabilitator and should not be rejected by the reviewing court unless the rehabilitator has abused that discretion.”) (citing *Mutual Fire II*, 614 A.2d at 1092).

- A rehabilitation plan can modify the rights and obligations of policyholders under policy contracts. *Mutual Fire II*, 614 A.2d at 1094; *Consendine v. Penn Treaty Network Am. Ins. Co.*, 63 A.3d 368, 452 (Pa. Commw. 2012) (“*Penn Treaty*”).
- A rehabilitation plan does not have to restore the company to its exact original condition as long as it “properly conserves and equitably administers the assets of the involved corporation in the interests of investors, the public and others, with the main purpose being the public good....” *Mutual Fire II*, 614 A.2d at 1094 (internal quotations, citations omitted).
- The *Carpenter* test (set forth in *Neblett v. Carpenter*, 305 U.S. 297 (1938) (“*Carpenter*”)) does not require that every single policyholder get at least what he or she would get in a liquidation, if the plan meets a compelling public purpose. *Mutual Fire II*, 614 A.2d at 1094; *Penn Treaty*, 63 A.3d at 453.

The Intervening Regulators state that they have “substantial arguments that the Court’s approval of the Plan should be reversed because the Plan is based on errors of law.” Application at 10. Yet, as discussed below, the Application cites virtually no factual basis or legal authority in support of the propositions it advances. What the Intervening Regulators would really like to do is substitute their judgement for the judgment of the Rehabilitator. But the fact that they would choose a different

path (liquidation) does not mean the Rehabilitator has abused her discretion in pursuing the Plan.

A. Feasibility.

The Intervening Regulators challenge the Plan on the basis that is not “feasible.” Application at 10-14. They cite testimony from the Special Deputy Rehabilitator to the effect that the Plan will not restore SHIP to solvency. Fairly characterized, the testimony of the Special Deputy Rehabilitator was that Phase One of the Plan was unlikely to return SHIP to solvency, but that Phase Two of the Plan could do so, depending on the results of Phase One.

Q. So do you see Phase Two as the phase at which a funding gap that remains at the end of Phase One is addressed and resolved?

A. Yes.

Q. So at the end of Phase Two, is it your view there will be no funding gap?

A. That would be ideal, but as I think I also said yesterday, we can’t guarantee that that will be the result.

Q. Yes. Yesterday you testified that it was unlikely, I think highly unlikely that the plan could eliminate the funding gap. Did you mean Phase One and Phase Two?

A. I meant Phase One and Phase Two. Certainly Phase One but, as I said yesterday in candor, given the magnitude of the funding, it is possible that for Phase Two to eliminate the remaining gap depending on what happens in Phase One would put such a burden on policyholders, that a different alternative might be preferable.

Tr. at 306. The Plan contemplates the restoration of SHIP to solvency through at least two phases, the second of which could restore SHIP to solvency, though such restoration is uncertain. The Intervening Regulators do not cite a single case for the proposition that a plan of rehabilitation must be “feasible” or that a plan cannot proceed in phases. Nor do they cite any authority for the proposition that rehabilitation plans must be certain to succeed in order to be undertaken.

To the contrary, in the Confirmation Order, the Court observed that neither Article V nor the case law sets “feasibility” as an independent requirement of a plan, but only requires a plan to properly conserve and administer the assets of the insurer in the interest of investors, the public and others. Confirmation Order at 66. Under this standard, proper stewardship in the service of the stakeholders is required. A definite return to solvency is not. Again, the Intervening Regulators cite no contrary authority. In addition, there is precedent for rehabilitation plans in Pennsylvania to proceed in phases. *See Mutual Fire II* at 635-36 (amending the plan of rehabilitation after implementation to achieve its rehabilitative purpose).

The Plan does not impair Guaranty Association coverage, and all policyholders have the option to retain their existing policies with only a requirement to pay an actuarially justified premium, as required by the terms of the policy itself. *See, e.g.,* Tr. at 102-03, 188, 331-32. Benefit modifications are entirely voluntary, and the evidence establishes many reasons why policyholders may want to modify

their benefits when presented with the opportunity. *See, e.g.*, Tr. at 85-86 (estimating that SHIP’s “indemnity” policies provide \$400 million in benefits in excess of what is needed for the costs of care, and that policyholders may not want to pay for such excess benefits); Tr. at 86-87 (noting that there are likely many policyholders who no longer need a lengthy or unlimited benefit period, either because of their attained age or current health circumstances.)

The evidence shows that a return to solvency is contemplated by the Special Deputy Rehabilitator at the end of the Phase Two of the Plan. The Intervening Regulators cite no authority that feasibility must be shown under Pennsylvania law, that a plan implemented in phases is *per se* not feasible, or that a plan must be certain to restore solvency. Thus, it is unlikely that the Intervening Regulators have substantial prospects for reversal of the Confirmation Order on this basis.

B. Best Interest of Policyholders

The Intervening Regulators’ appear to contend that the only means by which the burden of an insolvency can be distributed is by triggering the Guaranty Associations in a liquidation and invoking the assessment mechanisms. “The legislatures in Pennsylvania and other states have chosen to protect policyholders of insolvent insurers by establishing guaranty associations to provide coverage (subject to certain limits), and they have chosen how to spread the burden of those protections through the assessment mechanism.” Application at 19. The Intervening Regulators

claim that “[t]he Court improperly overrode these legislative judgments.” *Id.* at 20. First, and fatally to this argument, the Intervening Regulators fail to recognize that those same legislatures chose *not* to mandatorily trigger the Guaranty Associations upon “insolvency.” *See, e.g.*, 40 P.S. § 991.1706(b) (providing for mandatory trigger only if the insurer is placed under an order of liquidation with a finding of insolvency); National Association of Insurance Commissioners Life and Health Insurance Guaranty Association Model Act at § 8(b) (same). Second, if this were the only means by which insurance company insolvencies could be addressed under Pennsylvania law, then Article V and case law in Pennsylvania should bar the modification of policies in a rehabilitation proceeding. But, of course, the contrary is true. Pennsylvania precedent clearly contemplates that policies can be modified. *Mutual Fire II*, 614 A.2d at 1094; *Penn Treaty*, 63 A.3d at 452.

Moreover, the Intervening Regulators mischaracterize the operation of the Plan in making their arguments. They imply that the Plan involuntarily modifies the contractual rights of the policyholders, which it does not. The Plan imposes rate increases on policyholders under the If Knew Premium methodology in Phase One and the Self-Sustaining Premium methodology in Phase Two. Plan at 23. The policies by their terms allow for rate increases.² Tr. at 331-32. The undisputed

² The question of whether the policyholders – or the Intervening Regulators – have a contractual or other right to have rates determined by the regulator in the state that issued the policy is dealt with in Section D below.

testimony is that the actuarial methods applied to both phases are legitimate and recognized methods of setting premium rates. Tr. at 107-08; 399-400. The Plan provides policyholders options other than accepting the rate increase, but these are entirely voluntary.

The Intervening Regulators are also wrong in asserting that the Rehabilitator and the Court cannot consider the interests of other stakeholders. Indeed, *Mutual Fire II* establishes that a main purpose of a plan of rehabilitation is the public good. *Mutual Fire II*, 614 A.2d at 1094. *See also id.* 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). Under the three-part test established in *Mutual Fire II*, the Court should confirm a plan of rehabilitation so long as the Rehabilitator has acted for a legitimate and significant public purpose and the adjustment of contractual rights is reasonable and of a nature appropriate to that public purpose. *Penn Treaty*, 63 A.3d at 453 (discussing the three-part test established in *Mutual Fire II*). As part of that analysis, “the Court **must** consider the greater good, including the consequences to the larger class of policyholders **and the taxpaying public.**” *Id.* (citing *Vickodil*, 559 A.2d at 1013) (emphasis added); *see also* Confirmation Order at 62-63 (discussing same). The Court expressly determined that the Plan—even assuming, *arguendo*, that it substantially impairs policies—serves a legitimate and significant public purpose, and the policy

modifications are reasonable and appropriate to that purpose. Confirmation Order at 63.

The Plan achieves its objectives by requiring all policyholders to pay an actuarially justified premium consistent with the terms of their policies, or choose another option that reduces both benefits and premiums. In all cases their Guaranty Association protections remain intact. On these facts, found by the Court (and not challenged by the Intervening Regulators), it seems highly unlikely that the Intervening Regulators would prevail on these issues on appeal.

C. The *Carpenter* test

The Intervening Regulators argue that *Carpenter* “established a floor of liquidation value that each policyholder should be able to obtain if desired.” Application at 21. The Pennsylvania Supreme Court disagrees with this interpretation of *Carpenter*. *Mutual Fire II*, 614 A.2d at 1094; *Penn Treaty*, 63 A.3d at 453. As the Court stated in the Confirmation Order:

if a particular policyholder is found to be worse off under a rehabilitation plan than in liquidation, and the 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.

Confirmation Order at 63. The Court went on to find that 85% of policyholders would receive an option under the Plan with a value equal or greater than what they would receive in a current liquidation based on the Intervening Regulators’ own

metrics. But more importantly, the Court found that the Plan serves a “legitimate and significant public purpose” by requiring policyholders to pay a fair premium for their policies on an ongoing basis (as required by their policies) instead of shifting the burden of historical rate suppression to the Guaranty Associations and the taxpayers. *Id.* at 63-64.

In reaching this conclusion, the Court’s decision fell squarely within the four corners of *Mutual Fire II*. It is highly unlikely that the Pennsylvania Supreme Court would reverse the Confirmation Order given the Supreme Court’s specific pronouncements on the interpretation of the *Carpenter* test.

D. State authority over the regulation of rates

As observed by the Court, Pennsylvania authority clearly interprets the rehabilitation statute to allow a rehabilitator to impair policies by reducing benefits under them pursuant to a rehabilitation plan. *Mutual Fire I*, 572 A.2d at 804, *affirmed Mutual Fire II*, 614 A. 2d at 1086; Confirmation Order at 50. The Court reasoned that increasing premiums would be authorized by the same statutes and is conceptually no different from a reduction in benefits. Confirmation Order at 51. This contention goes unanswered in the Intervening Regulators’ Application. They argue that Article V does not give authority to the Rehabilitator to either modify policies or rates. Application at 25. But this is clearly not the law in Pennsylvania.

The Intervening Regulators also reject the Court’s explanation of why the Full Faith and Credit clause of the U.S. Constitution does not require ceding control over rate-making to numerous state regulators, who have refused to set adequate rates in the past. But they do nothing to distinguish the cases cited by the Court or refute the contention that the statutory rate provisions in the three objecting states are substantially similar to those in Pennsylvania, and implicate the same public policies. The wide acceptance of the Plan’s rate-making methodologies by insurance regulators across the country, including Maine, Massachusetts and Washington, was established during the hearing on the Plan through undisputed expert testimony. Tr. at 107-08; 399-400; 442-43; 456-57. *See also* Confirmation Order at 61 (finding that “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.”). The Intervening Regulators could not refute that testimony then, nor can they now.³

Finally, the Intervening Regulators reject the “opt-out” provisions of the Plan as a measure designed to allow them to exercise rate-making authority within the

³ The Health Insurers’ Pre-hearing Memorandum discussed at length the reasons why the Plan’s provisions governing the approval of premium rates are authorized by Article V and are not violative of the U.S. Constitution. Health Insurers’ Pre-hearing Memorandum at 4-22. The Health Insurers incorporate that analysis by reference, and note that the Intervening Regulators’ Application does not raise any arguments that were not already addressed in the Health Insurers’ Pre-hearing Memorandum or by the Court in the Confirmation Order.

framework of the Plan. They contend that the Plan does not give them enough time to perform a review and creates disincentives for them to do so. Application at 28. But as the Special Deputy Rehabilitator testified, providing the states with an unlimited review period would bring the progress of the Plan to a halt. Tr. at 162-63. The disincentives are slight. Policyholders will still have option to keep their policy at the rate prescribed by the opt-out regulator, though with reduced benefits if the premium is below the If Knew Premium. They can also keep the full benefit of their policy at the If Knew Premium rate or they can elect policy modifications similar to those available to policyholders in opt-in states. Plan at 108-14 (Phase One); 114-16 (Phase Two). These provisions of the Plan strike a reasonable balance between the overall goals of the Plan, which require speed and uniformity, with the desire of the Intervening Regulators to exercise authority over rate review.

It is highly unlikely that the Pennsylvania Supreme Court will find that the Plan deprives policyholders of a meaningful contract right, that the Full Faith and Credit clause invests the Intervening Regulators with the right to set rates in the context of this rehabilitation case or that the Plan has not made reasonable accommodation for the Intervening Regulators to exercise their rate-making authority if they choose to do so.

III. The Intervening Regulators Will Not Suffer Irreparable Injury Without a Stay

Perhaps the most glaring element missing from the Application is any showing by the Intervening Regulators that the implementation of the Plan harms them in their capacity as regulators in any way. The sole allegation of harm is that if the Plan is implemented, the Rehabilitator might someday make an argument that an appeal would be equitably moot. They speculate that:

The practical realities suggest that at some point the Rehabilitator may contend that the Plan has been “substantially consummated” so that the appeal should be dismissed under the doctrine of equitable mootness.

Application at 31. This potential, speculative “harm” falls well short of the harm a party must demonstrate to justify the drastic remedy of a stay. On the other hand, as discussed below, a stay would work concrete, quantifiable harm to the interests of the Rehabilitator, as established by evidence in the record.

The doctrine of equitable mootness has not been developed in the Pennsylvania case law. It is largely a creature of Federal Bankruptcy law. Under those cases, the possibility of equitable mootness is not, without more, justification for a stay. *See, e.g., BDC Cap., Inc. v. Thoburn Ltd. P’ship*, 508 B.R. 633, 640 (E.D. Va. 2014) (“the fact that an appeal may become moot without a stay does not alone constitute irreparable harm”); *In re DJK Residential, LLC*, No. 08-10375, 2008 WL 650389, at *3 (S.D.N.Y. Mar. 7, 2008) (“a ‘majority of courts have held that a risk of mootness, standing alone, does not constitute irreparable harm’”); *N.L.R.B. v. 710*

Long Ridge Rd. Operating Co. II, LLC, No. CIV.A. 14-832 CCC, 2014 WL 906128, at *1 (D.N.J. Mar. 6, 2014) (“Even if the Court were to accept the NLRB’s proposition that the denial of a stay would render its appeal equitably moot, a risk of equitable mootness by itself is insufficient to justify a stay pending appeal.”); *In re Baker*, CV05–3487, 2005 WL 2105802, at *9 (E.D.N.Y. Aug. 31, 2005) (“As other courts have noted, the possibility that an appeal will be rendered moot by a denial of stay does not, in and of itself, constitute irreparable harm.”); *In re Windstream Holdings, Inc.*, No. 20 CV 4276, 2020 WL 4481933, at *3 (S.D.N.Y. Aug. 3, 2020) (“But equitable mootness is a risk present in any post-confirmation appeal of a Chapter 11 plan; merely invoking that risk in a demand for expedition is not enough to show irreparable harm.”).

Even the few cases concluding that the possibility of equitable mootness could constitute irreparable injury have only done so where the appellant has made a strong showing that it is likely to prevail on the merits. *See, e.g., In re Los Angeles Dodgers LLC*, 465 B.R. 18, 30-1 (D.C. Del. 2011) (“Appellant has shown a strong likelihood of success on the merits of its appeal.”); *In re Cujas*, 376 B.R. 480, 491 (Bankr. E.D. Penn. 2007) (“In this sense, GJR does not have a reasonable likelihood of success. It is only a question of whether the likely outcome happens sooner or later.”).

As set forth in Section II, the Intervening Regulators do not have substantial claims of error or a strong possibility of success on appeal, given the prior decisions

of the Pennsylvania Supreme Court. Their prospects for success are even further limited by the relief that they seek, which is sweeping in its scope. They want the consummation of the Plan “undone by deeming the policyholder elections and regulator opt-outs nullities in the event the Court’s approval is reversed.” Application at 30. Even they recognize that this would “be administratively difficult and confusing to policyholders and regulators to undo those steps.” Application at 30. The prospects for obtaining this relief are remote even if their appeal succeeded. First, this relief is premised on a complete reversal of all elements of the Plan. The Intervening Regulators do not, by their own express admission, represent policyholders, and the Court has ruled that they “lack standing to assert the claim that the Plan treats ‘policyholders in different States differently.’ They expressly disavowed that they were appearing in a *parens patriae* or other representative capacity for policyholders in their states.” Confirmation Order at 68 (citing Tr. at 541-47). This means that they only have standing to raise issues that involve their rights as regulators rather than the rights of the policyholders. Therefore, the relief that they could obtain on appeal could only relate to the opt-out provisions of the Plan, not the policy modifications.

Second, even if the Intervening Regulators were entitled to represent the interest of policyholders (contrary to their own concession), they would surely only represent the interests of policyholders of policies issued in their states, which

comprise only 1,405 of the 33,261 policyholders of SHIP – approximately 4%. Exhibit RP-30 (figures as of Jan. 21, 2021, excluding policyholders who have taken NFOs and are thus not eligible to make elections under the Plan). Thus, even in the unlikely event that the Pennsylvania Supreme Court were inclined to recognize the standing of the Intervening Regulators to represent the interests of some policyholders, it is a very small subset of SHIP's total policyholder population. Reversing the effects of the Plan for *all* policyholders and *all* regulators would vastly exceed any possible harm to the Intervening Regulators resulting from the Plan's rate-making provisions for the 1,405 policies issued in their states. *See* Tr. at 155-59 (discussing the ordinary course process in which the regulator in the state where a policy was issued will set the rate and why the application of that procedure in receivership is infeasible).

In sum, the mere possibility of equitable mootness raised by the Intervening Regulators has widely been rejected by courts as a basis for establishing irreparable injury. Even the courts that have accepted it have only done so when the moving party has made a strong showing of likelihood of success on the merits. As set forth in Section II, the Confirmation Order is supported by undisputed facts in the evidentiary record and well-established Pennsylvania Supreme Court authority. The relief sought by the Intervening Regulators is well beyond the scope of any injury that they may sustain either as regulators (which is the only capacity in which they

appear) or even as representatives of holders of policies issued in their states (if the Court were to permit them to assert such interests).

IV. SHIP and Other Interested Parties Will be Substantially Harmed By a Stay

Unlike the speculative harm asserted by the Intervening Regulators that might someday result from implementing the Plan, the issuance of the stay sought by the Intervening Regulators will result in immediate harm to the Rehabilitator's interests, and the interests of the SHIP estate and other interested parties. Currently, appeals from rulings of the Commonwealth Court have taken nearly a year to resolve. (See Exhibit A, which sets forth information about the timing of recent appeals from filing to decision.⁴) The passage of a year without implementation of the Plan will significantly diminish SHIP's assets, further delay the implementation of necessary rate increases and jeopardize the prospects for accomplishing the rehabilitative purpose set out in the Plan. The Intervening Regulators admit the harm to the estate and the fact that it will "reduce amounts that can be paid to policyholders." Application at 32.

The Intervening Regulators did not dispute the testimony and exhibits of the Rehabilitator establishing that SHIP continues to hemorrhage money year after year. The disparity between claims paid and premiums plus investment income continues

⁴ This material is compiled from public records. Accordingly, this Court may take judicial notice of it. Pa. R. Evid. 201.

to average approximately \$200 million per year.⁵ This is quantifiable and significant harm to the SHIP receivership estate, and ultimately to policyholders if the Plan is upheld.

The fundamental problem caused by delay was stated succinctly by the Special Deputy Rehabilitator as follows:

Unfortunately, management and the regulators all recognized that simply seeking rate increases wasn't going to help SHIP because there is such a short premium runway left that is, as I said earlier, the average age of our policyholders is 86, they don't have that many premium paying years ahead of them, unfortunately, so other measures would have to be implemented to improve the company's financial condition.

Tr. at 67-68 (emphasis added). Each year of delay in implementing the Plan decreases the runway. Not only does SHIP lose the benefit of a year of increased, actuarially justified premium (as to those who elect to keep their policies at the If Knew Premium), but SHIP also loses the benefit of decreased policy obligations from elected policy modifications. The benefits of increased premium and reduced policy obligations cannot be regained other than by imposing further burdens on the policyholders. The Special Deputy Rehabilitator made a similar observation in connection with the potential delay caused by submitting to the ordinary rate making process advocated by the Intervening Regulators:

⁵ Exhibit RP-12 at 1 (calculated as follows: FY 2019 benefits paid of \$369,626,000 less premiums received of \$80,672,000 less net investment income of \$66,717,000 equals \$222,237,000; FY 2020 Benefits paid of \$333,201,000 less premiums received of \$66,982,000 less net investment income of \$69,368,000 equals \$196,851,000).

But we concluded pretty early on that that approach [46 state regulatory approval] overlooked all of the history where the company had the checkerboard experience from rate increase across the country and it would take far too long for the plan to become effective in time to do much good. So we thought ancillary approval of the modifications just wasn't going to be an effective strategy for SHIP.

Tr. at 82-83 (emphasis added); *see also* Plan at 34 (“Moreover, the delay and expense of ‘traditional’ state-by-state rate or benefit approval would make the Plan unfeasible.”). Even under the most conservative scenario (81% of policyholders elect to keep the policy at If Knew Premium), the Plan will close the Funding Gap by \$525 million. Tr. at 113. Losing a year on a short premium runway is bound to cut into this amount. This harm is concrete and supported by the evidentiary record in this case. It clearly outweighs the Intervening Regulators’ conjectured harm from the possible application of equitable mootness.

Conspicuously absent from the Application is any offer to provide security as a condition to the granting of a stay. Pa.R.A.P. 1733(a) provides that an appeal from an order that is not solely for the payment of money “shall, unless otherwise prescribed in or ordered pursuant to this chapter, operate as a supersedeas **only** upon the filing with the clerk of the court below of appropriate security as prescribed in this rule.” (Emphasis added.) In any such appeal, the Court “may, upon its own motion or application of any party in interest, impose such terms and conditions as it deems just and will maintain the res or status quo pending final judgment or will facilitate the performance of the order if sustained.” Pa.R.A.P. 1733(a). “The trial

court, in the first instance, and thereafter the appellate court, are afforded broad discretion to fix security in such amount as the trial court or the appellate court deems appropriate under the circumstances.” G. Ronald Darlington et al., 20A West’s Pa. Prac., Appellate Practice § 1733:3. In this case, if the Court is willing to entertain a stay pending appeal, it should be conditioned on a bond in an appropriate amount, and the Court should conduct a hearing to determine the amount.⁶

A recent Third Circuit decision in a bankruptcy appeal is instructive. *See In re Tribune Media Co.*, 799 F.3d 272 (3d Cir. 2015). In approving the trial court’s reasoning in setting the bond amount, the Third Circuit explained that such a bond was required “to indemnify the party prevailing in the original action against loss caused by an unsuccessful attempt to reverse the holding of the bankruptcy court.” *Id.* at 281-82.

It then described the lower court’s process and reasoning when setting the bond amount at issue:

The Bankruptcy Court held a hearing on the motion at which it considered whether to issue a stay and, if so, whether to condition it on a bond. Aurelius opposed posting a bond in any amount. The Court stayed its confirmation order, but it also considered **how much an unsuccessful appeal by Aurelius would cost Tribune [the debtor]**. As a result of this valuation, the Court conditioned its stay on Aurelius’s posting a \$1.5 billion bond to indemnify Tribune against the estimated costs associated with staying the order for the likely time to appeal.

⁶ There are a variety of methodologies that could be used to calculate the bond. While it would be premature to explore them at this stage, it is very likely that the harm to the estate as a result of the stay will be approaching or greater than \$100 million.

...

In this case, the Bankruptcy Court carefully calculated **the likely damage to the estate of a stay pending an appeal from its confirmation order**. In particular, it analyzed the following costs to Tribune and its creditors that a stay would cause: **additional professional fees, opportunity costs to creditors who would receive delayed distributions from the DCL Plan or delayed interest and principal payments from reorganized Tribune, and a loss in market value to equity investors caused by the delayed emergence**. We need not go through the opinion in detail, as Aurelius does not squarely argue that the bond requirement was an abuse of discretion, but **we note that the valuation was well-considered and as convincing as the alchemy of valuation in bankruptcy can be**.

In re Tribune Media Co., 799 F.3d 272, 276, 281-82 (3d Cir. 2015) (emphasis added) (discussing *In re Tribune Co.*, 477 B.R. 465, 482 (Bankr. D. Del. 2012)).

The Court should deny the Application on the basis that the harm to the estate and other parties substantially outweighs any potential harm to the Intervening Regulators, particularly in light of their low likelihood of success on the merits. If the Court is willing to entertain such a stay, a bond should be required to protect the estate and the parties from the loss inherent in delay. If such a bond will be required, a hearing on the amount of that bond should be held in order to permit the type of expert testimony and determinations as were made in the *Tribune* case on a fully developed record.

V. The Issuance of a Stay Would Adversely Affect the Public Interest

The Intervening Regulators and the Rehabilitator both claim to be custodians of the public interest as state appointed officials. The Intervening Regulators argue

that a stay of Plan implementation would promote the public interest because they are seeking to invoke the Guaranty Associations and vindicate their role and the role of other regulators in setting premium rates. However, the Intervening Regulators seem to forget that they only represent themselves. They certainly do not represent all other regulators, and the Court has found that they do not even represent the interests of the policyholders in their states.

By contrast, the Rehabilitator is charged with promoting the state's "significant interest...[in] regulat[ing] the fiscal affairs of its insurers for the welfare of the public." *Mutual Fire II*, 614 A.2d at 1094, n.4. (emphasis added). The Rehabilitator has undertaken this obligation by proposing the Plan which has two goals:

First, we reduce or eliminate the funding [gap] or the deficit.
Second, eliminate the inequitable and discriminatory rate structure that's currently in place and eliminate the subsidies across policyholders...prospectively.

Tr. at 105.

The Court summarized the public policy arguments supporting the Rehabilitator's position as follows:

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.

Confirmation Order at 81. The stay sought by the Intervening Regulators would undermine the Plan and the advancement of the policies it embodies. For that reason, the Application should be denied.

CONCLUSION

The Application does not satisfy the four factors required for the entry of a stay pending appeal under Pennsylvania law. The Intervening Regulators are not likely to succeed on the merits of their appeal. It is undisputed that a stay would injure the interests of the Rehabilitator, SHIP's estate and other parties. The possibility of equitable mootness is not recognized in the vast majority of the case law as an injury to the appellant, and even in the minority of cases (none of which is a Pennsylvania receivership case), it is only an injury if there is a strong showing of likelihood of success on the merits. Finally, the Plan serves the public interest by reducing the Funding Gap and more equitably distributing the burden of premiums. For these reasons, the Application should be denied.

Respectfully submitted,

Dated: October 15, 2021 MORGAN, LEWIS & BOCKIUS LLP

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EXHIBIT A

Docket No.	Days from Allocatur to Argument	Days from Argument to Decision	Days from Allocatur to Decision
59 MAP 2020	168 days	212 days	380 days
58 MAP 2020	168 days	212 days	380 days
36 EAP 2020	133 days	173 days	306 days
3 MAP 2021	118 days	127 days	245 days
74 MAP 2020	140 days	127 days	267 days
71 MAP 2020	126 days	161 days	287 days
4 EAP 2021	127 days	127 days	254 days
20 WAP 2020	N/A	N/A	371 days
22 WAP 2020	182 days	162 days	344 days
9 WAP 2020	205 days	279 days	484 days
Average	152 days	176 days	332 days

PROOF OF SERVICE

I, John P. Lavelle, Jr., hereby certify that on October 15, 2021, the foregoing document was served via the PACFile system as well as via e-mail upon the following counsel:

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Dated: October 15, 2021

/s/ John P. Lavelle, Jr.
John P. Lavelle, Jr.

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

**STATE INSURANCE REGULATORS’
 APPLICATION FOR EXPEDITED RULING ON
 APPLICATION FOR STAY PENDING APPEAL**

Pursuant to Pa. R.A.P. 123 and 1732(a), the Intervenor Superintendents of Insurance of the State of Maine, Commissioner of Insurance of the Commonwealth of Massachusetts, and Insurance Commissioner of the State of Washington (“State Insurance Regulators”), request that the Court expedite its consideration and ruling on the State Insurance Regulators’ Application for Stay Pending Appeal (the “Application for Stay”) of the Orders approving the Second Amended Plan of Rehabilitation (“Plan”) for Senior Health Insurance Company of Pennsylvania (“SHIP”). As reasons therefor, the State Insurance Regulators state as follows:

1. On September 21, 2021, the State Insurance Regulators appealed from the Court’s August 24, 2021 Order granting the application of the Insurance Commissioner of the Commonwealth of Pennsylvania as Rehabilitator (“Rehabilitator”) of SHIP for approval of the Plan, as well as the May 21, 2021 ruling granting the Rehabilitator’s motion in the nature of a directed verdict

regarding issue state rate approval and the August 25, 2021 Order denying reconsideration.

2. On October 1, 2021, the State Insurance Regulators filed their Application for Stay with the Court pursuant Pa. R.A.P. 123 and 1732(a).

3. On October 15, 2021, the Rehabilitator filed her Answer and Brief in Opposition to the Intervenor State Insurance Regulators' Application for Stay Pending Appeal. That same day, the Intervenor Health Insurers filed their Response to the Intervening Regulators' Application for Stay Pending Appeal.

4. An expedited ruling on the Application for Stay is necessary because the Rehabilitator has set a November 15, 2021 deadline for state insurance regulators to "opt-out" of the Plan. The imminence of an approximate November 15, 2021 "opt-out" deadline was noted in the State Insurance Regulators' Application (see pages 4, 29-30 and Exhibit A to the Application). The Rehabilitator has firmly set the November 15, 2021 deadline in a letter received by counsel after the Application was filed. *See* the Special Deputy Rehabilitator's letter dated September 30, 2021 attached as Exhibit 1 hereto.

5. In the absence of a stay, state insurance regulators around the country will be required to make an "opt-out" decision on or before November 15, 2021. This places regulators in the position of either implicitly acquiescing to what the State Insurance Regulators maintain is the Plan's usurpation of state regulatory

authority or “opting-out” and then either approving the Rehabilitator’s rate submission or placing policyholders in their state in a worse position than policyholders in other states.¹

6. The imminence of the November 15, 2021 deadline requires the State Insurance Regulators to make this request for expedited ruling. In the event that the Court were to deny the Application for Stay, the State Insurance Regulators intend to apply to the Supreme Court for a stay pending appeal pursuant to Pa. R.A.P. 1732. To allow any reasonable opportunity for the Supreme Court to make a decision on the application for stay in advance of the November 15, 2021 deadline, the State Insurance Regulators will need to file the application with the Supreme Court on or about November 5, 2021. The State Insurance Regulators will want to advise the Supreme Court of the Court’s reasons for denying a stay (if it were to do so) in accordance with Pa. R.A.P. 1732(b).

7. The absence of a ruling on the Application for Stay as the November 15, 2021 “opt-out” deadline approaches effectively constitutes a denial of the Application for Stay as to state regulators. In such circumstances, the State Insurance Regulators would need to consider applying to the Supreme Court for a

¹ A stay pending appeal is also necessary because of the harm to policyholders that will result from the implementation of the policyholder election process. However, the Rehabilitator has advised that the policyholder election packages will be mailed around year-end, so they do not implicate this application for expedited ruling.

stay on the ground that the trial court had failed to afford the relief which the applicant requested under Pa. R.A.P. 1732(b). The State Insurance Regulators would strongly prefer, however, to determine how to proceed based on a ruling of the Court regarding the Application for Stay.

Conclusion

For the above reasons, the State Insurance Regulators request that the Court expedite its ruling on their Application for Stay Pending Appeal.

November 2, 2021

Respectfully submitted,

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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: November 4, 2021

Before the Court is an application for a stay pending appeal (Stay Application) filed by Intervenor Superintendent of Insurance of the State of Maine, Commissioner of Insurance of the Commonwealth of Massachusetts and Insurance Commissioner of the State of Washington (collectively, Intervening Regulators). The Intervening Regulators seek a stay of this Court's August 24, 2021, order granting the application of Jessica K. Altman, Insurance Commissioner of Pennsylvania, in her capacity as the Statutory Rehabilitator (Rehabilitator) of Senior Health Insurance Company of Pennsylvania (SHIP), for approval of the Second Amended Plan of Rehabilitation for SHIP. The Intervening Regulators also seek a stay of the Court's May 21, 2021, ruling granting the Rehabilitator's motion in the nature of a directed verdict regarding issue state rate approval and the Court's August 25, 2021, order denying reconsideration of that ruling. Because the Intervening Regulators fail to meet the requirements for a stay pending appeal, the Court denies the Stay Application.

On August 24, 2021, this Court approved the Rehabilitator's Second Amended Plan of Rehabilitation (Plan)¹ for SHIP, a long-term care insurer that currently has an operating deficit of approximately \$1.2 billion. In broad terms, the Plan seeks to reduce or eliminate SHIP's deficit by increasing premium revenue and modifying the existing terms of most of the approximately 39,000 policies in force. The multi-phased Plan does so by offering policyholders an array of options to either maintain their coverages and pay an actuarially justified premium or reduce their coverages to avoid or temper a premium increase. The Plan also seeks to correct SHIP's discriminatory premium rate structure, whereby policyholders whose state of issue has approved requested rate increases over the years are paying more for the same coverages than policyholders whose state of issue has disapproved requested rate increases. The Plan contains an Issue State Rate Approval Option, by which a state may opt out of the rate approval section of the Plan.²

The Intervening Regulators objected to the Plan in its totality. One of their principal objections to the Plan was that, in their view, it unlawfully allows premium rates to be set by the Rehabilitator and this Court rather than by state-of-issue regulators. The Intervening Regulators asserted that the Plan's deviation from the ordinary state-by-state rate review process violated the Full Faith and Credit

¹ The Second Amended Plan of Rehabilitation is now known as the "Approved Plan." See Praecipe to Substitute Approved Plan of Rehabilitation, filed September 30, 2021, and the Court's order filed October 28, 2021, approving the substitution.

² If a state opts out, the Rehabilitator will file an application to increase rates for policies issued in that state to an actuarially justified 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. The Rehabilitator's unrefuted evidence established that policyholders in an opt-out state will, like their counterparts in opt-in states, have four options for adjusting their coverages and premium rate. Their choices will not, however, be exactly the same as those offered in the Plan.

Clause of the United States Constitution³ and was inconsistent with the principle of comity. They argued that the Plan's Issue State Rate Approval Option did not cure these infirmities because it is coercive and provides them with no meaningful review of the rate filings.

At the close of the hearing on the Plan on May 21, 2021, the Rehabilitator made an oral motion for judgment in the nature of a directed verdict on the claim of the Intervening Regulators that the Issue State Rate Approval Option was unlawful. In support, the Rehabilitator argued that the Intervening Regulators had not presented any evidence that their interests would be harmed by the Issue State Rate Approval Option, and as such, their objection to that aspect of the Plan could not serve as a basis for the Court to disapprove the Plan. The Court granted the Rehabilitator's motion from the bench. The Intervening Regulators sought reconsideration of the Court's ruling, which the Court denied by order dated August 25, 2021. In doing so, the Court reasoned, *inter alia*, that the Intervening Regulators had not presented any evidence to support their challenge to the opt-out provision.

The Intervening Regulators have appealed the Court's orders approving the Plan, granting the directed verdict and denying reconsideration of that verdict. Pursuant to Pa. R.A.P. 1732,⁴ they seek a stay of those orders pending a decision by the Pennsylvania Supreme Court. Under Pennsylvania law,

³ 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.

U.S. CONST. art. IV, §1.

⁴ Rule of Appellate Procedure 1732(a) provides, in relevant part, that an "[a]pplication for a stay of an order of a trial court pending appeal ... must ordinarily be made in the first instance to the trial court. Pa. R.A.P. 1732(a).

on an application for a stay pending appeal the movant is required to make a substantial case on the merits and to show that without the stay, irreparable injury will be suffered. Additionally, before granting a request for a stay, the court must be satisfied the issuance of the stay will not substantially harm other interested parties in the proceedings and will not adversely affect the public interest.

Maritrans G.P., Inc. v. Pepper, Hamilton & Scheetz, 573 A.2d 1001, 1003 (Pa. 1990) (citing *Pennsylvania Public Utility Commission v. Process Gas Consumers Group*, 467 A.2d 805, 808-09 (Pa. 1983)).

Under the first prong of the *Process Gas* standard, the Intervening Regulators must establish a substantial case on the merits of their appeal. In summary, the Intervening Regulators argue on appeal that the Plan is not feasible as required by law; constitutes an abuse of discretion because it does not serve the best financial interests of policyholders; fails to place policyholders in at least as good a position as in a liquidation, as required under *Neblett v. Carpenter*, 305 U.S. 297 (1938); exceeds the Rehabilitator's authority under Article V of the Insurance Department Act of 1921 (Article V);⁵ and violates the Full Faith and Credit Clause of the United States Constitution by superseding the regulatory authority of other states over premium rates.

The first impediment to the Intervening Regulators' case on appeal is their lack of standing to assert claims on behalf of policyholders. The Intervening Regulators' position in SHIP's rehabilitation proceedings is uncontroverted: they do not represent any policyholders, even those with policies issued in their own

⁵ Act of May 17, 1921, P.L. 789, added by Section 2 of the Act of December 14, 1977, P.L. 280, as amended, 40 P.S. §§221.1 – 221.63.

respective states.⁶ The Court granted the Intervening Regulators' request for limited intervention in the hearing on the Plan based on their purported interests as regulators, and not in any *parens patriae* or other representative capacity for policyholders. Indeed, at the hearing, counsel for the Intervening Regulators expressly disavowed that they are acting in any "sort of a *parens patriae* capacity on behalf of . . . policyholders [from their respective states] who have chosen not to intervene." Notes of Testimony (N.T.), 5/19/2021, at 543. As a result, the Court held that the Intervening Regulators lacked standing to assert claims on behalf of policyholders that they do not purport to represent.

The Court's opinion in this matter addressed at length the substance of the Intervening Regulators' arguments. *See generally In Re: Senior Health Insurance Company In Rehabilitation* (Pa. Cmwlth., No. 1 SHP 2020, filed August 24, 2021) (*In Re: SHIP*). For purposes of the *Process Gas* analysis, the Court will summarize the portions of its analysis relevant to the Intervening Regulators' likelihood of success on the merits.

First, the Intervening Regulators continue to assert that the Plan is not "feasible." They are not likely to prevail on this argument, however, because, as the Court explained, Article V does not require that the Plan be "feasible" in order to be approved. *Id.* at 68. In any event, the Court also held that the Plan is feasible to the extent such a requirement exists, because the Plan will materially reduce the Funding Gap, significantly improve SHIP's financial condition, and if successful, will restore SHIP to its pre-receivership condition of an insurer winding down its long-term care insurance business. The Intervening Regulators have not offered any evidence in support of a different conclusion.

⁶ Notably, the number of policies issued in Maine, Massachusetts and Washington, 1,405, is approximately 4% of the policies in force as of January 21, 2021. *See* Exhibit RP-30.

Second, the Intervening Regulators contend that the Plan is not in the best financial interests of policyholders. Setting aside that the Intervening Regulators lack standing to assert such an argument, their position reflects only that “they would have exercised their discretion differently” than the Rehabilitator, which the Court held “is not a basis for the Court to disapprove the Plan.” *Id.* at 80. The Intervening Regulators favor an immediate liquidation of SHIP because that will trigger guaranty association coverage. The Intervening Regulators cannot establish that they are likely to prevail on the merits simply because they disagree with the Rehabilitator’s exercise of her discretion in deciding that a rehabilitation is to be preferred for several sound policy reasons. Moreover, they do not address the Court’s finding that in a liquidation, some policyholders will pay less than the actuarially justified premium for their coverage and other policyholders will, as a result, pay more for identical coverage. Nor do the Intervening Regulators address the fact that in a liquidation, policyholders will have little or no choice over their coverage once their policies are terminated, as is required by a liquidation order. Their replacement policy from the guaranty association will cap the limits of coverage.

Third, the Intervening Regulators continue to misconstrue *Neblett v. Carpenter*, 305 U.S. 297 (1938). Even accepting their interpretation, however, 85% of SHIP’s policyholders will be offered at least one option with a value equal to or higher than the value of the policy that they might have in liquidation. Accordingly, the Court held that even if the Plan substantially impairs policies, under any measure created by *Carpenter* “it serves a legitimate and significant public purpose, and the policy modifications are reasonable and appropriate to that purpose.” *In Re: SHIP* at 63. The Stay Application offers no basis for overturning the Court’s findings.

Finally, the Intervening Regulators argue that the Plan exceeds the Rehabilitator's authority under Article V and violates the Full Faith and Credit Clause. The Stay Application does not identify any specific statutory provision that the Plan violates, and this Court's opinion approving the Plan explained at length how the Plan's provisions fully comport with Pennsylvania law. The Court also explained why the Full Faith and Credit Clause does not require the Rehabilitator to submit premium rate increase requests to 46 states, the District of Columbia, and the U.S. Virgin Islands for their review and approval. To the contrary, such a requirement "would fracture Pennsylvania's 'own legitimate public policy' in the rehabilitation of SHIP," in contravention of the Full Faith and Credit Clause. *Id.* at 61. The Intervening Regulators cannot satisfy their burden under *Process Gas* by simply repeating these failed arguments.

Having determined that the Intervening Regulators cannot make a substantial case on the merits of their appeal, the Court could deny the Stay Application without considering the remaining three *Process Gas* factors. *See Maritrans*, 573 A.2d at 1004 ("In view of that failure [to show a substantial case on the merits, the court] need not scrutinize compliance with the remaining three criteria."). Even so, the Intervening Regulators cannot satisfy the remaining factors.

Under the second *Process Gas* factor, the Intervening Regulators must establish that without the stay, they will suffer irreparable injury. They allege here that a stay is necessary to prevent "harm [to] both policyholders and regulators because both will be forced to make decisions that may not be reversible even if the Court's decision is reversed on appeal." Stay Application at 29. This argument fails for several reasons.

First, the Intervening Regulators cannot request a stay based on hypothetical harm to third parties, *i.e.*, policyholders and other state regulators. When our Supreme Court adopted the federal law on supersedeas, it defined the second factor as requiring “the petitioner [to] show[] that without the requested relief, *he* will suffer irreparable injury.” *Process Gas*, 467 A.2d at 808 (emphasis added). In granting the stay in that case, the Supreme Court found a “sufficient showing of irreparable harm likely to result to the [movants],” a group of industrial gas consumers directly impacted by the surcharge allocation at issue. *Id.* at 809. Thus, a stay can only be entered upon a showing of irreparable harm to the moving party. To the extent the Intervening Regulators allege that other regulators or policyholders will be harmed absent a stay, such allegations are immaterial to the *Process Gas* analysis.

Second, to the extent the Intervening Regulators argue they will themselves be harmed absent a stay, the Court notes that their asserted right to regulatory authority over policies issued in their states and the rate review process is preserved by the Issue State Rate Approval Option. To date, the Intervening Regulators have offered no evidence to support their challenge to the legality of this opt-out provision in the Plan. For this reason, the Court entered a directed verdict in favor of the Rehabilitator on that issue.

Third, the alleged harms cited by the Intervening Regulators are not irreparable or imminent. The only alleged injury to the Intervening Regulators themselves, *i.e.*, the decision to participate in the Plan or opt out, is reparable because if the Court’s approval of the Plan is reversed, then the decision to participate or opt out will be rendered moot. Even if the Intervening Regulators are correct that it may be “administratively difficult and confusing . . . to undo” implementation of the Plan,

Stay Application at 30, that situation would not constitute irreparable harm under *Process Gas*.⁷

Regarding the final two *Process Gas* factors, harm to other parties and harm to the public interest, the Intervening Regulators' arguments are unpersuasive. They assert that a stay will not cause injury to other parties before the Court because it will maintain the status quo, *i.e.*, policyholders will continue to receive coverage, the agents and brokers have settled, and the guaranty associations have not been triggered. With respect to the public interest, the Intervening Regulators claim their appeal is designed to benefit policyholders and other regulators, and that the requested stay supports that mission.

The record before this Court established that delay itself is damaging to the rehabilitation of SHIP and, thus, to policyholders. The Court emphasized that rehabilitation is preferable to liquidation in part because it avoids delay: "a plan can be implemented quickly, thereby addressing the causes of SHIP's financial distress, preserving assets, and reserving flexibility." *In Re: SHIP* at 47. In reaching that conclusion, the Court noted that the Rehabilitator could learn the impact of Phase One and the potential scope of Phase Two within a year of approval, which is a favorable timeline over liquidation, where rate approvals could take as long as two years, and in which there would be little certainty as to the impact on policyholders for some time. The Plan is designed to be implemented as quickly as possible so that policyholders can minimize any potential loss or burden from SHIP's receivership by allocating the premiums and coverages available to best suit their individual

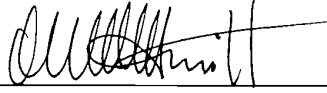
⁷ The Intervening Regulators also argue that a stay should be entered because, if the Plan is implemented before the appeal is heard and decided, the Rehabilitator may contend that the appeal should be dismissed under the doctrine of equitable mootness. *See In re Tribune Media Co.*, 799 F.3d 272 (3d Cir. 2015). The question of mootness is not before the Court at this time, and the mere possibility that the Rehabilitator may raise an argument in the future is not an imminent harm.

needs. The Court notes, further, that any harm to policyholder interests caused by a delay in implementing the Plan will be irreparable.⁸

The Intervening Regulators' arguments with respect to the public interest are similarly unpersuasive. They point to the various state legislatures' allocation of the burden of policyholder losses through the guaranty association system, claiming that a deeper deficit cannot harm the public because using guaranty association funds to cover SHIP's deficit, regardless of its size, is simply the system functioning as intended. But SHIP is not yet in liquidation, and the Pennsylvania legislature, like that of many other states, has enacted a law that favors meaningful efforts at rehabilitation over immediate liquidation. As this Court has previously observed, "[t]he 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) (quoting Section 501 of Article V, 40 P.S. §221.1). Similarly, "[t]he benefits of rehabilitation—its flexibility and avoidance of inherent delays—are preferable to the static and cumbersome procedures of statutory liquidation." *Id.* Thus, recognizing the legislative interest in effective and meaningful efforts at rehabilitation, allowing estate assets to be depleted during an appeal can only harm the public interest by making the rehabilitation process more difficult.

⁸ In addressing the need for a bond in the event a stay is granted, the Rehabilitator estimates that the irreparable damage from a one-year delay would be between \$55 and \$70 million. The Rehabilitator posits that such damage equates to one year of the most costly long-term care services for approximately 500 policyholders.

For all of the above reasons, the Court denies the Intervening Regulators' application for a stay pending appeal.

A handwritten signature in black ink, appearing to read 'M. Leavitt', is written over a horizontal line.

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 4th day of November, 2021, the Application for Stay Pending Appeal filed by Intervenors Superintendent of Insurance of the State of Maine, Commissioner of Insurance of the Commonwealth of Massachusetts and Insurance Commissioner of the State of Washington is DENIED. The Intervenors' Application for Expedited Ruling on Application of Stay Pending Appeal is DISMISSED as moot.



MARY HANNAH LEAVITT, President Judge Emerita

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11/04/2021

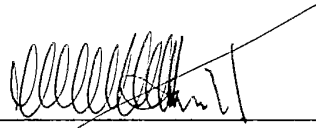
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IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

AMENDMENT ORDER

AND NOW, this 4th day of November, 2021, the opinion in the above matter, filed August 24, 2021, is amended as follows (see attached opinion).



MARY HANNAH LEAVITT, President Judge Emerita

Order Exit
11/04/2021

SIR App. 445

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

FILED: August 24, 2021

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 Conseco, Inc., and renamed Conseco Senior Health Insurance Company. In 2002, Conseco, Inc. filed a petition for reorganization under Chapter 11 of the United States Bankruptcy Code.¹ In 2003, Conseco, Inc. emerged from bankruptcy as CNO Financial Group. In 2003, Conseco 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, Conseco 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; 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 claim costs 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 increase 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

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.

respond to changes in the amount of the Funding Gap as SHIP moves through Phase 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 to establish the 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

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.

sequence: elimination of benefit restoration provisions; elimination of benefit 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.

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.

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 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 elect 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%.

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.

Cantilo described the option election process, which will begin with the Rehabilitator sending every policyholder a packet of information containing three 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 the 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.

⁹ If the state takes no action on the rate application within 60 days, it will be deemed denied.

Cantilo next addressed the Intervening Regulators' argument that immediate liquidation of SHIP is preferable to rehabilitation. In this regard, the 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 amount of 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

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.

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 as 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 for the premium the policyholder is willing to pay.

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 preceding 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

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).

2019, Lambright assisted Vincent Bodnar as he built the corrective action plan that would become the rehabilitation plan.

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 have 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 insurance 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 and 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 and 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 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

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.

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 indicated premium increase.

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 power 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 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

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.

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)).

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.

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

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).

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 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).

Because Maine, Massachusetts, and Washington have adopted the UILA and Pennsylvania has adopted the similar Model Act, a single, cohesive, uniform handling of SHIP’s rehabilitation through a single state is consistent with 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

¹⁵ *See* 24-A Me. Stat. Ann. §4364; Mass. Gen. Laws Ann. 175 §180B; Wash. Rev. Code §48.99.020.

upon a just obligation might be demanded as of right, irrespective of the state of its origin.

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

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.

in determining the law applicable to a controversy, 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.²¹ 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

²¹ The judicially created requirement that a rehabilitation must treat policyholders better than would a liquidation pre-dates the creation of guaranty associations. Arguably, guaranty association protection should not be part of that analysis because the associations exist as a matter of legislative grace. Legislatures can repeal the guaranty association statutes or reduce the benefit caps. As it is, there is commonality but not uniformity. In any event, the existence of guaranty association protection was part of the Rehabilitator's analysis and, practically speaking, that protection cannot be ignored. Nor can its cost to other stakeholders, *i.e.*, policyholders of the guaranty associations' member insurers and taxpayers.

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. *Id.* 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 for the same 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

harm 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.* at 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.”²² 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*

²² 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.

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.²³ Pennsylvania Rule of Civil Procedure 226(b) 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 nonsuit²⁴ 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

²³ 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.'").

²⁴ 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).

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)).

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 Knew 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.

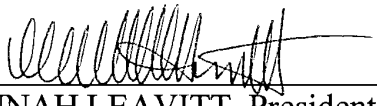
s/Mary Hannah Leavitt
Mary Hannah Leavitt, President Judge Emerita

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

ORDER

AND NOW, this 4th day of November, 2021, it is hereby ORDERED that the above-captioned opinion filed August 24, 2021, as amended on November 4, 2021, shall be designated OPINION rather than MEMORANDUM OPINION, and it shall be REPORTED.



MARY HANNAH LEAVITT, President Judge Emerita

Order Exit
11/04/2021

SIR App. 533

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

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Docket No.: 1 SHP 2020

**JOINT APPLICATION FOR INTERVENTION OF THE
MAINE SUPERINTENDENT OF INSURANCE AND THE
MASSACHUSETTS COMMISSIONER OF INSURANCE
AND REQUEST TO GRANT LEAVE TO EXTEND THE TIME
TO INTERVENE**

Pursuant to Pa.R.A.P. 123, 1531(b) & 3775 and the Court's *Case*

Management Order for Comments and Hearing on the Proposed Plan of

Rehabilitation, dated June 12, 2020 ("Case Management Order"), the Maine

Superintendent of Insurance ("Superintendent") and the Massachusetts

Commissioner of Insurance ("Commissioner") (collectively, the "State Insurance

Regulators"), by and through undersigned counsel, ask that the Court enter an

order permitting them to intervene for the limited purpose of participating in the proceedings concerning and potentially opposing the Rehabilitator's *Application for Approval of the Plan of Rehabilitation for Senior Health Insurance Company of Pennsylvania* as described below.

The State Insurance Regulators further request that the Court grant leave to extend the time for other state insurance regulators to join as intervenors together with the Maine and Massachusetts insurance regulators until and including September 15, 2020 (the formal comment deadline).

In support thereof, the State Insurance Regulators state as follows:

Background

1. Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as Statutory Rehabilitator ("Rehabilitator"), has applied for approval of a plan of rehabilitation (the "Proposed Plan") for Senior Health Insurance Company of Pennsylvania ("SHIP"), an insurance company that specialized in long-term care coverage. The Proposed Plan is attached as Exhibit A to the Rehabilitator's Application.

2. In addition to the business that SHIP transacted within Pennsylvania, SHIP also operated for several decades as a licensed foreign insurer in 45 other states, the District of Columbia, and the U.S. Virgin Islands, subject to the laws of

those respective jurisdictions and the regulatory authority of each jurisdiction's insurance commissioner or comparable state official.

3. Under the terms of the Proposed Plan, "other state insurance departments" are specifically identified as "affected parties," and the Rehabilitator expressly seeks to have them "bound by the Court's approval of the Plan, and its modification of policies and premium rates as part of the Plan." *See* Proposed Plan at p. 80. Accordingly, the Proposed Plan acknowledges that state insurance departments should be "provided an opportunity to object." *Id.* The Case Management Order issued by this Court outlines how such an opportunity may be exercised through informal or formal comments, or intervention in the proceeding. The Case Management Order specifies further: "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." *See* Case Management Order at ¶ 9.

4. Pennsylvania Rule of Appellate Procedure 3775 states in pertinent part:

Intervention in a formal proceeding shall be allowed if the proven or admitted allegations of the application establish a sufficient interest in the proceedings, unless the interest of the applicant is already adequately represented or intervention will unduly delay or prejudice the adjudication of the rights of the parties.

* * *

(2) *Limited intervention.* When the applicant's interest involves a discrete controversy relating to the administration of the insurer's business or estate, the Court may grant the applicant limited intervention to participate as a party in the discrete controversy. The limited intervenor shall not be placed upon the master service list unless the Court orders otherwise.

Pa.R.A.P. 3775(c). The State Insurance Regulators satisfy the standard for limited intervention concerning the Rehabilitator's Application for Approval of the Proposed Plan, and they are seeking intervention in accordance with the Case Management Order.

Application for Intervention

Interests of the Applicants

5. The State Insurance Regulators have a direct and substantial interest in the Proposed Plan collectively and in their own respective rights. SHIP was licensed in both Massachusetts and Maine, and policyholders from each of those jurisdictions will be subject to the Proposed Plan, if approved. The State Insurance Regulators seek to intervene for the purpose of better understanding how the Proposed Plan affects those interests and to protect those interests by participating in discovery, participating in and presenting evidence at the hearing, and potentially objecting to the Proposed Plan.

State-Specific Interests

Maine

6. The Superintendent enforces state insurance laws and undertakes the duties of regulating insurers. *See* Maine Insurance Code, Title 24-A of the Maine Revised Statutes; specifically, 24-A Me. Rev. Stat. § 211.

7. The Superintendent regulates SHIP. SHIP was licensed in Maine from 1991 until its license was suspended in March 2020. Previously, SHIP sought approval from the Superintendent for long-term care policy rate increases in Maine. SHIP made its most recent Maine rate increase requests between 2011 and 2019. The Superintendent reviewed each increase in accordance with Maine law. SHIP's 2011 and 2019 rate requests were disapproved as excessive after the Superintendent found that SHIP had failed to demonstrate that they met the rating standards required by the applicable regulation; and the Superintendent approved SHIP's 2016 rate request at a level slightly lower than requested.

8. The Proposed Plan will affect Maine policyholders. According to data provided to the Superintendent by the Rehabilitator, there were 388 Maine policies subject to the Proposed Plan as of November 30, 2019. The average estimated Phase One rate increase for Maine policyholders under the Proposed Plan is nearly 70%. Furthermore, that projected increase is not evenly distributed: 146 policies would have no rate increase; 47 policies would have rate increases

below 20%; 160 policies would have increases ranging between 20.1% and 199%; and 33 policies would have rate increases in excess of 200%, reaching as high as 1,275%.¹

9. At the time this information was compiled, 38 Maine residents were entitled to “on-claim waiver” of premium, meaning they are not paying premium because they are currently receiving long-term care. Another 78 policies were entitled to “active waiver,” either because the policyholder’s spouse was currently on claim or because the policyholder’s spouse has already died and the terms of the policy entitled the surviving spouse to a lifetime waiver of premium. 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. The Proposed Plan would take this benefit away from patients who are already receiving it, turning their premium waiver into a premium discount capped at a fixed dollar amount.

¹ The information about policies in this and the following paragraph was provided by the Rehabilitator to the Superintendent in a May 3, 2020 email and attachments from Patrick H. Cantilo to Benjamin Yardley. The estimated rate increases were calculated based upon that information. The number of policies referred to in this paragraph do not add up to 388 because there were two policies for which the estimated Phase One rate increase could not be calculated.

10. Like other jurisdictions in the United States, Maine has an extensive body of law, in both statute and regulation, protecting insurance policyholders by ensuring that they receive the insurance coverage they have been promised, and prohibiting excessive or unfairly discriminatory rate increases. In particular, long-term care insurance rates must be submitted for review by the Superintendent, which includes an actuarial analysis, and increases may not be implemented unless the Superintendent determines that they comply with applicable legal standards. *See e.g.* 24-A Me. Rev. Stat. § 2736 (“Every 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 Superintendent can determine that the filing complies with “requirements that rates not be excessive, inadequate or unfairly discriminatory”); 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 Proposed Plan purports to set aside these laws, and comparable laws in other jurisdictions, and replace them with a process for setting rates on a nationwide basis.

Massachusetts

11. The Commissioner enforces state insurance laws and undertakes the duties of regulating insurers. *See* Massachusetts General Laws, Chapter 175; specifically, M.G.L. c. 175, § 3A.

12. The Commissioner regulates SHIP. SHIP has been licensed in Massachusetts to write long term care insurance since 1990. Previously, SHIP sought approval from the Commissioner for long-term care policy rate increases in Massachusetts. SHIP made its most recent Massachusetts rate increase requests in 2011 and 2019. The Commissioner reviewed each increase in accordance with Massachusetts law. The Commissioner permitted SHIP to increase rates at a level lower than requested in the 2011 filing and only after satisfying the applicable statutory and regulatory requirements. The 2019 rate request was withdrawn by SHIP in April 2020 prior to the Commissioner issuing a decision. The reason provided for the withdrawal of the 2019 rate request was SHIP's desire to include the pending rate increases in the Proposed Plan.

13. The Proposed Plan will affect Massachusetts policyholders. According to data provided to the Commissioner by the Rehabilitator, there were 345 Massachusetts policies subject to the Proposed Plan as of November 30, 2019. The average estimated Phase One rate increase for Massachusetts policyholders under the Proposed Plan is nearly 45%. Furthermore, that projected increase is not

evenly distributed: for example, 174 policies without inflation protection would have an average rate increase of 24%; 27 policies with lifetime benefits would have an average increase of 64%; and 11 policies issued to policyholders under age 70 would have an average rate increase of 97%.²

14. At the time this information was compiled, 39 Massachusetts residents were entitled to “on-claim waiver” of premium, meaning they are not paying premium because they are currently receiving long-term care. Another 91 policies were entitled to “active waiver,” either because the policyholder’s spouse was currently on claim or because the policyholder’s spouse has already died and the terms of the policy entitled the surviving spouse to a lifetime waiver of premium. 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. The Proposed Plan would take this benefit away from patients who are already receiving it, turning their premium waiver into a premium discount capped at a fixed dollar amount.

² The information about policies in this and the following paragraph was provided by the Rehabilitator to the Commissioner in a December 20, 2019 email and attachments from Laura Lyon Slaymaker to Christopher M. Joyce. The estimated rate increases were calculated based upon that information.

15. Like other jurisdictions in the United States, Massachusetts has an extensive body of law, in both statute and regulation, protecting insurance policyholders by ensuring that they receive the insurance coverage they have been promised, and prohibiting excessive or unfairly discriminatory rate increases. In particular, long-term care insurance rates must be submitted for review by the Commissioner, which includes an actuarial analysis, and increases may not be implemented unless the Commissioner determines that they comply with applicable legal standards. *See* M.G.L. c. 175, § 108, 211 CMR 42.00 and 211 CMR 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.” M.G.L. c. 175, § 108(8)A; *see also Genworth Life Ins. Co. v. Comm’r of Ins.*, 126 N.E.3d 1019, 1023 (Mass. App. Ct. 2019)(affirming the Commissioner’s disapproval of requested long-term care insurance rate increases). The Proposed Plan purports to set aside these laws, and comparable laws in other jurisdictions, and replace them with a process for setting rates on a nationwide basis.

Overarching Regulatory Interests

16. The State Insurance Regulators have a regulatory interest in seeing that contract rights of Maine and Massachusetts policyholders are respected and that the standards and protections of the statutory rate-setting process are honored. The Proposed Plan acknowledges that the policies are structured as “level-premium guaranteed-renewable contracts” and that “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 then same type of policy, and then only if the state regulator approved the increase.” Proposed Plan at 73.

17. The Proposed Plan, however, seeks to restructure the policies and ultimately to discharge certain benefit liability, *see* Proposed Plan at 77, and it expressly seeks to avoid review by Maine and Massachusetts insurance regulators of premium increases and policy modifications, *see* Proposed Plan at 22. It seeks to bind “affected parties (including other state insurance departments)” to the Plan’s “modification of policies and premium rates.” Proposed Plan at 80.

18. The Proposed Plan implicitly 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. *See Foster v. Mutual Fire, Marine and Inland Ins.*

Co., 531 Pa. 598, 613 (1992) (“Under *Neblett [v. Carpenter]*, 305 U.S. 297 (1938)], creditors must fare at least as well under a rehabilitation plan as they would under a liquidation”). The State Insurance Regulators seek to understand how the Plan can comport with this standard in light of the apparently significant premium increases and/or benefit cuts proposed, in particular where those increases or cuts will vary across states. *See* Proposed Plan at 11, 22, 72, and 74.

19. In sum, the Proposed Plan is unprecedented and ignores the long-standing allocation of authority for state insurance regulators to approve or set rates on a state-specific basis. When a Maine or Massachusetts 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. Maine and Massachusetts residents are entitled to the same protection when they buy coverage from a Pennsylvania insurer. The State Insurance Regulators’ concerns in this matter include protecting Maine and Massachusetts residents from unfair and excessive rate increases and unreasonable benefit decreases; and preserving a process for reviewing rate increases and benefit decreases that respects state sovereignty and interstate comity.

Purposes for which Intervention is Sought

20. In these circumstances, the State Insurance Regulators seek limited intervention for the purposes of participating in discovery, participating in and presenting evidence at the hearing, and potentially objecting to the Proposed Plan and appealing from orders entered concerning the Proposed Plan. Evidence may include facts such as those cited in paragraphs 8-9 and 13-14 above demonstrating the effect of the Proposed Plan on policyholders and the differing treatment of policyholders both within a state and across states. The potential objections may include non-compliance with the rate-setting statutes of the various states cited in paragraphs 10 and 15 above and the statutory and constitutional limitations on rehabilitation plans. Intervention is necessary because “the fundamental Plan structure is unlikely to change unless the Court requires it.” Proposed Plan at 11.

21. The State Insurance Regulators are considering and analyzing the factual and legal issues presented by the Proposed Plan. The State Insurance Regulators will file Formal Comments on or before September 15, 2020, in accordance with the schedule set in paragraphs 8 and 9 of the Case Management Order. If permitted to intervene, the State Insurance Regulators will provide information concerning the witnesses and exhibits they intend to introduce at the hearing on or before September 30, 2020 in accordance with the schedule set in paragraph 9 of the Case Management Order. In light of the Case Management

Order's schedule for filings, the provision of Pa.R.A.P. 3775(b) concerning attachment of the document to be filed if intervention is granted does not apply.

Request to Grant Leave to Extend the Time to Intervene

22. If other states determine that a similar intervention in this proceeding is an appropriate process for protecting the interests of their own residents, it would promote efficiency and judicial economy to grant all interested states the option of consolidating their claims in a single intervention. The State Insurance Regulators making this application request further that the Court grant leave to permit other state insurance regulators to join as intervenors with the Maine and Massachusetts insurance regulators, until and including September 15, 2020, or other date set by the Court.

Conclusion

For all of the above reasons, the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance request that the Court (1) grant them intervention in this matter for the limited purpose of participating in the proceedings concerning and potentially opposing the Rehabilitator's Application for Approval of the Proposed Plan and appealing from orders concerning the Proposed Plan, and (2) grant leave to extend the time for other state insurance regulators to join as intervenors together with the Maine and Massachusetts

insurance regulators by application filed with the Court until and including September 15, 2020, or other date set by the Court.

Respectfully submitted,

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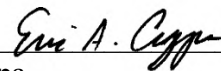
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Counsel to the Maine Superintendent of Insurance and
the Massachusetts Commissioner of Insurance and
Massachusetts Special Assistant Attorneys General

Dated: July 31, 2020

VERIFICATION

I, Eric A. Cioppa, Maine Superintendent of Insurance, hereby state that the facts stated in paragraphs 2, 5, 6–10, 16, and 19–21 above are true and correct to the best of my knowledge, information, and belief. I understand that the statements herein are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities).

Date: July 31, 2020



Eric A. Cioppa
Superintendent of Insurance

VERIFICATION

I, Gary D. Anderson, Commissioner of Insurance of the Massachusetts Division of Insurance, hereby state that the facts stated in paragraphs 2, 5, 11-15, 16, and 19-21 above are true and correct to the best of my knowledge, information, and belief. I understand that the statements herein are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities).

Date: July 31, 2020



Gary D. Anderson
Commissioner of Insurance

PROOF OF SERVICE

I, Stephen G. Harvey, Esq., hereby certify that on this date, I caused a true and correct copy of the foregoing Joint Application for the Intervention of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance and Request to Grant Leave to Extend the Time to Intervene, to be served upon the following and in the manner indicated below:

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Dated: July 31, 2020

PROOF OF SERVICE

I, Stephen G. Harvey, Esq., hereby certify that on this date, I caused a true and correct copy of the foregoing Joint Application for the Intervention of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance and Request to Grant Leave to Extend the Time to Intervene, to be served upon the following and in the manner indicated below:

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Dated: July 31, 2020

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

**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**

Pursuant to Pa.R.A.P. 123, 1531(b) & 3775 and the Court's *Case*

*Management Order for Comments and Hearing on the Proposed Plan of
 Rehabilitation*, dated June 12, 2020 ("Case Management Order"), the Insurance
 Commissioner of the State of Washington ("Washington Commissioner"), by and
 through undersigned counsel, joins in the Joint Application for Intervention of the
 Maine Superintendent of Insurance and the Massachusetts Commissioner of
 Insurance ("Joint Application") and asks that the Court enter an order permitting
 him to intervene along with the Maine Superintendent and the Massachusetts
 Commissioner for the limited purpose of participating in the proceedings
 concerning and potentially opposing the Rehabilitator's *Application for Approval
 of the Plan of Rehabilitation for Senior Health Insurance Company of
 Pennsylvania* as described below.

In support thereof, the Washington Commissioner states as follows:

Background

1. In the Joint Application, the Maine Superintendent and the Massachusetts Commissioner requested that the Court grant leave to extend the time for other state insurance regulators to join as intervenors until and including September 15, 2020 (the formal comment deadline).

2. In the Rehabilitator's Answer to the Joint Application, the Rehabilitator opposed the request to extend time. However, after the Maine and Massachusetts regulators reported in their Further Answer that the Washington Commissioner wished to join in the Joint Application and to intervene, the Rehabilitator filed an Application for Leave to File a Response that attached the Rehabilitator's Response to Answer and Further Answer of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance dated September 4, 2020 ("Rehabilitator's Response").

3. The Rehabilitator's Response states that "[t]he Rehabilitator will not oppose the Washington Commissioner's application to intervene in this proceeding consistent with Paragraph 9 of the Court's June 12, 2020 Case Management Order if such an application is filed prior to the Formal Comment Deadline of September 15, 2020." Rehabilitator's Response at 2 (emphasis added). The Washington Commissioner accordingly files this application to intervene.

Joinder in Joint Application and Request to Intervene

4. The Washington Commissioner hereby joins the Joint Application filed by the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance and requests leave to intervene along with those state regulators. The Washington Commissioner adopts the Joint Application, including the description of regulatory interests and the purposes for intervention and the relief sought therein, and will not repeat what has already been stated in the Joint Application. The Washington Commissioner adds the following with respect to the State of Washington:

Specific Interests of the Applicant

5. The Washington Commissioner has a direct and substantial interest in the Proposed Plan. SHIP was licensed in Washington, and policyholders in the State will be subject to the Proposed Plan, if approved. The Washington Commissioner seeks to intervene for the purpose of better understanding how the Proposed Plan affects those interests and to protect those interests by participating in discovery, participating in and presenting evidence at the hearing, and potentially objecting to the Proposed Plan.

6. The Washington Commissioner enforces state insurance laws and undertakes the duties of regulating insurers. *See* Wash. Rev. Code §§ 48.01.020; 48.02.060.

7. The Washington Commissioner regulates SHIP. SHIP has been licensed in Washington to write long term care insurance since October 20, 1989. Previously, SHIP sought approval from the Commissioner for long-term care policy rate increases in Washington. SHIP made its most recent Washington rate increase requests in September 2018. The Commissioner reviewed this increase in accordance with Washington law, but upon raising multiple substantive legal issues with the company regarding the request, SHIP chose to withdraw the filing, as also occurred with the company's 2016 rate increase request. The last approved rate increase request for SHIP's long-term care business occurred in 2012.

8. The Proposed Plan will affect Washington policyholders. According to data provided to the Commissioner by the Rehabilitator, there were 1,509 Washington policies subject to the Proposed Plan as of November 30, 2019. The average estimated Phase One rate increase for Washington policyholders under the Proposed Plan is 41%. Furthermore, that projected increase is not evenly distributed: 334 policies would have a 30% rate increase; 949 policies would have a rate increase of 40%; 202 policies would have rate increases of 49%; and 24 policies would have rate increases ranging between 88% and 140%.¹

¹ The information about policies in this and the following paragraph was provided by the Rehabilitator to the Commissioner in a December 20, 2019 email. The estimated rate increases were calculated based upon that information.

9. At the time this information was compiled, 96 Washington residents were entitled to “on-claim waiver” of premium, meaning they are not paying premium because they are currently receiving long-term care. Another 252 policies were entitled to “active waiver,” either because the policyholder’s spouse was currently on claim or because the policyholder’s spouse has already died and the terms of the policy entitled the surviving spouse to a lifetime waiver of premium. 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. The Proposed Plan would take this benefit away from patients who are already receiving it, turning their premium waiver into a premium discount capped at a fixed dollar amount.

10. Like other jurisdictions in the United States, Washington has an extensive body of law, in both statute and regulation, protecting insurance policyholders by ensuring that they receive the insurance coverage they have been promised, and prohibiting excessive or unfairly discriminatory rate increases. In particular, long-term care insurance rate increase requests must be submitted for review by the Commissioner, which 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. A long-term care insurance rate increase request may be disapproved by the Commissioner if “the benefits provided therein are unreasonable in relation to the premium charged.” Wash. Rev. Code § 48.18.110. In addition, the Commissioner will deny rates if he finds “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. The Proposed Plan purports to set aside these laws, and comparable laws in other jurisdictions, and replace them with a process for setting rates on a nationwide basis.

Overarching Regulatory Interests

11. As set forth in the Joint Application, the Washington Commissioner and the other State regulators have a regulatory interest in seeing that contract rights of policyholders in their States are respected and that the standards and protections of the statutory rate-setting process are honored. The State Insurance Regulators’ concerns in this matter include protecting their residents from unfair and excessive rate increases and unreasonable benefit decreases; and preserving a

process for reviewing rate increases and benefit decreases that respects state sovereignty and interstate comity.

Purposes for which Intervention is Sought

12. As set forth in the Joint Application, the Washington Commissioner joins the Maine Superintendent and the Massachusetts Commissioner in seeking limited intervention for the purposes of participating in discovery, participating in and presenting evidence at the hearing, and potentially objecting to the Proposed Plan and appealing from orders entered concerning the Proposed Plan.²

13. The State Insurance Regulators, including the Washington Commissioner, will file Formal Comments on or before September 15, 2020, in accordance with the schedule set in paragraphs 8 and 9 of the Case Management Order. If permitted to intervene, the State Insurance Regulators will provide information concerning the witnesses and exhibits they intend to introduce at the hearing on or before September 30, 2020 in accordance with the schedule set in paragraph 9 of the Case Management Order.

² As stated in the Rehabilitator's Response, the Rehabilitator does not oppose limited intervention by Maine and Massachusetts (and now presumably Washington) for the purposes set forth in paragraph 9 of the June 12, 2020 Case Management Order, and the Rehabilitator acknowledges that, should the Court grant limited intervention, "that would necessarily include the right to object to the Proposed Plan and appeal relevant orders concerning the Proposed Plan." Rehabilitator's Response at 3.

Conclusion

For the reasons set forth above and in the Joint Application, the Washington Commissioner requests that the Court grant him intervention along with the Maine Superintendent and the Massachusetts Commissioner for the limited purpose of participating in the proceedings concerning and potentially opposing the Rehabilitator's Application for Approval of the Proposed Plan and appealing from orders concerning the Proposed Plan.

September 15, 2020

Respectfully submitted,

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the Maine Superintendent of Insurance, and
the Massachusetts Commissioner of Insurance and
Washington Special Assistant Attorneys General and
Massachusetts Special Assistant Attorneys General

PROOF OF SERVICE

I, Stephen G. Harvey, hereby certify that on September 15, 2020, I served the foregoing 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 via PACFile system as well as via email upon the following counsel:

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Dated: September 15, 2020

PROOF OF SERVICE

I, Stephen G. Harvey, hereby certify that on September 15, 2020, I served the foregoing 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 via PACFile system as well as via email upon the following counsel:

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Dated: September 15, 2020

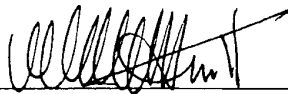
IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

ORDER

AND NOW, this 15th day of September, 2020, upon consideration of the Joint Application for Intervention of the Maine Superintendent 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 above-captioned 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.



 MARY HANNAH LEAVITT, President Judge

Certified from the Record

SEP 15 2020

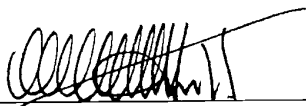
And Order Exit
 SIR App. 568

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

SIR App. 569

VERIFICATION

I, Robert Alan Wake, verify that the documents referenced herein and included in the accompanying appendix at pages SIR App. 9-17, SIR App. 19, and SIR App. 20-21 are true and correct copies of the documents included and referenced. I understand that this verification is made subject to the penalties of 18 Pa. C.S. § 4904 relating to unsworn falsification to authorities.

Dated: November 5, 2021



Robert Alan Wake, General Counsel
Maine Bureau of Insurance

IN THE SUPREME COURT OF PENNSYLVANIA

In Re: Senior Health Insurance Company of : 71 MAP 2021
Pennsylvania (In Rehabilitation) :
:

Appeal of: 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

PROOF OF SERVICE

I hereby certify that this 8th day of November, 2021, I have served the attached document(s) to the persons on the
date(s) and in the manner(s) stated below, which service satisfies the requirements of Pa.R.A.P. 121:

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Harrisburg, PA 17120
Phone: 717--78-7-2567
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Appellee Senior Health Insurance Company of Pennsylvania

Served: Dexter Ryan Hamilton
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IN THE SUPREME COURT OF PENNSYLVANIA

PROOF OF SERVICE

(Continued)

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IN THE SUPREME COURT OF PENNSYLVANIA

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IN THE SUPREME COURT OF PENNSYLVANIA

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/s/ Stephen G. Harvey

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EXHIBIT 6

IN THE SUPREME COURT OF PENNSYLVANIA

No. 71 MAP 2021

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

*Appeal from the Order of the Commonwealth Court Entered on August 24, 2021
in 1 SHP 2020*

**MOTION FOR LEAVE TO FILE BRIEFS AS AMICI CURIAE STATE
INSURANCE REGULATORS
[Identified on Following Page]**

November 12, 2021

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COMMISSIONER
CONNECTICUT INSURANCE DEPARTMENT, BY ANDREW N. MAIS,
COMMISSIONER
IDAHO DEPARTMENT OF INSURANCE, BY DEAN L. CAMERON,
DIRECTOR
DOUGLAS M. OMMEN, INSURANCE COMMISSIONER OF THE STATE
OF IOWA
LOUISIANA DEPARTMENT OF INSURANCE, BY JAMES J. DONELON,
COMMISSIONER
MARYLAND INSURANCE ADMINISTRATION, BY KATHLEEN A.
BIRrane, COMMISSIONER
MISSISSIPPI DEPARTMENT OF INSURANCE, BY MIKE CHANEY,
COMMISSIONER
TROY DOWNING, MONTANA COMMISSIONER OF SECURITIES AND
INSURANCE AND STATE AUDITOR
NEW HAMPSHIRE DEPARTMENT OF INSURANCE, BY
CHRISTOPHER R. NICOLOPOULOS, COMMISSIONER
NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE, BY
MAUREEN CARIDE, COMMISSIONER
HON. RUSSELL TOAL, SUPERINTENDENT OF INSURANCE FOR THE
STATE OF NEW MEXICO
NORTH CAROLINA DEPARTMENT OF INSURANCE,
BY MIKE CAUSEY, COMMISSIONER
NORTH DAKOTA INSURANCE DEPARTMENT, BY
JON GODFREAD, COMMISSIONER
OKLAHOMA DEPARTMENT OF INSURANCE, BY GLEN MULREAY,
COMMISSIONER

[continued on next page]

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SOUTH DAKOTA COMMISSIONER OF INSURANCE, BY LARRY
DEITER, DIRECTOR
UTAH INSURANCE DEPARTMENT, BY JONATHAN T. PIKE,
COMMISSIONER
WISCONSIN OFFICE OF THE COMMISSIONER OF INSURANCE, BY
MARK AFABLE, COMMISSIONER
WYOMING DEPARTMENT OF INSURANCE, BY JEFFREY P. RUDE,
COMMISSIONER**

AND NOW comes the Departments of Insurance, through their regulators, of the nineteen states indicated in the above caption (the “Proposed Amici Curiae State Insurance Regulators”) and respectfully request leave from this Honorable Court to file briefs as amici in this matter (a) supporting the Application for Stay Pending Appeal of the Order (“Order”) Approving the Second Amended Plan (“Plan”) of Senior Health Insurance Company of Pennsylvania (“SHIP”) and/or, if one or more of them deem it to be helpful (b) supporting the position on the merits of this appeal filed by appellants-intervenors 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 (“Appellants”).

The proposed Amici Curiae are the chief insurance regulatory officials for their respective states. The instant appeal involves issues of due process and constitutional importance to proposed amici, policyholders of SHIP, and policyholders of future insurer insolvencies. The state-based system of regulation exists for the protection of insurance policyholders. It is the legislature of each state that establishes policy for the regulation of insurance by enacting appropriate legislation. Only the state 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.

Approval of the Plan by the receivership court does not cure the unconstitutional exercise of authority by the Rehabilitator. The Plan unconstitutionally authorizes the Rehabilitator to set rates in states other than Pennsylvania through imposition of the If-Knew or self-sustaining premium and the consequential reduction of benefits for policyholders in states that refuse to delegate to the Rehabilitator the authority that has been conferred upon state regulators by their legislatures. Courts, including those overseeing rehabilitation proceedings, do not have the authority to set rates different from those filed and approved by each state insurance commissioner. The receivership court's Order conflicts with the insurance laws of the states of the proposed amici that require insurance policy rates to be reviewed and approved by the state's insurance director or designee. By requiring an affirmative opt-out, the Rehabilitator attempts to coerce states into a Plan that they never opted into. While the approved Plan purports to allow the insurance regulator of an opt-out state to approve rates, if the regulator determines

not to approve a rate increase in the amount determined by the Rehabilitator, the Plan will reduce the benefits of the policyholders in that state unless policyholders agree to continue to pay more for less benefits or select a nonforfeiture option. The downgrade of policy benefits for the same or higher premiums is a rate increase.

Proposed Amici Curiae submit that this case presents *res nova* issues of extraordinary national impact and importance for the protection of insurance consumers. Amici believe, as do Appellants, that rehabilitation of SHIP is unlikely, liquidation is inevitable, and the Plan circumvents the guaranty fund system that exists for the very reason to protect policyholders from insurer insolvencies.

It is well-established that the regulation of policy rates and benefits for insurance policies issued in a state is within the exclusive jurisdiction of the insurance regulators of each state. Proposed Amici Curiae State Insurance Regulators believe that this unconstitutional Plan will be sought to be imposed in future insurer insolvencies where the insurance industry attempts avoid its policy obligations to the detriment of policyholders. Proposed Amici Curiae submit that they could be of assistance to this Honorable Court by offering information and analysis on the impact of this decision on the policyholders as well as the laws of

their states that may be useful to the Court in addressing the novel issue before it. The Order that is the subject of this appeal violates the rights of policyholders, the insurance laws of the various states, and attempts to unconstitutionally reject and override the authority reserved to and exercised by the individual states to protect the rights of their policyholders.

WHEREFORE the Proposed Amicus Curiae State Insurance Regulators respectfully request this Honorable Court to allow the filing of briefs amici curiae as referenced above.

Respectfully submitted,

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PUBLIC ACCESS POLICY CERTIFICATE OF COMPLIANCE

It is hereby certified by the undersigned that this filing complies with the provisions of the *Public Access Policy of the Unified Judicial System of Pennsylvania: Case Records of the Appellate and Trial Courts* that require filing confidential information and documents differently than non-confidential information and documents.

November 12, 2021

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I, James J. Lawless, hereby certify that on November 12, 2021, the foregoing document was served via mail or e-mail upon the following counsel:

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IN THE SUPREME COURT OF PENNSYLVANIA

No. 71 MAP 2021

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

*Appeal from the Order of the Commonwealth Court Entered on August 24, 2021 in
1 SHP 2020*

**BRIEF OF AMICI CURIAE STATE INSURANCE REGULATORS
IN SUPPORT OF APPELLANTS' APPLICATION FOR STAY
PENDING APPEAL**

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INTRODUCTION

The Departments of Insurance of the Amici Curiae State Insurance Regulators through their chief insurance regulatory officials having been granted permission by this Honorable Court respectfully submit this Brief as *amici curiae* in support of the Application for Stay filed by Appellants 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, “SIR Appellants”).

STATEMENT OF INTEREST

The Amici Curiae State Insurance Regulators are the statutory insurance regulators in their respective states. Each state regulator is charged with enforcing the insurance laws and regulations affecting policyholders within their respective jurisdiction. The policyholders of Senior Health Insurance Company of Pennsylvania (In Rehabilitation) (“SHIP”) reside in or have policies governed by the laws of each such state.

The Second Amended SHIP Rehabilitation Plan (“Plan”) approved by the Commonwealth Court violates long-standing law and jurisprudence providing that

the regulation of rates for insurance policies issued in a state is within the sole jurisdiction of the insurance regulators of each state of issuance. The Plan directly affects the authority of the Amici State Insurance Regulators and contradicts and is inconsistent with the law governing the jurisdiction and authority of a rehabilitator. The Amici Curiae State Insurance Regulators have a duty to protect the policyholders within their states from the unconstitutional exercise of the authority by the Pennsylvania Rehabilitator. They must maintain and act consistently with the regulatory authority that has been delegated to them by the legislatures of their respective states for the protection of policyholders and reject any attempts by others to exercise that police power.

This brief was prepared by counsel for the Departments of Insurance for the States of South Carolina and Louisiana, was paid for the Departments of Insurance for the States of South Carolina and Louisiana and was reviewed and approved by each of the Amici Curiae State Insurance Regulators. Pursuant to Pa. R.A.P. 531(b)(2), no other person or entity has paid for the preparation of or authored this brief in whole or in part.

ARGUMENT FOR AMICI CURIAE

This Court has broad authority to consider the interests of justice and grant the motion for a stay to ensure the implementation of the Plan does not proceed and render moot SIR Appellants' claims during the pendency of this appeal. The requested stay is necessary to preserve the status quo and prevent irreparable harm to SHIP policyholders and protect Amici Curiae State Insurance Regulators and insurance consumers while this matter proceeds on appeal. The interests in this action are not limited to the 39,000 policyholders of SHIP. Rather, the decision in this matter affects the insurance guaranty fund system – the safety net that protects insurance consumers – the regulation of insurer insolvencies, and the federal adoption of the state-based system of insurance regulation and rate-making.

The Amici Curiae State Insurance Regulators support the Application seeking a stay of the Orders approving the Rehabilitator's Plan. As set forth by SIR Appellants, each state regulator is confronted with the Rehabilitator's impending deadline for state insurance regulators requiring each to make a decision whether on behalf of the policyholders in their states to "opt-out" of the Plan. By design, states are deemed to be in the Plan unless they execute the opt-out

election.

One of the key provisions of the Plan is that the Rehabilitator will submit proposed rate increases and policy modifications to the Commonwealth Court for opt-in states but not to the insurance regulators in the states in which the policies were issued. (Plan, pp. 33-34.) The Rehabilitator will only make rate filings in states where the state regulator makes an opt-out election. Under those circumstances, if the proposed premium rate increase is not granted in full, the benefits of a policyholder under an existing policy will be downgraded or otherwise altered to a benefit level determined by the Rehabilitator that “may include a reduced number of meaningful options for affected policyholders” and “[i]n addition, some policyholders who do not make an election may face involuntary benefit reductions.” (Plan, p. 109.) Rates will be set by the Rehabilitator on a seriatim basis by policyholder; consequently, policyholders in the same state could pay different premium rates based on the benefits in their policies. Whether a state opts-in or opts-out, the Rehabilitator will be setting rates for policyholders in states other than Pennsylvania either directly via the opt-in approach or indirectly via benefit downgrades for states that decide to opt-out.

The approval of policy premiums and policy benefits is one of the principal consumer protection responsibilities of state insurance regulators. This Plan attempts to unconstitutionally usurp that authority under the guise of allowing an “opt-out” state to review and approve a rate application. However, if the opt-out state disapproves the application based on the laws and regulations in its state that it is constitutionally and statutorily bound to follow, its policyholders will pay the price through increased rates or benefit reductions.

In 1945, Congress enacted the McCarran-Ferguson Act, 15 U.S.C. §1011, by which Congress stated the following as a declaration of policy: “Congress hereby declares 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.” Section 1012(a) of the McCarran-Ferguson Act provides that “[t]he business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.” The empowerment of each state with respect to the business of insurance was reinforced by Congress in 1999 with the

enactment of the Gramm-Leach-Bliley Act, 15 U.S.C. § 6701 *et seq.* In that Act, Congress stated that the McCarran-Ferguson Act “remains the law of the United States” and that “the insurance activities of any person...shall be functionally regulated by the States.”

Granting the application for stay will allow this Honorable Court time to thoroughly review (1) this matter of utmost importance to insurance consumers and state insurance regulators and (2) the merits of the other issues regarding the Plan presented on appeal while maintaining the status quo. Therefore, the Amici Curiae State Insurance Regulators respectfully request that SIR Appellants’ Application for a Stay be granted pending the appeal of the Court Order Approving the Second Amended Plan of Rehabilitation.

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I further certify that pursuant to Pa. R. App. P 531(b)3() that this Brief contains no more than 2876 words which is less than the allowable 7000 words.

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Exhibit U

dures impracticable. No harm is done by the presence of such a ground. If needed, it will be important for it to be there ready for use.

645.32 Introductory comment: This section is designed to make rehabilitation a very flexible procedure. It is essential that it be regarded as a management rather than as a legal task. Though it is called a formal proceeding because it begins with a formal petition to a court and a hearing, thereafter it should be essentially informal in operation. The order is formulated to emphasize flexibility and informality, and the rehabilitator is given broad powers. He must act under the supervision of the court, of course, but the court's control should be liberal, not strict, and should be provided without cumbersome procedures.

645.32 REHABILITATION ORDERS. (1) APPOINTMENT OF REHABILITATOR. An order to rehabilitate the business of a domestic insurer, or an alien insurer domiciled in this state, shall appoint the commissioner and his successors in office rehabilitator and shall direct the rehabilitator forthwith to take possession of the assets of the insurer and to administer them under the orders of the court. The filing or recording of the order with any register of deeds in the state imparts the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that register of deeds.

Comment on sub. (1): This subsection makes it clear that publicity is not to be avoided in the formal rehabilitation proceeding. Nor was it avoided under prior statutes.

Because it is a public proceeding, rehabilitation can only work if the rehabilitator pays a good deal of attention to public relations and prevents the "run-on-the-bank" psychology. Rehabilitation may be a futile exercise, if the wrong psychology develops. This danger makes summary proceedings under ss. 645.21 to 645.24 a more desirable alternative when they are appropriate. Rehabilitation, however, is appropriate for insurers in serious difficulty, when the problem is no longer easily correctable, and no choice remains except between rehabilitation and liquidation. Once the commissioner goes beyond fairly simple acts and orders and actually manages a company, the proceeding must be public, and this chapter so provides.

The chapter also makes a more realistic and careful designation of the status of the rehabilitator than does the Uniform Insurers Liquidation Act. That Act contemplates different categories of receivers, but does not adequately distinguish among them. For example, it transfers title to all receivers indiscriminately. However, in a rehabilitation proceeding, the rehabilitator is, in effect, simply the new management of the company and title remains and should remain in the company. From s. 645.33 (2) he gets all the powers of management. If the Uniform Act were followed at this point, the first sentence of sub. (1) would be followed by the sentences that now appear as the 2nd and 3rd sentences in s. 645.42 (1), applying to liquidators. But this chapter distinguishes between the 2 main classes of receivers in accordance with their disparate functions.

(2) ANTICIPATORY BREACH. Entry of an order of rehabilitation shall not constitute an anticipatory breach of any contracts of the insurer.

Comment on sub. (2): The anticipatory breach provision is merely a precaution. The rehabilitator takes over the company as a new manager, and will be able to fulfill all contracts. Sound management practices may sometimes lead him to try to negotiate for the termination of contract rights, however.

645.33 Introductory comment: In this section, the rehabilitator is given only broadly stated powers. In general, this technique is adequate since he simply acts as manager subject to court approval. The analogous section dealing with the powers of the liquidator (645.46) is much more specific. The different nature of the proceeding seems to justify use of more

general language here than for liquidation. Here the rehabilitator is merely made manager; under new management the insurer continues much as before. Rehabilitation must parallel the ordinary processes of management rather than the extraordinary actions in a liquidation.

645.38 POWERS AND DUTIES OF THE REHABILITATOR. (1) SPECIAL DEPUTY COMMISSIONER. The commissioner as rehabilitator shall make every reasonable effort to employ an active or retired senior executive from a successful insurer to serve as special deputy commissioner to rehabilitate the insurer. The special deputy shall have all of the powers of the rehabilitator granted under this section. To obtain a suitable special deputy, the commissioner may consult with and obtain the assistance and advice of executives of insurers doing business in this state. Subject to court approval, the commissioner shall make such arrangements for compensation as are necessary to obtain a special deputy of proven ability. The special deputy shall serve at the pleasure of the commissioner.

Comment on sub. (1): What is needed, if rehabilitation is to succeed, is expert management. It is hoped that the industry can be induced to provide competent men for this purpose as a public service as well as in the self-interest of the industry. If no such person can be obtained, the approach followed in the past is still available. And the new ideal just might work.

The new management concept of rehabilitation is of fundamental importance to set the tone of the rehabilitation process. It is lodged in a seemingly minor part of the statutory structure, but may have far-reaching reverberations. What is important is not the specific powers, but the attitude with which the process is approached.

Once appointed, the special deputy should have great freedom of operation, subject of course to protection of the public by an official bond, and by court and department supervision. But court supervision must be liberal and general, not strict or detailed. The commissioner will be *de jure* rehabilitator; the special deputy *de facto* rehabilitator.

Here the commissioner is merely empowered to consult insurance executives, not obliged to do so. A requirement that he consult them would not mean much if he is not required to follow their advice. It does seem important to urge that he do so, however, and that is the effect of the section. If he ignores sound advice, there is some sanction in loss of prestige with the industry. On the other hand the commissioner is the responsible official and should have the ultimate power to select a special deputy.

(2) GENERAL POWER. Subject to court approval, the rehabilitator may take such action as he deems necessary or expedient to reform and revitalize the insurer. He shall have all the powers of the officers and managers, whose authority shall be suspended, except as they are re-delegated 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. *Comment on sub. (2):* Under the Uniform Insurers Liquidation Act but not under this chapter, the rehabilitator gets title and so is properly described as having the powers of an "owner." Here, he is merely "manager."

Broad and flexible powers are needed. The rehabilitator can obtain early instruction by the court respecting the range of action he may take without specific approval. Compare Virginia s. 38.1-133, where the state corporation commission, when authorized to rehabilitate a company, is given all the power and authority of a court of record and may proceed without court supervision. That seems unrealistic, but court control of the rehabilitation process should be very liberal. Success may depend on the court's understanding of the imperative need for the rehabilitator to have broad discretion and freedom to act quickly. The rehabilitator, not the court, must make the day-to-day decisions.

Exhibit V

5. To Study Administration Experience of Proxy Regulations and Insider Trading Regulations and Make Recommendations (D5) Subcom. Report (Mtg. #21)
(Formerly (D6) Subcom.)

Hon. David O. Maxwell, Chm., Pa.

Refs: 1965 Proc. VOL. I pp. 155-170 (Proxy Regulations)
1965 Proc. VOL. I pp. 175-178 (Stockholder Information Supplement)
1966 Proc. VOL. I pp. 111-120 (Insider Trading Regulations)
1966 Proc. VOL. II pp. 389-394 (Summary and Suggested Revisions)
1968 Proc. VOL. I p. 111
1968 Proc. VOL. II pp. 559-567

6. Future Studies:

A. Uniform Agents License.

B. Model Bill Covering Unsecured Notes.

7. Any other matter submitted for consideration.

LAWS AND LEGISLATION (D) COMMITTEE Report (Mtg. 41)

The Standing (D) Committee on Laws and Legislation met at 10:30 A.M. in Los Angeles in the Santa Monica Room of the Century Plaza Hotel.

The reports of the following Subcommittees were presented.

It was moved that the report of the (D1) Subcommittee To Draft Model Legislation Relating to Insurance Holding Companies be received and adopted by the Committee with the additional recommendation that the Committee express itself as preferring the draft as prepared by the (D1) Subcommittee and the report with the additional recommendation was duly adopted by the Committee. It was then moved that the report be adopted by recommendation as the interim NAIC suggested bill. Motion was duly received and adopted.

The report of the (D2) Subcommittee To Make Recommendations, including drafting of Model Legislation, if necessary, to Regulate Long Term Credit Insurance was received and adopted by the Committee. The (D2) Subcommittee was discharged.

The report of the (D3) Subcommittee To Make Recommendations, including drafting of Model Legislation, if necessary, dealing with Unauthorized Insurers was received and adopted by the Committee.

The report of the (D4) Subcommittee To Study Procedures of Reorganization, Receivership and Liquidation was received and adopted by the Committee. The Subcommittee was discharged.

The report of the (D5) Subcommittee To Study Administration

Experience of the Proxy Regulations and Insider Trading Regulations and to consider suggested revisions was received and adopted by the Committee.

In addition to the reports of the various Subcommittees, two subjects were considered by the Committee for the possible establishment of a Subcommittee for their future study. The subjects were Uniform Agents Licensing and a Model Bill covering Unsecured Notes. Motion was made and adopted that the questions be referred to the Chairman of the Committee for such action as the Chairman considers appropriate.

No further business coming before the Chairman, a motion was received and adopted that the meeting be adjourned.

Hon. David M. Pack, Chm., Tenn.; Hon. C. Eugene Farnam, V.Chm., Mass.; Hon. W. W. Fritz, Alaska; Hon. Allan W. Horne, Ark.; Hon. John F. Bolton, Jr., Ill.; Hon. Lorne R. Worthington, Iowa; Hon. Robert D. Preston, Ky.; Hon. David J. Dykhouse, Mich.; Hon. Thomas C. Hunt, Minn.; Hon. Walter D. Davis, Miss.; Hon. Benjamin C. Neff, Jr., Neb.; Hon. Louis T. Mastos, Nev.; Hon. John A. Durkin, N. H.; Hon. Ralph F. Apodaca, N. M.; Hon. Richard E. Stewart, N. Y.; Hon. James R. Faulstich, Ore.; Hon. David O. Maxwell, Pa.; Hon. Warren E. Dirks, S. D.; Hon. Durwood Manford, Tex.; Hon. C. N. Ottosen, Utah; Hon. Robert J. Shipman, W. Va.; Hon. Robert D. Haase, Wis.; Hon. William G. Walton, Wyo.

To Study Procedures of Reorganization, Receivership and Liquidation
(D4) Subcom. Report
(Mtg. 28)
(Formerly (D5) Subcom.)

The (D4) Subcommittee met at 2:30 P.M., Monday, December 2, 1968 in the Pacific Room of the Century Plaza Hotel. A quorum was present.

The following report to the parent committee was adopted:
"Resolved that the Liquidation Act adopted by the State of Wisconsin be recommended as the basis for model legislation in the various states replacing the current uniform National Association of Insurance Commissioners resolution in this respect and further that this committee now be discharged."

Hon. John F. Bolton, Jr., Chm., Ill. by Donald Karnes; Hon. Allan W. Horne, Ark.; Hon. Benjamin C. Neff, Jr., Neb.; Hon. Louis T. Mastos, Nev.; Hon. Durwood Manford, Tex.; Hon. Robert D. Haase, Wis.

PRESIDENT HOWELL: The motion on the floor is for the adoption of the report. There were two requests that I believe I heard, one that the report of the Industry Advisory Committee as given by Mr. Frost be attached to the report. If there is no objection, I believe that could be done. And there was a request, I believe, from Director Neff.

DIRECTOR NEFF: We can't make it a part of it, Charlie.

PRESIDENT HOWELL: No, but we can attach it. And there was a request by Director Neff that certain assistance of the Central Office be afforded and I see no reason why there should be any objections to that request being carried out. Therefore, we are now at the position of taking a vote on the adoption of the report. It has been moved and seconded that the report of the Laws and Legislation Committee be adopted. All those in favor, say "Aye." Opposed, "No." It is so ordered.

I have one more authorization for voting submitted by Commissioner Short of Delaware, designating Mr. Frank J. De Geeter, Jr., Deputy Commissioner, to represent him in any official capacity in voting at this session. This is the most fancy authorization I have received. It is subscribed and sworn to, with a gold seal and everything, and sworn to before a notary public, and we'll receive that.

RECEIVED

Dec 12 2022

SC Court of Appeals

Certificate of Counsel

The undersigned hereby certifies that the Amended Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

December 12, 2022

/s/ Dakota E. Knehans

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