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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

MARLENE CARIDE, as Commissioner of the New Jersey Department of Banking and Insurance, and THE NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE, Plaintiffs, vs. JESSICA K. ALTMAN, as Rehabilitator of Senior Health Insurance Company of Pennsylvania and her successors in office, in their capacity as Rehabilitator of Senior Health Insurance Company of Pennsylvania, PATRICK H. CANTILO, as Special Deputy Rehabilitator of Senior Health Insurance Company of Pennsylvania, MICHAEL HUMPHREYS, as Successor Rehabilitator of Senior Health Insurance Company of Pennsylvania, and SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, Defendants.	Case No. _____ [formerly Superior Court of New Jersey, Law Division, Civil Part, Mercer County, Docket No. MER-L-000448-22]

NOTICE OF REMOVAL

Defendants Michael Humphreys, Acting Insurance Commissioner of the Commonwealth of Pennsylvania,[1] in his capacity as Rehabilitator of Senior Health Insurance Company of Pennsylvania ("Rehabilitator"); Patrick Cantilo, in his capacity as Special Deputy Rehabilitator of

[1] As Acting Insurance Commissioner of Pennsylvania, Michael Humphreys is the successor to named defendant Jessica K. Altman, the former Insurance Commissioner of Pennsylvania.

Senior Health Insurance Company of Pennsylvania ("SDR"); and Senior Health Insurance Company of Pennsylvania ("SHIP," and, together with the Rehabilitator and SDR, "Defendants") remove this action pursuant to 28 U.S.C. §§ 1332, 1441, and 1446 from the Superior Court of New Jersey, Law Division, Civil Part, in and for Mercer County, New Jersey ("Superior Court"), to the United States District Court for the District of New Jersey.

INTRODUCTION

1. On or about March 9, 2022, Plaintiffs Marlene Caride ("Commissioner Caride") and the New Jersey Department of Banking and Insurance ("DOBI," and, together with Commissioner Caride, "Plaintiffs") filed a Verified Complaint ("Complaint") in the Superior Court, captioned *Marlene Caride, as Commissioner of the New Jersey Department of Banking and Insurance, and the New Jersey Department of Banking and Insurance v. Jessica K. Altman, as Rehabilitator of Senior Health Insurance Company of Pennsylvania and her successors in office, in their capacity as Rehabilitator of Senior Health Insurance Company of Pennsylvania; Patrick H. Cantilo, as Special Deputy Rehabilitator of Senior Health Insurance Company of Pennsylvania; Michael Humphreys, as Successor Rehabilitator of Senior Health Insurance Company of Pennsylvania; and Senior Health Insurance Company of Pennsylvania*, Docket No. MER-L-000448-22.

2. Pursuant to 28 U.S.C. § 1446(d) and Local Rule 5.2(2), copies of all process, pleadings, and orders served to date upon the Defendants and all documents previously filed in state court in this action, including Plaintiffs' Complaint and proposed Order to Show Cause described below, are attached hereto as Exhibits 1.

3. Upon information and belief, copies of the Complaint were sent via email and mail on or around March 9, 2022, but formal service of the Complaint has not yet been effected

4. Also on or around March 9, 2022, Plaintiffs filed a proposed Order to Show Cause. No hearing on the proposed Order to Show Cause was held or scheduled prior to the filing of this Notice of Removal and no order has issued.

5. Plaintiffs captioned their Complaint for the Superior Court of New Jersey, Chancery Division, General Equity Part, but it was accepted, docketed, and tracked by the Superior Court in the Law Division, Civil Part. *See* Assignment, attached as Exhibit 2.

REQUIREMENTS FOR REMOVAL

6. A notice of removal shall be filed within 30 days after service of the initial pleading. 28 U.S.C. § 1446(b).

7. 28 U.S.C. § 1441(a) authorizes removal of any civil action brought in a state court of which the district courts of the United States have original jurisdiction.

8. Original jurisdiction exists pursuant to 28 U.S.C. § 1332 where there is a civil action in which: (a) the action is between citizens of different states; and (b) the amount in controversy exceeds $75,000.00, exclusive of interest and costs. 28 U.S.C. § 1332(a).

9. As set forth below, removal is proper here.

This Notice of Removal Is Timely

10. Upon information and belief, formal service has not yet been effected. This Notice of Removal is therefore being timely filed within thirty days after the service of the Complaint and Summons on Defendants pursuant to 28 U.S.C. § 1446(b).

Complete Diversity Exists Between Plaintiffs and Defendants

11. Upon information and belief, Plaintiffs are citizens of New Jersey for purposes of diversity jurisdiction. Plaintiffs allege that Commissioner Caride is acting "in her capacity as Commissioner of the State of New Jersey" and "maintains her office address at 20 West State

Street, Trenton[,] New Jersey 08625." Compl. at 1, ¶ 6. Plaintiffs further allege that "DOBI is a department within New Jersey State government" and "maintains an office address at 20 West State Street, Trenton, New Jersey 08625." Compl. ¶ 7.

12. Defendants, by contrast, are not citizens of New Jersey for purposes of diversity jurisdiction.

13. Plaintiffs allege that the named defendant Jessica K. Altman, predecessor to Acting Insurance Commissioner Humphreys, is the former Commissioner of Insurance for the Commonwealth of Pennsylvania and maintains her office address in Harrisburg, Pennsylvania. Compl. ¶ 8.

14. Plaintiffs allege that Defendant Michael Humphreys is the Acting Commissioner of Insurance for the Commonwealth of Pennsylvania and is the successor in office to Former Commissioner Altman. Compl. ¶ 9. Acting Insurance Commissioner Humphreys is a resident of Pennsylvania.

15. Plaintiffs allege that Defendant Patrick H. Cantilo is the Special Deputy Rehabilitator of SHIP appointed by the Rehabilitator and maintains his office address in Austin, Texas. Compl. ¶ 10. SDR Cantilo is also a resident of the State of Texas.

16. Finally, Plaintiffs allege that Defendant SHIP is a Pennsylvania-domiciled life and health insurance company, which maintains its principal place of business in Carmel, Indiana. Compl. ¶ 11.

17. Accordingly, there is complete diversity of citizenship between the parties to this action.

The Amount in Controversy Requirement Is Met

18. Pursuant to 28 U.S.C. § 1446(c)(2)(A)(ii), Defendants assert that the amount in controversy exceeds $75,000.00, exclusive of interest and costs.

19. Plaintiffs seek injunctive relief. In such cases, the amount in controversy is "measured by the value of the object of the litigation." *Hunt v. Wash. State Apple Advertising Comm'n*, 432 U.S. 333, 347 (1977); *accord Auto–Owners Ins. Co. v. Stevens & Ricci Inc.*, 835 F.3d 388, 398 (3d Cir. 2016); *see also Angus v. Shiley Inc.*, 989 F.2d 142, 146 (3d Cir. 1993) ("[T]he amount in controversy is not measured by the low end of an open-ended claim, but rather by a reasonable reading of the value of the rights being litigated.").

20. The object of the litigation is the rehabilitation of SHIP pursuant to its court-approved rehabilitation plan, including specifically the premiums paid by and benefits owed to New Jersey policyholders. These amounts in controversy far exceed $75,000.

21. SHIP is a life and health insurance company domiciled in Pennsylvania, and its entire insurance business consists of long-term care insurance ("LTCI") policies. Compl. ¶ 17. Since 2003, the focus of SHIP's business has been running off its LTCI business until there are no policies remaining; it is not writing any new business. *See* Compl. ¶ 18.

22. On January 29, 2020, as a result of its long financial decline, the Commonwealth Court of Pennsylvania ("Commonwealth Court") ordered that SHIP be placed into rehabilitation under the Pennsylvania Insurance Department Act, 40 P.S. §§ 221.1-221.63. *See* Compl. ¶¶ 22-24. No order of insolvency has been entered, but SHIP's deficit at the time of the rehabilitation order exceeded $1 billion. *See* Compl. ¶ 21.

23. At the direction of the Commonwealth Court, the Rehabilitator prepared a rehabilitation plan for SHIP. The Commonwealth Court approved the Second Amended Plan on August 24, 2021 ("Approved Plan"). *See* Compl. ¶ 26.

24. The Rehabilitator, acting under the direction of the Pennsylvania courts, is now implementing that Approved Plan, including through an election package process that may result in modifications to policyholders' premiums or benefits. *See* Compl. ¶¶ 47, 54–55. Plaintiffs' Complaint challenges the Rehabilitator's authority and ability to implement this Approved Plan. *See* Compl. ¶¶ 52, 56.

25. The value of the Rehabilitator's ability to implement the Approved Plan is considerable—including for New Jersey policyholders. For example, Plaintiffs allege that, through the Approved Plan, SHIP seeks to "eliminate a $1.2 billion funding gap . . . by increasing premium revenue and modifying the existing terms of SHIP's 39,000 policies in force, including approximately 592 of said policies in New Jersey." Compl. ¶ 4. And, according to exhibits filed by Plaintiffs, each policyholder could pay thousands of dollars in premiums each year and have coverage exceeding $100,000. *See* Ex. 1, Part 3 to this Notice of Removal at 91 (Troublefield Cert. Ex. 11 at 3).

26. Thus, the cost of complying with the prospective equitable relief sought by the Complaint—that is, refraining from implementing any rehabilitation plan and making any changes to the premiums or benefits of New Jersey SHIP policyholders—easily eclipses $75,000.

27. Further, the Complaint seeks the New Jersey court's intervention in the ongoing rehabilitation proceedings in the Pennsylvania courts, requesting that the court enjoin Defendants from implementing the Approved Plan in the state of New Jersey, or otherwise from affecting New

Jersey policyholders without prior approval by Plaintiffs or the New Jersey court. *See* Compl. ¶¶ 78-80, WHEREFORE p. 19 ¶¶ A, B.

28. The Complaint also seeks a declaratory finding that orders in the Pennsylvania court—including its Supreme Court—are void, unenforceable, and not entitled to full faith and credit. *See* Compl. ¶¶ 59-77, WHEREFORE ¶¶ A-E. Plaintiffs appears to seek to force SHIP into liquidation, thus placing the entire $1 billion deficit, as well as SHIP's assets ($1.4 billion) and all policies and policyholders at issue. Thus, the direct value of the relief Plaintiffs seek also exceeds $75,000.

29. Accordingly, the amount in controversy exceeds $75,000 as required by 28 U.S.C. § 1332(a), and this action is therefore removable to this Court pursuant to 28 U.S.C. § 1441(b).

30. As a result and pursuant to 28 U.S.C. §§ 1332 and 1441, this Court has original jurisdiction over this action by reason of diversity of citizenship and an amount in controversy which exceeds the sum or value of $75,000, exclusive of interest and costs.

31. This action may be removed to this Court by the Defendants pursuant to 28 U.S.C. § 1441(a), which allows for the removal of any civil action brought in a state court of which the District Courts of the United States have original jurisdiction to the district court of the United States for the district and division embracing the place where such action is pending.

Removal Requirements Are Satisfied

32. Defendants are providing notice of the removal of this action to Plaintiffs and to the Superior Court by filing a "Notice of Filing of Notice of Removal" together with a copy of this Notice of Removal in the Superior Court and by serving copies of the same on Plaintiffs pursuant to 28 U.S.C. §1446(d).

WHEREFORE, Defendants respectfully submit and give notice that the above-captioned matter has been properly removed to this Court.

Dated: March 11, 2022

COZEN O'CONNOR
By: */s/ Michael J. Broadbent*
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Attorneys for Defendants

CERTIFICATE OF SERVICE

I hereby certify that on March 11, 2022 the foregoing NOTICE OF REMOVAL, along with the exhibits thereto, was filed with the Clerk of Court using the CM/ECF system and served upon all parties to this action by placing a copy of the same in the United States mail, postage prepaid, addressed as follows:

G. Glennon Troublefield, Esq.
Brian H. Fenlon, Esq.
Sean Kiley, Esq.
CARELLA, BYRN, CECCHI, OLSTEIN,
BRODY & AGNELLO, P.C.
Roseland, New Jersey 07068-1739
(973) 994-1700
Copy by email to GTroublefield@carellabyrne.com, BFenlon@carellabyrne.com, and SKiley@carellabyrne.com

/s/ Michael J. Broadbent
Michael J. Broadbent

EXHIBIT 1

(PART 1)

Civil Case Information Statement

Case Details: MERCER | Civil Part Docket# L-000448-22

Case Caption: MARLENE CARIDE, COMM . DOBI VS COMM. JESSICA K.
Case Initiation Date: 03/09/2022
Attorney Name: SEAN M KILEY
Firm Name: CARELLA BYRNE CECCHI OLSTEIN BRODY & AGNELLO PC
Address: 5 BECKER FARM RD ROSELAND NJ 070681738
Phone: 9739941700
Name of Party: PLAINTIFF : Marlene Caride, Comm. DOBI
Name of Defendant's Primary Insurance Company (if known): None

Case Type: OTHER Order to Show Cause - Declaratory Relief
Document Type: Verified Complaint
Jury Demand: NONE
Is this a professional malpractice case? NO
Related cases pending: NO
If yes, list docket numbers:
Do you anticipate adding any parties (arising out of same transaction or occurrence)? NO

Are sexual abuse claims alleged by: Marlene Caride, Comm. DOBI? NO

Are sexual abuse claims alleged by: NJ Dept. Banking & Ins.? NO

THE INFORMATION PROVIDED ON THIS FORM CANNOT BE INTRODUCED INTO EVIDENCE

CASE CHARACTERISTICS FOR PURPOSES OF DETERMINING IF CASE IS APPROPRIATE FOR MEDIATION

Do parties have a current, past, or recurrent relationship? NO

If yes, is that relationship:

Does the statute governing this case provide for payment of fees by the losing party? NO

Use this space to alert the court to any special case characteristics that may warrant individual management or accelerated disposition:

Do you or your client need any disability accommodations? NO
If yes, please identify the requested accommodation:

Will an interpreter be needed? NO
If yes, for what language:

Please check off each applicable category: Putative Class Action? NO **Title 59?** NO **Consumer Fraud?** NO

I certify that confidential personal identifiers have been redacted from documents now submitted to the court, and will be redacted from all documents submitted in the future in accordance with *Rule* 1:38-7(b)

03/09/2022
Dated

/s/ SEAN M KILEY
Signed

G. Glennon Troublefield, Esq. 042321991
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MARLENE CARIDE, as Commissioner of the New Jersey Department of Banking and Insurance, and THE NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE, Plaintiffs, v. JESSICA K. ALTMAN, as Rehabilitator of Senior Health Insurance Company of Pennsylvania and her successors in office, in their capacity as Rehabilitator of Senior Health Insurance Company of Pennsylvania, PATRICK H. CANTILO, as Special Deputy Rehabilitator of Senior Health Insurance Company of Pennsylvania, MICHAEL HUMPHREYS, as Successor Rehabilitator of Senior Health Insurance Company of Pennsylvania, and SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, Defendants.	SUPERIOR COURT OF NEW JERSEY CHANCERY DIVISION GENERAL EQUITY PART MERCER COUNTY DOCKET NO. MER-C-_____22 Civil Action

Plaintiffs Marlene Caride, in her capacity as Commissioner of the State of New Jersey Department of Banking and Insurance (the "Commissioner"), and the New Jersey Department of Banking and Insurance ("DOBI"), by way of Verified Complaint against defendants Jessica K. Altman, in her capacity as the court appointed Rehabilitator of Senior Health Insurance Company of Pennsylvania ("Altman" or the "Rehabilitator"), and her successors in office, in their capacity as Rehabilitator of Senior Health Insurance Company of Pennsylvania, Michael Humphreys, as Acting Insurance Commissioner of Pennsylvania and successor to Altman, Patrick H. Cantilo, in his capacity as Special Deputy Rehabilitator of Senior Health Insurance Company of Pennsylvania ("Cantilo" or "the Special Deputy Rehabilitator"), and Senior Health Insurance Company of Pennsylvania ("SHIP") (collectively, the "Defendants"), hereby state:

NATURE OF THE ACTION

1. This action is directed to Defendants' violation of New Jersey insurance laws. Despite their acute knowledge of the exclusive authority of Commissioner Caride over entities transacting insurance business in New Jersey, Defendants have attempted to undermine and side-step the express authority granted to Commissioner Caride. Specifically, Defendants have announced plans to, without first obtaining required regulatory approval from New Jersey, raise premium rates and/or reduce benefits rates for long-term care insurance products purchased or held by residents of the State of New Jersey.

2. The exclusive authority of Commissioner Caride and/or DOBI to review, regulate and approve rates for long-term insurance products marketed to residents of the State of New Jersey is undisputed. As the administrator and the Chief Executive Office of DOBI, Commissioner Caride is granted the statutory authority to determine all matters of policy within and to perform, exercise, and discharge the powers and duties of DOBI over the business of insurance within New

Jersey. The mission of DOBI is to, inter alia, regulate the banking, insurance, and real estate industries of New Jersey in a professional and timely manner, protect and educate consumers, and promote the growth, financial stability, and efficiency of these industries. In furtherance of its mission, the New Jersey Legislature has vested exclusive statutory authority in Commissioner Caride and DOBI over long-term care insurance policies issued in New Jersey.

3. Under the authority vested in the Commissioner and DOBI by statute, every long-term care insurance policy or contract, including any application, certificate, rider, or endorsement to be issued or delivered, shall be filed with the Commissioner for prior approval. N.J.S.A. 17B:27E-10. An insurer providing long-term care insurance issued on an individual basis in New Jersey is required to file, for the commissioner's approval, its rates, rating schedule, and supporting documentation demonstrating that it is in compliance with the applicable loss ratio standards of New Jersey. All filings of rates, rating schedules, and supporting documentation shall demonstrate to the satisfaction of Commissioner Caride that the benefits are reasonable in relation to the premium charged and the rates are not excessive, inadequate, or unfairly discriminatory. N.J.S.A. 17B:27E-11.

4. DOBI seeks the immediate intervention of this court to protect the interests of over 500 New Jersey policyholders who risk suffering irreparable harm. The policyholders are senior citizens who have an estimated average age of 89 years old and who purchased long-term care policies from defendant SHIP. The policyholders have paid for their long-term care policies for over 20 years. As part of SHIP's rehabilitation, the Rehabilitator has proposed a plan of rehabilitation. The Rehabilitator's plan's ultimate goal is to, inter alia, eliminate a $1.2 billion funding gap experienced by SHIP by increasing premium revenue and modifying the existing terms of SHIP's 39,000 policies in force, including approximately 592 of said policies in New

Jersey. The Rehabilitator's goal is not to honor SHIP's contractual obligations owed to policyholders, but rather to reduce SHIP's liabilities/deficit, by increasing premium revenue and reducing policyholder benefits. The increased premiums and modification of the benefits selected by the Rehabilitator was done without the approval of DOBI in violation of N.J.S.A. 17B:27E-11.

5. DOBI requests this Court to immediately enjoin Defendants' implementation of the Rehabilitator's plan in New Jersey. This court should enjoin Defendants from undertaking any further communications with New Jersey policyholders and enter an order that voids any Plan elections that were previously made by the policyholders. An injunction of this type will preserve the rights of the New Jersey policyholders as they existed before the Rehabilitator's attempt to implement the Plan.

PARTIES

6. Commissioner Caride is the commissioner of DOBI, and maintains her office address at 20 West State Street, Trenton New Jersey 08625.

7. DOBI is a department within New Jersey State government and is charged by the New Jersey Legislature with the exclusive authority to regulate the business of insurance in New Jersey. DOBI maintains an office address at 20 West State Street, Trenton, New Jersey 08625.

8. Commissioner Altman is the former Commissioner of Insurance for the Commonwealth of Pennsylvania. On January 23, 2022, pursuant to the Order of Rehabilitation (the "Order"), entered by the Commonwealth Court of Pennsylvania, Commissioner Altman was appointed as the Rehabilitator of SHIP. Commissioner Altman maintains her office address at Commissioner of Insurance, Commonwealth of Pennsylvania, 1326 Strawberry Square, Harrisburg, Pennsylvania 17120.

9. Michael Humphreys is the Acting Commissioner of Insurance for the Commonwealth of Pennsylvania and is the successor in office to Commissioner Altman.

10. Cantilo is the Special Deputy Rehabilitator for SHIP who was appointed by Commissioner Altman. Special Deputy Cantilo maintains his office address at Cantilo & Bennett, L.L.P., 11401 Century Oaks Terrace, Suite 300, Austin, Texas 78758.

11. SHIP is a life and health insurance company domiciled in the Commonwealth of Pennsylvania that administers a closed block of long-term care insurance policies. SHIP maintains its office address at 550 Congressional Boulevard, Suite 200, Carmel, Indiana 46032.

JURISDICTION AND VENUE

12. Defendants, as insurers and/or representatives of SHIP, are doing business in New Jersey and have consented to the jurisdiction of the Courts of the State of New Jersey.

13. SHIP has in the past and continues to engage in substantial, continuous, and systematic business with residents of the State of New Jersey. For several years, SHIP marketed, sold, and serviced long-term care policies to New Jersey policyholders having received the approval of the Commissioner of Insurance of DOBI to do so. After it had sold its last long-term care policy to New Jersey policyholders in 2003, SHIP and/or its predecessors, successors, and/or assigns, submitted requests for rate increases to DOBI for approval from approximately 2003 to 2020.

14. Defendants have purposely availed themselves of the privilege of conducting activities within New Jersey, thus invoking the benefit and protection of the laws of the State of New Jersey. Also, because Defendants, as insurers and/or representatives, have entered into contractual relationships with New Jersey policyholders who purchased long-term care policies from SHIP, relative to the authority that the Commissioner granted to SHIP to sell long-term

insurance policies to New Jersey residents, they have reasonably anticipated being subjected to lawsuits in New Jersey.

15. Defendants' actions as set forth herein that occurred within New Jersey has given rise to the causes of action asserted in this Verified Complaint and the jurisdiction of this court.

16. Venue is proper in the Superior Court of New Jersey, Chancery Division, Mercer County, New Jersey.

FACTUAL BACKGROUND AND SUBSTANTIVE ALLEGATIONS

A. SHIP – Long-term Care Business

17. SHIP is a life and health insurance company domiciled in the Commonwealth of Pennsylvania that administers a closed block of long-term care insurance policies. SHIP commenced business on July 5, 1887, as the Home Beneficial Society. By the 1980s, SHIP was known as American Travelers Insurance Company and was primarily writing long-term care insurance policies. It was then acquired by, and merged into, CIHC, Inc., which was a wholly-owned subsidiary of Conseco, Inc. Ex. 1. [1]

18. Upon information and belief, in 2002, Conseco filed a petition for bankruptcy protection, emerged from bankruptcy as CNO Financing Group. By 2003, CNO Financial Group's successor, Conseco Senior Health Insurance Company, ceased writing long-term care insurance policies. Conseco Senior Health Insurance Company has not sold any new policies since 2003. Ibid.

19. In October 2008, Conseco Senior Health Insurance Company changed its name to Senior Insurance Company of Pennsylvania (*i.e.* "SHIP"), and its ownership was transferred from CNO Financial Group to the newly-formed nonprofit Senior Health Care Oversight Trust, which

[1] Reference herein to numbered Exhibits (e.g., "Ex. 1"), are attached to the Troublefield Cert., which is filed simultaneously herewith.

has managed the run-off of SHIP's long-term care insurance business since 2008. At the time SHIP was transferred to the Senior Oversight Trust, SHIP had approximately 165,000 policyholders and approximately $3.2 billion in assets. Ibid.

20. SHIP was licensed in 46 states, including the State of New Jersey. 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. SHIP's policies are approximately thirteen percent (13%) home health care coverage, eighteen percent (18%) facility care coverage (inclusive of nursing homes and/or assisted living facilities), and sixty-nine percent (69%) comprehensive coverage. Upon information and belief, the average age of a SHIP long-term care policyholder is 89 years old and the average age of a policyholder claim is the same. Ibid.

21. SHIP's financial condition deteriorated and required rehabilitation. By 2020, SHIP's assets were $1.4 billion and its liabilities were $2.6 billion, which created the Funding Gap.

B. SHIP's Rehabilitation Proceeding

22. On January 23, 2020, pursuant to Article V of the Insurance Department Act of 1921, Act of May 17, 1921, P.L. 789, as amended, ("Article V"), 40 P.S. § 221.1-221.63, and Rule 3774(c) of the Pennsylvania Rules of Appellate Procedure, Pa. R.A.P. 3774(c), the Rehabilitator filed an application for an order placing SHIP in rehabilitation. The application was filed in the Commonwealth Court of Pennsylvania and titled Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania v. Senior Health Insurance Company of Pennsylvania, Docket No. 1 SHIP 2020, (the "Rehabilitation Proceeding"). Ex. 1.

23. Among other grounds, the Rehabilitator asserted that SHIP committed one or more acts which constitute grounds for rehabilitation as set forth in 40 P.S. § 221.14 and 221.15, in that

SHIP'S most recent annual statement demonstrated that it is statutorily insolvent as defined by 40 P.S. § 221.3 and that its most recent risk-based capital report ("RBC"), indicated that its total adjusted capital is substantially below its mandatory control level RBC, which triggered a "mandatory control level event" as that term is defined in 40 P.S. § 221.1A. SHIP's directors consented to being placed in rehabilitation. Ibid.

24. On January 29, 2020, the Commonwealth Court in the Rehabilitation Proceeding entered an Order of Rehabilitation and appointed the Rehabilitator. The Rehabilitator appointed Cantilo as Special Deputy Rehabilitator. Ex. 2.

25. On April 22, 2020, the Rehabilitator filed a proposed plan of rehabilitation and over the course of several months proposed two amended plans. Ex. 3.

26. On August 24, 2021, the Commonwealth Court in the Rehabilitation Proceeding entered a Memorandum Opinion and Order approving the Plan. Exs. 4 and 5.

27. On September 21, 2021, the State Insurance Regulators filed a direct appeal to the Supreme Court of Pennsylvania of the Commonwealth Court's order approving the Plan. The appeal is titled In re: Senior Health Insurance Company of Pennsylvania (In Rehabilitation) - Appeal of: The Superintendent of Insurance of the State of Maine, Commissioner of Insurance of the Commonwealth of Massachusetts, and Insurance Commissioner of the State of Washington, Docket No. 71 MAP 2021. Ex. 6.

28. On October 1, 2021, the State Insurance Regulators filed a motion in the Rehabilitation Proceeding to stay implementation of the Plan pending the appeal. Ex. 7. The motion was denied.

29. On November 8, 2021, the State Insurance Regulators filed a motion in the Supreme Court of Pennsylvania for a stay pending appeal of, inter alia, the Commonwealth Court's order approving the Plan. Ex. 8.

30. On December 22, 2021, Amici Curiae filed a brief in support of the State Insurance Regulators' appeal of the Commonwealth Court's order approving the Plan. Ex. 9.

31. On January 31, 2022, the Pennsylvania Supreme Court denied the State Insurance Regulators' motion for a stay pending appeal. Ex. 10.

C. Commissioner Caride's Authority

32. The New Jersey Legislature has expressly authorized the commissioner of insurance to be the administrator and chief executive officer of DOBI. N.J.S.A. 17:1-2 and 17:1-15. Among other duties and responsibilities, the commissioner of insurance has the exclusive authority to "perform, exercise, and discharge the functions, powers, and duties of the department through these divisions established by law or as the commissioner deems necessary." N.J.S.A. 17:1-15(c).

33. The New Jersey Legislature has also expressly authorized the commissioner of insurance to "determine all matters of policy within the commissioner's jurisdiction" and to "institute or cause to be instituted the legal proceedings or process necessary to enforce properly and give effect to any of the commissioner's powers or duties; and perform such other functions as may be prescribed by law in this act or by another other law." N.J.S.A. 17:1-15(f) and (g).

34. As to long-term care insurance, the New Jersey Legislature enacted the New Jersey Long-Term Care Insurance Act, N.J.S.A. 17B:27E-1, et seq. (the "Act"). The stated purpose of the Act is to "promote the public interest, to promote the availability of long-term care insurance policies, to protect applications for long-term care insurance from unfair or deceptive sales or

enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage." N.J.S.A. 17B:27E-1.

35. Commissioner Caride is empowered to enforce the Act in New Jersey.

D. Required Filing And Approval

36. Under Section 10 of the Act, long-term care policies, certificates, riders, or endorsements are required be filed with Commissioner Caride for approval. Section 10 of the Act provides:

> Every long-term care insurance policy or contract, including any application, certificate, rider, or endorsement to be issued or delivered in this State shall be filed with the commissioner for prior approval as provided in this section.
>
> [N.J.S.A. 17B:27E-10.]

37. Similarly, Section 11 of the Act provides:

> An insurer providing long-term care insurance issued on an individual basis in this State shall file, for the commissioner's approval, its rates, rating schedule, and supporting documentation demonstrating that it is in compliance with the applicable loss ratio standards of this State. All filings of rates and rating schedules shall demonstrate that the benefits are reasonable in relation to the premium charged and that the rates are not excessive, inadequate, or unfairly discriminatory.
>
> [N.J.S.A. 17B:27E-11.]

38. Under N.J.A.C. 11:4-34.17, premium and benefits under long-term care policies that are subject to the Act are required to be reviewed by Commissioner Caride:

> (a) This section applies to all rates for individual long-term care policies except those covered pursuant to N.J.A.C. 11:4–34.8 and 34.18.

> (b) Premiums and benefits under long-term care insurance policies whose rates are subject to this section shall meet the loss ratio requirements of N.J.A.C. 11:4–18.5.
>
> (c) Carriers shall include with each submission of new or revised rates for individual long-term care insurance an actuarial memorandum which includes anticipated loss ratio, methodology for calculating gross premiums, an explanation and documentation supporting the premium assumptions and the objective basis for any rate differentials. . .
>
> [N.J.A.C. 11:4-34.17].

E. SHIP's Policies In New Jersey

39. As of January 12, 2021, SHIP has approximately 592 active long-term care policies in New Jersey. Of that group of policies, 17 policies were terminated, 523 policies are still in force, and approximately 49 policies are identified as being "NFO" – which means non-forfeiture option and no premium is due.

40. From approximately 2003 to 2019, either SHIP or one its successors and/or assigns submitted requests for rate increases for its long-term care policies issued to New Jersey policyholders. SHIP's requests were either approved, denied or withdrawn. On August 26, 2019, SHIP filed its last application for a rate increase with DOBI. On March 13, 2020, SHIP withdrew that request. See Certification of Gale Simon, dated March 8, 2022 ("Simon Cert."), Exhibit A.

F. SHIP, The Rehabilitator, And The Plan

41. SHIP is insolvent. Because SHIP is insolvent, a liquidation would inevitably result in the triggering of the state life and health insurance guaranty associations ("GA's") if SHIP cannot be successfully rehabilitated. Mandatory triggers of guaranty association benefits include an insurer being placed in liquidation with a finding of insolvency. Once "triggered," GA's commence the payment of policy benefits. The GA's generally provide for the continuation of insurance coverage provided by the failed insurer, up to the statutory maximum coverage amounts.

Unlike GA's in other states, New Jersey does not have a limit or "cap" on what benefits will be paid to health insurance policyholders, including long-term care insurance policyholders. The benefits recoverable from LHIGA are subject to the policy limits. In addition, under the LHIGA, each provider receiving payments from the guaranty association must agree to a 20% discount pursuant to N.J.S.A. 17B:32A-3(e) as follows:

> A provider of health care services, in order to receive payment directly from the association upon a claim of the provider against an insured, shall agree to forgive the insured of 20% of the obligation which would otherwise be paid by the insurer had it not been insolvent. The obligations of solvent insurers to pay all or part of the covered claim are not diminished by the forgiveness provided in this paragraph. The association is not bound by an assignment of benefits executed with respect to the coverage provided by the insolvent insurer. The association may aggregate all claims owed health care providers when negotiating direct payment of claims of all covered individuals.
>
> [N.J.S.A. 17B:32A-3(e)].

42. After the GA's are triggered, the liquidator and the GA's work together to make loss adjustment on claims. The GA becomes a creditor of the liquidation estate and can submit a claim to the liquidation estate for the loss adjustment expense. GA's also receive all ongoing policy premiums once triggered. See N.J.S.A. 17B:32A-7(g). The GA's use the premium and estate assets to fulfill, in part, their obligations to policyholders. The GA's supplement those amounts by making assessments on their member insurance companies.

43. In a liquidation, virtually all of SHIP's long-term care insurance policies would be covered by the state guaranty association system, subject to the individual state statutory conditions and limits. Thus, if SHIP is placed into liquidation because of its insolvency, the SHIP long-term care policies purchased by New Jersey residents would be covered by New Jersey's guaranty association. Because New Jersey does not have statutory limits on its guaranty

association with respect to benefits paid to health insurance policyholders, New Jersey policyholders would be in a better position if SHIP is liquidated than they would be if the plan of rehabilitation is implemented.

44. Rather than deem SHIP insolvent, the Rehabilitator has proposed the Plan as a means of curing SHIP's insolvency. Through the Plan, the burden of reducing the Funding Gap rests exclusively on SHIP's current policyholders who have not taken non-forfeiture options, i.e. the premium paying policyholders. The Plan does not involve any financial assistance from guaranty associations. This strategy reflects a policy judgment by the Rehabilitator not to spread the burden of SHIP's insolvency through the guaranty association system but rather to place the burden solely on the backs of elderly policyholders through higher premiums or reduced benefits. The Rehabilitator has chosen to burden the elderly policyholders even though they paid premiums for years, which contractually guaranty their benefits under their policy and are supposed to be protected by guaranty association support in the event of company insolvency.

45. The Rehabilitator knew or should have known that implementation of the Plan has left its mostly elderly policyholders with no option but to accept this ultimatum. Because of their age, the elderly policyholders do not have the option to obtain a new long-term care policy from a different carrier. Their advanced age makes them uninsurable based on present industry standards associated with long-term care policy products offered in the life and health insurance market. As a result, the elderly policyholders have no choice but to either accept paying increased premiums or accept reduce benefits if they want to keep their long-term care policy from SHIP. That is patently unfair to the elderly policyholders. They faithfully paid their premiums over 20 years and, frankly, did nothing wrong. Now, at the time when they will need their contractually guaranteed long-term care policy benefits, they have to accept less than what their paid for because of SHIP's

insolvency. Worst yet, even though the guaranty association system exists in each state, including New Jersey, to protect the interests of the elderly policyholders, the Rehabilitator has chosen to ignore that option. The Rehabilitator would rather require the elderly policyholders to pay more money or receive less premiums under the Plan for the sole purpose of curing the Funding Gap. That is unfair to the elderly policyholders who have timely paid their premiums for over 20 years and unacceptable to DOBI.

46. The Plan is implemented in three phases. Phase One, which began immediately upon the Commonwealth Court's approval of the Plan, is the principal phase through which the Rehabilitator seeks to reduce or eliminate the Funding Gap. Ex. 5.

47. In Phase One, policyholders whose premiums are below the "If Knew" premium level will be required to elect among options to modify premiums and/or benefits. 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. Policyholders whose current premium (including the premium they would be paying but for a premium waiver) falls below the If Knew Premium rate for the policy's benefits are required to select among five options. Option 1 ("downgrade") reduces benefits to the level supported by current premium on an If Knew Premium basis. Option 2 is a "basic policy endorsement" with reduced benefits. Option 2(a) is an "enhanced basic policy" with somewhat smaller benefit reductions. Option 3 is "non-forfeiture option" or "NFO" with reduced benefits and no future premium. Option 4 is the current policy with premiums increased to If Knew levels.

48. Phase Two is intended to address the Funding Gap remaining after Phase One through further premium increases or benefit cuts largely based on Self-sustaining Premium. Phase Two will not affect policyholders who selected Options 2 or 3 in Phase One. Policyholders who

choose Options 1 or 4 in Phase One face the possibility of additional substantial rate increases or benefit reductions in Phase Two. The substance of Phase Two is otherwise unknown, as the Plan does not specify all remedial measures that may be applied to policyholders in Phase Two and provides for an "alternative premium structure." The alternative premium structure is a "placeholder," and the Rehabilitator does not know what it would be.

49. Phase Three will run-off the long-term care business in force.

50. Policyholder elections under the Plan will be permanent. If SHIP is placed in liquidation after the Plan is implemented, the policies to which the guaranty association coverage will apply will be those as modified under the Plan. The modified policies will also be the basis for distribution from the liquidation estate. Accordingly, the total policy obligations will be reduced by the elections made by policyholders during implementation of the Plan.

51. State insurance regulators other than Pennsylvania were given the option under the Plan to either 'opt in' or 'opt out'. By letter dated September 30, 2021, the Rehabilitator communicated this option to Commissioner Caride. Simon Cert., Exhibit B. A state which opts out is one that elects to make its own determinations as to modifications of premium rates. Ibid. If a state opts in, the state agrees that the Rehabilitator may make rate increases and benefit changes to that state's policyholders (pursuant to the Plan). If a state opts out, then the Rehabilitator will file a premium rate application for all policies below the If Knew premium. If a state denies the requested premium or approves only a lower premium, the Rehabilitator will then unilaterally adjust the benefits to the level that is determined to be appropriate.

52. Commissioner Caride disagreed that the Rehabilitator had the unilateral right or ability to alter benefits or premium rates for New Jersey policyholders without her approval. By letter dated November 9, 2021, Commissioner Caride rejected the options presented to her by the

Rehabilitator in the September 20, 2021 letter. Simon Cert., Exhibit C. In her letter, Commissioner Caride stated:

> [G]iven that rate regulation has long been reserved to the insurance commissioners of each state, the purpose of this letter is to notify you that (a) the Department will not respond to the Notice, and (b) the Department does not believe the Rehabilitator has authority to impose rate increases on our policyholders without the Department's approval.

Ibid.

53. Commissioner Caride further stated to the Rehabilitator that DOBI objects to the Plan, as expressed by State Insurance Regulators. Ibid.

54. In late January 2022, the Rehabilitator mailed "Coverage Election Packages" to New Jersey policyholders which contained the options referred to in the Plan.

55. On February 2, 2022, the Commonwealth Court approved SHIP's use of nationwide-premium rates including New Jersey. The "Coverage Election Packages" do not provide legally sufficient notice to New Jersey policyholders of SHIP's proposed rate increases, which have not been approved by Commissioner Caride. If a New Jersey policyholder does not make an option election by March 15, 2022, SHIP will on its own elect the basic policy coverage option for the non-responding policyholder, resulting in a significant benefit reduction under a New Jersey insurance policy. Ex. 11.

56. Neither the laws of Pennsylvania, nor proceedings under the laws, nor the full faith and credit clause of the United States Constitution supersede or nullify the Constitution and laws of New Jersey. Nor do they command that New Jersey, DOBI or Commissioner Caride implement any rehabilitation plan which violates or contravenes New Jersey law.

57. As a direct and proximate result of their conduct as aforesaid, Plaintiffs have suffered and will continue to suffer immediate and irreparable harm.

58. Defendants' conduct as aforesaid was intentional, willful, and malicious and designed to inflict immediate and irreparable harm upon plaintiffs.

COUNTS

FIRST COUNT
(Declaratory Judgment)

59. Plaintiffs repeat and re-allege all allegations above as if fully set forth at length herein.

60. The Declaratory Judgments Act, N.J.S.A. 2A:16-51, et seq., authorizes courts to declare the rights, status and other legal relations so as to afford litigants relief from uncertainty and insecurity.

61. Defendants are currently implementing the Plan pursuant to an order that disregards New Jersey law. The order approving the Plan was entered by the Commonwealth Court, which has no jurisdiction over New Jersey, DOBI or Commissioner Caride.

62. The Commonwealth Court's authority over SHIP does not give the Rehabilitator appointed by that court with authority over DOBI or Commissioner Caride.

63. The Commonwealth Court's authority over SHIP does not give the Rehabilitator the authority over the laws or legislature of New Jersey.

64. The Rehabilitator, who stands in the shoes of SHIP, does not have authority to change the rates and benefits of SHIP's long-term care policies in New Jersey without compliance with New Jersey law.

65. Upon information and belief, Defendants seek to enforce the Plan on New Jersey policyholders. However, under the McCarren-Ferguson Act, the Act, and the Police Powers of

New Jersey, New Jersey has the exclusive authority and right to govern the business of insurance in New Jersey.

66. The New Jersey Legislature created DOBI for the purpose of, inter alia, regulating the business of insurance in New Jersey.

67. Under N.J.S.A. 17B:27E-10 and -11, the New Jersey Legislature empowered DOBI with the exclusive authority to regulate long-term care policies in New Jersey. Pursuant to those statutory sections, Commissioner Caride has a duty and is empowered to review and approve any changes to premiums and benefits for long-term care policies purchased by residents of New Jersey.

68. DOBI and Commissioner Caride's exclusive authority extends to and covers SHIP long-term policies purchased by residents of or issued in New Jersey.

69. The Rehabilitator's premium increases or benefit changes to SHIP's long-term care policies under the Plan, that were purchased by New Jersey policyholders, were required to be with the review and approval of DOBI and Commissioner Caride.

70. An actual controversy exists between Commissioner Caride and Defendants regarding Defendants' plans and actions to implement and enforce the Plan in New Jersey.

71. Commissioner Caride in her oversight and regulatory role has a significant interest in obtaining a judicial declaration that the actions taken by Defendants by seeking to implement the Plan in New Jersey, violate the Act.

72. Commissioner Caride is standing in the shoes of all New Jersey policyholders who purchases long-term care policies from SHIP.

73. Commissioner Caride has the duty and is empowered to protect the interests of New Jersey policyholders from Defendants' conduct.

74. Accordingly, Plaintiffs seek a declaratory judgment form this Court that any order entered in Pennsylvania by the Commonwealth Court, which grants Defendants' authority to impose unilateral premium increases and policy modifications on SHIP's New Jersey policyholders is void.

75. Plaintiffs also seek a declaratory judgment from this Court that any unilateral premium increases and policy modifications on SHIP's New Jersey policyholders pursuant to the Plan is void.

76. Plaintiffs further seek a declaratory judgment from this Court that any action by the Defendants to implement the Plan in New Jersey is void.

77. The declaratory judgments sought in this action will ensure that Plaintiffs can perform their statutory duties and faithfully execute the insurance laws of New Jersey without interference by Defendants.

WHEREFORE, Plaintiffs seek the entry of a declaratory judgment:

A. Declaring that any order or decree entered in the Rehabilitation Proceeding or that is entered by the Pennsylvania Supreme Court that approves the Plan or any other SHIP rehabilitation Plan and/or that purports to grant Defendants the authority to impose long-term care insurance premium increases or changes to policy benefits on SHIP's New Jersey policies without the approval of Commissioner Caride is void and unenforceable in New Jersey.

B. Declaring that any order or decree entered in the Rehabilitation Proceeding or by the Pennsylvania Supreme Court purporting to compel New Jersey SHIP policyholders to comply with the Plan, or any other SHIP rehabilitation plan, is not enforceable in New Jersey.

C. Declaring that Defendants must comply with the insurance rate making laws and regulations of New Jersey if they seek to implement the Plan, or any other SHIP rehabilitator plan,

in New Jersey.

D. Declaring that Defendants may not implement any provisions of the Plan, or any other SHIP rehabilitation plan, that would allow Defendants to modify SHIP long-term care insurance premium rates or benefits for New Jersey policyholders without first complying with the insurance laws and regulations of New Jersey.

E. Declaring that Defendants' communications with New Jersey policyholders to implement the Plan, which results in any changes to their policy premiums or benefits, are void and not enforceable.

SECOND COUNT
(Injunctive relief)

78. Plaintiffs repeat and re-allege all of the above allegations in the Complaint as if fully set forth at length herein.

79. As a direct result of Defendants' conduct, Plaintiffs and New Jersey policyholders have suffered irreparable harm because of: (a) Defendants' actions to knowingly and intentionally avoid complying with the express statutory authority of Commissioner Caride to review and approve in advance any changes to rates, rating schedules, and benefits associated with long-term care policies issued by SHIP; (b) Defendants' actions to communicate with existing New Jersey policyholders who purchased long-term care policies from SHIP and/or one of its predecessors, successors, or assigns; (c) unauthorized solicitation of existing New Jersey policyholders who have chosen an option to modify the terms and conditions of their long-term care policy purchased from SHIP and/or one of its predecessors, successors, or assigns; and (d) implementation of the Second Amended Plan without obtaining the advance review and approval of Commissioner Caride.

80. As a result of Defendants' conduct, New Jersey policyholders have been or might be in the future lured into selecting options/changes to the rates, rating schedule, and benefits

associated with their long-term care policies issued by SHIP and/or one of its predecessors, successors, or assigns, who become locked in to those changes, notwithstanding the fact that the rates, rating schedule, and benefits to be modified by the Second Amended Plan were not previously submitted to Commissioner Caride for review and approval.

WHEREFORE, Plaintiffs seek the following relief against Defendants and any of their agents, servants, employees, successors, assigns and those persons acting in concert and participation therewith:

1. Temporary Restraints and Preliminary Injunction:

A. On the First and Second Counts of Plaintiffs' Verified Complaint, enjoining Defendants from communicating, implementing, or enforcing the Plan in the State of New Jersey, or otherwise interfering with the rights of SHIP's long-term care insurance policyholders in New Jersey or otherwise violating the insurance laws of the state of New Jersey, including, but not limited to, by offering any rates, forms, riders, or policy documents to any New Jersey SHIP policyholders that have not been previously authorized and approved by the Commissioner Caride.

B. On the First and Second Counts of Plaintiffs' Verified Complaint, enjoining Defendants and any of their respective principles, agents, employees, successors, and assigns from implementing the Plan including, any action to: (a) soliciting New Jersey policyholder elections of rates/premiums or benefits associated with the Election Coverage Packages or the Plan, to modify rates/premiums, rating schedules, and/or benefits associated with any long-term care policies purchased by New Jersey residents from SHIP, or any of its predecessors, or successors, (b) to implement the change to exiting rates/premiums, rating schedule and benefits of long-term care policies, purchased by New Jersey policyholders from SHIP, or any of its predecessors or successors, who have previously selected an option or an election in response to a solicitation from

Defendants, and (c) to make an endorsement to any term or condition of any long-term care policies purchased by any New Jersey policyholder from SHIP or any of its predecessors or successors.

C. On the First through the Fifth Counts of Plaintiffs' Verified Complaint, enjoining Defendants and any of their respective principles, agents, employees, successors, and assigns from altering, encumbering, or diminishing the rights and benefits of any New Jersey SHIP policyholders, in whole or in part, until and unless all policy forms, contractual changes, rate increases, and policyholder options offered by Defendants are approved by the Commissioner in accordance with the laws of the State of New Jersey, and/or until subsequent order of this Court;

D. On the First through the Fifth Counts of Plaintiffs' Verified Complaint, entering an order to provide that violations of the injunction may subject Defendants not only to appropriate action of the Court but to assessments by DOBI of administrative fines against SHIP and suspension or revocation of any licenses or certificates of authority granted to SHIP.

2. Final Judgment

A. On the First and Second Counts of Plaintiffs' Verified Complaint, enjoining Defendants from communicating, implementing or enforcing the Plan in the State of New Jersey, or otherwise interfering with the rights of SHIP long-term care insurance policyholders in New Jersey or those policies issued pursuant to New Jersey law or otherwise violating the insurance laws of the state of New Jersey, including, but not limited to, by offering any rates, forms, riders, or policy documents to any New Jersey SHIP policyholders that have not been previously authorized and approved of by the Commissioner Caride

B. On the First and Second Counts of Plaintiffs' Verified Complaint, enjoining Defendants and any of their respective principles, agents, employees, successors, and assigns from

implementing the Plan including, any action to: (a) solicit New Jersey policyholder elections of rates/premiums or benefits associated with the Election Coverage Packages or the Plan, to modify rates/premiums, rating schedules, and/or benefits associated with any long-term care policies purchased by New Jersey residents from SHIP or any of its predecessors or successors; (b) to implement the change to exiting rates/premiums, rating schedule, and benefits of long-term care policies, purchased by New Jersey policyholders from SHIP or any of its predecessors or successors, who have previously selected an option or an election in response to a solicitation from Defendants; and (c) to make an endorsement to any term or condition of any long-term care policies purchased by any New Jersey policyholder from SHIP or any of its predecessors or successors.

C. On the First and Second Counts of Plaintiffs' Verified Complaint, enjoining Defendants and any of their respective principles, agents, employees, successors, and assigns from altering, encumbering, or diminishing the rights and benefits of any New Jersey SHIP policyholders, in whole or in part, until and unless all policy forms, contractual changes, rate increases, and policyholder options offered by Defendants are approved by the Commissioner in accordance with the laws of the State of New Jersey, and or until subsequent order of this Court;

D. On the First and Second Counts of Plaintiff's Verified Complaint, taking any action in furtherance of their expressed plans to, without first obtaining required regulatory approval from Commissioner Caride, raise premium rats and/or reduce benefits under certain binding contracts of long-term care insurance policies issued in New Jersey or held by residents of New Jersey, including but not limited to, notifying policyholders of proposed rate or benefit changes or requesting that they select rates or benefits different than those authorized by DOBI and called for

under the terms of the contract, charging additional premiums or withholding, delaying or encumbering benefits in whole or in part.

E. On the First and Second Counts of Plaintiff's Verified Complaint, taking any action in furtherance of their expressed plans to, without first obtaining required regulatory approval from Commissioner Caride, raise premium rats and/or reduce benefits under certain binding contracts of long-term care insurance issued in New Jersey or held by residents of New Jersey, including but not limited to, notifying policyholders of proposed rate or benefit changes or requesting that they select rates or benefits different than those authorized by DOBI and called for under the terms of the contract, charging additional premiums or withholding, delaying or encumbering benefits in whole or in part.

F. On the First and Second Counts of Plaintiffs' Verified Complaint, entering an order to provide that violations of the injunction may subject Defendants not only to appropriate action of the Court but to assessments by DOBI of administrative fines against SHIP and suspension or revocation of any licenses or certificates of authority granted to SHIP.

G. Awarding Plaintiffs' counsel fees and costs.

H. Awarding Plaintiffs' pre and post judgement interest.

I. Granting such further relief as the court deems equitable and just.

DESIGNATION OF TRIAL COUNSEL

Pursuant to R. 4:25-4, notice is hereby given that G. Glennon Troublefield, Esq., is designated as Plaintiffs' trial counsel.

Dated: March 9, 2022

CARELLA, BYRN, CECCHI, OLSTEIN, BRODY & AGNELLO, P.C.

/s/ *G. Glennon Troublefield*
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CERTIFICATIONS PURSUANT TO RULE 4:5-1 AND R. 1:38-7(B)

I certify that this matter in controversy or facts related thereto are not the subject of any other action pending in any court or of a pending arbitration. I further certify that, at this time, Plaintiffs know of no other parties that should be joined in this action.

I certify that confidential personal identifiers have been redacted from documents now submitted to the court, and will be redacted from all documents submitted in the future.

Dated: March 9, 2022

CARELLA, BYRN, CECCHI, OLSTEIN, BRODY & AGNELLO, P.C.

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CERTIFICATION OF VERIFICATION

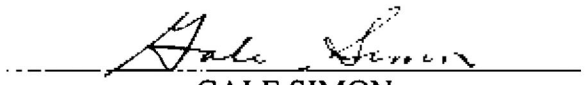
I, GALE SIMON, of full age, hereby certify the following:

1. I am the Assistant Commissioner, Consumer Protection Services, for plaintiff the New Jersey Department of Banking and Insurance ("DOBI").

2. I have read the Verified Complaint, the factual contents, and the factual statements contained therein. The factual content and statements contained in the Verified Complaint are known by me to be true based upon my personal knowledge of the files maintained by DOBI regarding this matter.

3. I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Dated: March 9, 2022



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MARLENE CARIDE, As Commissioner of the New Jersey Department of Banking and Insurance, and THE NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE, Plaintiffs, v. JESSICA K. ALTMAN, as Rehabilitator of Senior Health Insurance Company of Pennsylvania and her successors in office, in their capacity as Rehabilitator of SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, PATRICK H. CANTILO, as Special Deputy Rehabilitator of Senior Health Insurance Company of Pennsylvania, MICHAEL HUMPHREYS, as Successor Rehabilitator of Senior Health Insurance Company of Pennsylvania, and SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, Defendants.	SUPERIOR COURT OF NEW JERSEY CHANCERY DIVISION GENERAL EQUITY PART MERCER COUNTY DOCKET NO. MER-C-_____22 Civil Action

THIS MATTER being brought before the court by Carella, Byrne, Cecchi, Olstein, Brody & Agnello, P.C. (G. Glennon Troublefield, Esq., appearing), attorneys for Plaintiffs, Marlene Caride, in her

capacity as Commissioner of the New Jersey Department of Banking and Insurance ("Commissioner Caride"), and the New Jersey Department of Banking and Insurance ("DOBI"), pursuant to R. 4:52 based upon the facts set forth in the Verified Complaint, the Certification of Assistant Commissioner, Gale Simon, and the Certification of G. Glennon Troublefield filed herewith; and it appearing that Defendants, Jessica K. Altman, in her capacity as the court appointed Rehabilitator of Senior Health Insurance Company of Pennsylvania ("Altman" or the "Rehabilitator"), and her successors in office, in their capacity as Rehabilitator of Senior Health Insurance Company of Pennsylvania, Patrick H. Cantilo, in his capacity as Special Deputy Rehabilitator of Senior Health Insurance Company of Pennsylvania ("Cantilo" or "the Special Deputy Rehabilitator"), Michael Humphreys, as Successor Rehabilitator of Senior Health Insurance of Pennsylvania, and Senior Health Insurance Company of Pennsylvania ("SHIP"), (collectively, the "Defendants"), having received notice of this application; and for good cause having been shown;

It is on this _____ day of _____, 2022,

ORDERED as follows:

1. Defendants, and any of their respective principles, agents, employees, successors, and assigns, shall appear and show cause before the Superior Court of New Jersey at the Mercer County Courthouse, 175 South Broad Street, Trenton, New Jersey 08650 at 9 o'clock in the forenoon, or as soon thereafter as counsel can be heard, on the _____ day of _____, 2022, why an order should not be issued preliminarily enjoining and restraining Defendants and any of their respective principles, agents, employees, successors, assigns, and those persons acting in concert or participation therewith from:

A. On the First and Second Counts of Plaintiffs' Verified Complaint, enjoining Defendants from communicating, implementing, or enforcing the Second Amended Rehabilitation Plan (the "Plan") in the State of New Jersey, or otherwise interfering with the rights of SHIP's long-term care insurance policyholders in New Jersey or otherwise violating the insurance laws of the state of New Jersey, including, but not limited to, by offering any rates, forms, riders, or policy documents to any New Jersey SHIP policyholders that have not been previously authorized and approved by Commissioner Caride.

B. On the First and Second Counts of Plaintiffs' Verified Complaint, implementing the Plan, including, any action to: (a) solicit New Jersey policyholder elections of rates/premiums or benefits associated with the Election Coverage Packages or the Plan, to modify rates/premiums, rating schedules, and/or benefits associated with any long-term care policies purchased by New Jersey residents or issued pursuant to New Jersey law from SHIP or any of its predecessors or successors, (b) to implement the change to exiting rates/premiums, rating schedules, and benefits of long-term care policies, purchased by New Jersey policyholders or issued pursuant to New Jersey law from SHIP or any of its predecessors or successors, who have previously selected an option or an election in response to a solicitation from Defendants, and (c) to make an endorsement to any term or condition of any long-term care policies purchased by any New Jersey policyholder or issued pursuant to New Jersey law from SHIP or any of its predecessors or successors.

C. On the First and Second Counts of Plaintiffs' Verified Complaint, altering, encumbering, or diminishing the rights and benefits of any New Jersey SHIP policyholders or those policies issued pursuant to New Jersey law, in whole or in part, until and unless all policy forms, contractual changes, rate increases, and policyholder options offered by Defendants are

approved by Commissioner Caride in accordance with the laws of the state of New Jersey, and or until subsequent order of this Court;

D. On the First and Second Counts of Plaintiffs' Verified Complaint, taking any action in furtherance of their expressed plans to, without first obtaining required regulatory approval from Commissioner Caride, raise premium rates and or reduce benefits under certain binding contracts of long-term care insurance issued in New Jersey or held by residents of New Jersey, including, but not limited to, notifying policyholders of proposed rate or benefit changes, requesting that they select rates or benefits different than those authorized by DOBI and called for under the terms of the contract, charging additional premiums, or withholding, delaying, or encumbering benefits in whole or in part.

E. Awarding Plaintiffs counsel fees and costs.

F. Granting such further relief as the court deems equitable and just.

IT IS FURTHER ORDERED

2. That pending the return date herein, Defendants and any of their respective principles, agents, employees, successors, assigns, and those persons acting in concert or participation therewith are temporarily enjoined and restrained from:

A. On the First and Second Counts of Plaintiffs' Verified Complaint, enjoining Defendants from communicating, implementing, or enforcing the Plan in the State of New Jersey, or otherwise interfering with the rights of SHIP's long-term care insurance policyholders in New Jersey or those policies issued pursuant to New Jersey law or otherwise violating the insurance laws of the state of New Jersey, including, but not limited to, by offering any rates, forms, riders, or policy documents to any New Jersey SHIP policyholders that have not been previously authorized and approved by Commissioner Caride.

B. On the First and Second Counts of Plaintiffs' Verified Complaint, implementing the Plan including, any action to: (a) solicit New Jersey policyholder elections of rates, premiums, or benefits associated with the Election Coverage Packages or the Plan, to modify rates, premiums, rating schedules, and or benefits associated with any long-term care policies purchased by New Jersey residents or issued pursuant to New Jersey law from SHIP or any of its predecessors or successors, (b) to implement the change to exiting rates, premiums, rating schedules, and benefits of long-term care policies, purchased by New Jersey policyholders or issued pursuant to New Jersey law from SHIP or any of its predecessors or successors, who have previously selected an option or an election in response to a solicitation from Defendants, and (c) to make an endorsement to any term or condition of any long-term care policies purchased by any New Jersey policyholder or issued pursuant to New Jersey law from SHIP or any of its predecessors or successors.

C. On the First and Second Counts of Plaintiffs' Verified Complaint, altering, encumbering, or diminishing the rights and benefits of any New Jersey SHIP policyholders, in whole or in part, until and unless all policy forms, contractual changes, rate increases, and policyholder options offered by Defendants are approved of by the Commissioner in accordance with the laws of the state of New Jersey, and or until subsequent order of this Court;

D. On the First and Second Counts of Plaintiffs' Verified Complaint, taking any action in furtherance of their expressed plans to, without first obtaining required regulatory approval from Commissioner Caride, raise premium rates and or reduce benefits under certain binding contracts of long-term care insurance policies issued in New Jersey or held by residents of New Jersey, including, but not limited to, notifying policyholders of proposed rate or benefit changes, requesting that policyholders select rates or benefits different than those authorized by

DOBI and called for under the terms of the contract, charging additional premiums, and or withholding, delaying, or encumbering benefits in whole or in part.

3. Until further Order entered by this Court, Defendants' prior actions taken on New Jersey policies issued in New Jersey or held by New Jersey residents are void *nunc pro tunc* and any and all changes that have been made to the terms and conditions to any long-term care policies purchased by New Jersey residents or issued pursuant to New Jersey law who have elected to make changes to their respective policies purchased from SHIP that were modified based on communications from Defendants, to restore their rates and benefits to the point prior to receiving communications from Defendants or any effort by Defendants to implement the Second Amended Plan, and providing a list of the names and addresses of said New Jersey policyholders who have made elections or who have policies the terms or conditions of which have been altered as a result of Defendants' implementation of the Second Amended Plan.

4. Defendants may move to dissolve or modify the temporary restraints herein contained on two (2) days' notice to Plaintiffs' counsel.

5. Copies of this Order to Show Cause, Plaintiffs' Verified Complaint, the Certification of Gale Simon, Plaintiffs' Brief, and the Certification of G. Glennon Troublefield, Esq., shall be served upon Defendants personally, via email and by overnight delivery service within _____ days of the date hereof, in accordance with R. 4:4-3 and R. 4:4-4, this being original process.

6. Plaintiffs must file with the court their proof of service of the pleadings on Defendants no later than three (3) days before the return date.

7. Defendants shall file and serve written responses to this Order to Show Cause and the request for the entry of injunctive relief and proof of service by _____, 2022. The

original documents must be filed with the Clerk of the Superior Court in Mercer County. A directory of these offices is available in the Civil Division Management Office in the county listed above and online at http://www.judiciary.state.nj.us/prose/10153_deptyclerklawref.pdf. You must send a copy of your opposition papers directly to Judge _____, whose address is Mercer County Courthouse, Mercer County Courthouse, 175 South Broad Street, Trenton, New Jersey 08650. You must also send a copy of your opposition papers to Plaintiffs' attorney, G. Glennon Troublefield, Esq., Carella, Byrne, Cecchi, Olstein, Brody & Agnello, P.C., 5 Becker Farm Road, Roseland, New Jersey. A telephone call will not protect your rights; you must file your opposition and pay the required fee of one hundred seventy five dollars ($175) and serve your opposition upon your adversary, if you want the court to hear your opposition to the injunctive relief Plaintiffs are seeking.

8. Plaintiffs shall file and serve any written reply to Defendants' Order to Show Cause opposition by _____, 2022. The reply papers must be filed with the Clerk of the Superior Court in Mercer County and a copy of the reply papers must be sent directly to the chambers of Judge _____.

9. If Defendants do not file and serve opposition to this Order to Show Cause, the application will be decided on the papers on the return date and relief may be granted by default, provided that Plaintiffs file a proof of service and a proposed form of order at least three (3) days prior to the return date.

10. If Plaintiffs have not already done so, a proposed form of order addressing the relief sought on the return date (along with a self-addressed return envelope with return address and postage) must be submitted to the court no later than three (3) days before the return date.

11. Defendants take notice that Plaintiffs have filed a lawsuit against you in the Superior Court of New Jersey. The Verified Complaint served with this Order to Show Cause states the basis of the lawsuit. If you dispute this Complaint, you, or your attorney, must file a written Answer to the Complaint and proof of service within thirty five (35) days from the day of service of this Order to Show Cause; not counting the day you received it. These documents must be filed with the Clerk of the Superior Court in Mercer County. A directory of these offices is available in the Civil Division Management Office in the county listed above and online at http://www.judiciary.state.nj.us/prose/10153_deptyclerklawref.pdf. Include a one hundred seventy five dollar ($175) filing fee payable to the Treasurer State of New Jersey. You must also send a copy of your Answer to Plaintiffs' attorney, G. Glennon Troublefield, Esq., Carella, Byrne, Cecchi, Olstein, Brody & Agnello, P.C., 5 Becker Farm Road, Roseland, New Jersey 07068. A telephone call will not protect your rights; you must file and serve your Answer (with the fee) or judgment may be entered against you by default. Please note: Opposition to the Order to Show Cause is not an Answer and you must file both. Please note further: if you do not file and serve an answer within thirty five (35) days of this order, the court may enter a default against you for the relief Plaintiffs demand.

12. If you cannot afford an attorney, you may call the Legal Services office in the county in which you live or the Legal Services of New Jersey Statewide Hotline at 1-888-LSNJ-LAW (1-888-576-5529). If you do not have an attorney and are not eligible for free legal assistance you may obtain a referral to an attorney by calling one of the Lawyer Referral Services. A directory with contact information for local Legal Services Offices and Lawyer Referral Services is available in the Civil Division Management Office in the county listed above and online at http://www.judiciary.state.nj.us/prose/10153_deptyclerklawref.pdf.

13. The court will entertain argument, but not testimony, on the return date of the Order to Show Cause, unless the court and parties are advised to the contrary no later than _____ days before the return date.

_____

Hon.

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Attorneys for Plaintiffs

MARLENE CARIDE, As Commissioner of the New Jersey Department of Banking and Insurance, and THE NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE, Plaintiffs, v. JESSICA K. ALTMAN, as Rehabilitator of Senior Health Insurance Company of Pennsylvania and her successors in office, in their capacity as Rehabilitator of SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, PATRICK H. CANTILO, as Special Deputy Rehabilitator of Senior Health Insurance Company of Pennsylvania, MICHAEL HUMPHREYS, as Successor Rehabilitator of Senior Health Insurance Company of Pennsylvania, and SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, Defendants.	SUPERIOR COURT OF NEW JERSEY CHANCERY DIVISION GENERAL EQUITY PART MERCER COUNTY DOCKET NO. MER-C-_____22 Civil Action

THIS MATTER being brought before the court by Carella, Byrne, Cecchi, Olstein, Brody & Agnello, P.C. (G. Glennon Troublefield, Esq., appearing), attorneys for Plaintiffs, Marlene Caride, in her

capacity as Commissioner of the New Jersey Department of Banking and Insurance ("Commissioner Caride"), and the New Jersey Department of Banking and Insurance ("DOBI"), pursuant to R. 4:52 based upon the facts set forth in the Verified Complaint, the Certification of Assistant Commissioner, Gale Simon, and the Certification of G. Glennon Troublefield filed herewith; and it appearing that Defendants, Jessica K. Altman, in her capacity as the court appointed Rehabilitator of Senior Health Insurance Company of Pennsylvania ("Altman" or the "Rehabilitator"), and her successors in office, in their capacity as Rehabilitator of Senior Health Insurance Company of Pennsylvania, Patrick H. Cantilo, in his capacity as Special Deputy Rehabilitator of Senior Health Insurance Company of Pennsylvania ("Cantilo" or "the Special Deputy Rehabilitator"), Michael Humphreys, as Successor Rehabilitator of Senior Health Insurance of Pennsylvania, and Senior Health Insurance Company of Pennsylvania ("SHIP"), (collectively, the "Defendants"), having received notice of this application; and for good cause having been shown;

It is on this _____ day of _____, 2022,

ORDERED as follows:

1. Defendants, and any of their respective principles, agents, employees, successors, and assigns, shall appear and show cause before the Superior Court of New Jersey at the Mercer County Courthouse, 175 South Broad Street, Trenton, New Jersey 08650 at 9 o'clock in the forenoon, or as soon thereafter as counsel can be heard, on the _____ day of _____, 2022, why an order should not be issued preliminarily enjoining and restraining Defendants and any of their respective principles, agents, employees, successors, assigns, and those persons acting in concert or participation therewith from:

A. On the First and Second Counts of Plaintiffs' Verified Complaint, enjoining Defendants from communicating, implementing, or enforcing the Second Amended Rehabilitation Plan (the "Plan") in the State of New Jersey, or otherwise interfering with the rights of SHIP's long-term care insurance policyholders in New Jersey or otherwise violating the insurance laws of the state of New Jersey, including, but not limited to, by offering any rates, forms, riders, or policy documents to any New Jersey SHIP policyholders that have not been previously authorized and approved by Commissioner Caride.

B. On the First and Second Counts of Plaintiffs' Verified Complaint, implementing the Plan, including, any action to: (a) solicit New Jersey policyholder elections of rates/premiums or benefits associated with the Election Coverage Packages or the Plan, to modify rates/premiums, rating schedules, and/or benefits associated with any long-term care policies purchased by New Jersey residents or issued pursuant to New Jersey law from SHIP or any of its predecessors or successors, (b) to implement the change to exiting rates/premiums, rating schedules, and benefits of long-term care policies, purchased by New Jersey policyholders or issued pursuant to New Jersey law from SHIP or any of its predecessors or successors, who have previously selected an option or an election in response to a solicitation from Defendants, and (c) to make an endorsement to any term or condition of any long-term care policies purchased by any New Jersey policyholder or issued pursuant to New Jersey law from SHIP or any of its predecessors or successors.

C. On the First and Second Counts of Plaintiffs' Verified Complaint, altering, encumbering, or diminishing the rights and benefits of any New Jersey SHIP policyholders or those policies issued pursuant to New Jersey law, in whole or in part, until and unless all policy forms, contractual changes, rate increases, and policyholder options offered by Defendants are

approved by Commissioner Caride in accordance with the laws of the state of New Jersey, and or until subsequent order of this Court;

D. On the First and Second Counts of Plaintiffs' Verified Complaint, taking any action in furtherance of their expressed plans to, without first obtaining required regulatory approval from Commissioner Caride, raise premium rates and or reduce benefits under certain binding contracts of long-term care insurance issued in New Jersey or held by residents of New Jersey, including, but not limited to, notifying policyholders of proposed rate or benefit changes, requesting that they select rates or benefits different than those authorized by DOBI and called for under the terms of the contract, charging additional premiums, or withholding, delaying, or encumbering benefits in whole or in part.

E. Awarding Plaintiffs counsel fees and costs.

F. Granting such further relief as the court deems equitable and just.

IT IS FURTHER ORDERED

2. That pending the return date herein, Defendants and any of their respective principles, agents, employees, successors, assigns, and those persons acting in concert or participation therewith are temporarily enjoined and restrained from:

A. On the First and Second Counts of Plaintiffs' Verified Complaint, enjoining Defendants from communicating, implementing, or enforcing the Plan in the State of New Jersey, or otherwise interfering with the rights of SHIP's long-term care insurance policyholders in New Jersey or those policies issued pursuant to New Jersey law or otherwise violating the insurance laws of the state of New Jersey, including, but not limited to, by offering any rates, forms, riders, or policy documents to any New Jersey SHIP policyholders that have not been previously authorized and approved by Commissioner Caride.

B. On the First and Second Counts of Plaintiffs' Verified Complaint, implementing the Plan including, any action to: (a) solicit New Jersey policyholder elections of rates, premiums, or benefits associated with the Election Coverage Packages or the Plan, to modify rates, premiums, rating schedules, and or benefits associated with any long-term care policies purchased by New Jersey residents or issued pursuant to New Jersey law from SHIP or any of its predecessors or successors, (b) to implement the change to exiting rates, premiums, rating schedules, and benefits of long-term care policies, purchased by New Jersey policyholders or issued pursuant to New Jersey law from SHIP or any of its predecessors or successors, who have previously selected an option or an election in response to a solicitation from Defendants, and (c) to make an endorsement to any term or condition of any long-term care policies purchased by any New Jersey policyholder or issued pursuant to New Jersey law from SHIP or any of its predecessors or successors.

C. On the First and Second Counts of Plaintiffs' Verified Complaint, altering, encumbering, or diminishing the rights and benefits of any New Jersey SHIP policyholders, in whole or in part, until and unless all policy forms, contractual changes, rate increases, and policyholder options offered by Defendants are approved of by the Commissioner in accordance with the laws of the state of New Jersey, and or until subsequent order of this Court;

D. On the First and Second Counts of Plaintiffs' Verified Complaint, taking any action in furtherance of their expressed plans to, without first obtaining required regulatory approval from Commissioner Caride, raise premium rates and or reduce benefits under certain binding contracts of long-term care insurance policies issued in New Jersey or held by residents of New Jersey, including, but not limited to, notifying policyholders of proposed rate or benefit changes, requesting that policyholders select rates or benefits different than those authorized by

DOBI and called for under the terms of the contract, charging additional premiums, and or withholding, delaying, or encumbering benefits in whole or in part.

3. Until further Order entered by this Court, Defendants' prior actions taken on New Jersey policies issued in New Jersey or held by New Jersey residents are void *nunc pro tunc* and any and all changes that have been made to the terms and conditions to any long-term care policies purchased by New Jersey residents or issued pursuant to New Jersey law who have elected to make changes to their respective policies purchased from SHIP that were modified based on communications from Defendants, to restore their rates and benefits to the point prior to receiving communications from Defendants or any effort by Defendants to implement the Second Amended Plan, and providing a list of the names and addresses of said New Jersey policyholders who have made elections or who have policies the terms or conditions of which have been altered as a result of Defendants' implementation of the Second Amended Plan.

4. Defendants may move to dissolve or modify the temporary restraints herein contained on two (2) days' notice to Plaintiffs' counsel.

5. Copies of this Order to Show Cause, Plaintiffs' Verified Complaint, the Certification of Gale Simon, Plaintiffs' Brief, and the Certification of G. Glennon Troublefield, Esq., shall be served upon Defendants personally, via email and by overnight delivery service within _____ days of the date hereof, in accordance with R. 4:4-3 and R. 4:4-4, this being original process.

6. Plaintiffs must file with the court their proof of service of the pleadings on Defendants no later than three (3) days before the return date.

7. Defendants shall file and serve written responses to this Order to Show Cause and the request for the entry of injunctive relief and proof of service by _____, 2022. The

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8. Plaintiffs shall file and serve any written reply to Defendants' Order to Show Cause opposition by _____, 2022. The reply papers must be filed with the Clerk of the Superior Court in Mercer County and a copy of the reply papers must be sent directly to the chambers of Judge _____.

9. If Defendants do not file and serve opposition to this Order to Show Cause, the application will be decided on the papers on the return date and relief may be granted by default, provided that Plaintiffs file a proof of service and a proposed form of order at least three (3) days prior to the return date.

10. If Plaintiffs have not already done so, a proposed form of order addressing the relief sought on the return date (along with a self-addressed return envelope with return address and postage) must be submitted to the court no later than three (3) days before the return date.

11. Defendants take notice that Plaintiffs have filed a lawsuit against you in the Superior Court of New Jersey. The Verified Complaint served with this Order to Show Cause states the basis of the lawsuit. If you dispute this Complaint, you, or your attorney, must file a written Answer to the Complaint and proof of service within thirty five (35) days from the day of service of this Order to Show Cause; not counting the day you received it. These documents must be filed with the Clerk of the Superior Court in Mercer County. A directory of these offices is available in the Civil Division Management Office in the county listed above and online at http://www.judiciary.state.nj.us/prose/10153_deptyclerklawref.pdf. Include a one hundred seventy five dollar ($175) filing fee payable to the Treasurer State of New Jersey. You must also send a copy of your Answer to Plaintiffs' attorney, G. Glennon Troublefield, Esq., Carella, Byrne, Cecchi, Olstein, Brody & Agnello, P.C., 5 Becker Farm Road, Roseland, New Jersey 07068. A telephone call will not protect your rights; you must file and serve your Answer (with the fee) or judgment may be entered against you by default. Please note: Opposition to the Order to Show Cause is not an Answer and you must file both. Please note further: if you do not file and serve an answer within thirty five (35) days of this order, the court may enter a default against you for the relief Plaintiffs demand.

12. If you cannot afford an attorney, you may call the Legal Services office in the county in which you live or the Legal Services of New Jersey Statewide Hotline at 1-888-LSNJ-LAW (1-888-576-5529). If you do not have an attorney and are not eligible for free legal assistance you may obtain a referral to an attorney by calling one of the Lawyer Referral Services. A directory with contact information for local Legal Services Offices and Lawyer Referral Services is available in the Civil Division Management Office in the county listed above and online at http://www.judiciary.state.nj.us/prose/10153_deptyclerklawref.pdf.

13. The court will entertain argument, but not testimony, on the return date of the Order to Show Cause, unless the court and parties are advised to the contrary no later than _____ days before the return date.

_____

Hon.

MARLENE CARIDE, As Commissioner of the New Jersey Department of Banking and Insurance, and THE NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE, Plaintiffs, v. JESSICA K. ALTMAN, as Rehabilitator of Senior Health Insurance Company of Pennsylvania and her successors in office, in their capacity as Rehabilitator of SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, PATRICK H. CANTILO, as Special Deputy Rehabilitator of Senior Health Insurance Company of Pennsylvania, MICHAEL HUMPHREYS, as Successor Rehabilitator of Senior Health Insurance Company of Pennsylvania, and SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, Defendants.	SUPERIOR COURT OF NEW JERSEY CHANCERY DIVISION GENERAL EQUITY PART MERCER COUNTY DOCKET NO. MER-C-_____22 Civil Action

PLAINTIFFS' BRIEF IN SUPPORT OF THEIR ORDER TO SHOW CAUSE AND OTHER RELIEF

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PRELIMINARY STATEMENT

The Department of Banking and Insurance ("DOBI"), is vested with the authority to enforce the insurance laws and regulations in the State of New Jersey. Commissioner Marlene Caride ("Commissioner Caride"), is the chief regulatory official of DOBI. Commissioner Caride has a duty and is empowered, where necessary, to represent and protect the interests of policyholders and consumers. The jurisdiction of DOBI and the authority of Commissioner Caride are absolute.

DOBI seeks the immediate intervention of this court to protect the interests of over 500 New Jersey policyholders who risk suffering irreparable harm. The policyholders are senior citizens who have an estimated average age of 89 years old and purchased long-term care policies from defendant Senior Health Insurance Company of Pennsylvania ("SHIP"). Almost two decades ago, SHIP sold long-term care policies to the policyholders based on rates and associated benefits reviewed and approved by DOBI. In subsequent years, SHIP began to face financial hardships. By 2020, SHIP had approximately $1.4 billion in assets and $2.6 billion in liabilities, thereby producing a deficit of approximately $1.2 billion (referred herein as the "Funding Gap").

In 2020, due to SHIP's financial hardship, Jessica K. Altman, who was the Pennsylvania Insurance Commissioner ("Commissioner Altman" or the "Rehabilitator"), petitioned the Commonwealth Court of Pennsylvania to be appointed as Rehabilitator of SHIP.[1] Commissioner Altman's petition was granted, SHIP was placed in rehabilitation in accordance with laws of Pennsylvania, and Commissioner Altman submitted to the court a proposed second amended plan

[1] Commissioner Altman resigned effective February 25, 2022. Michael Humphreys was appointed as Acting Pennsylvania Insurance Commissioner effective February 26, 2022. He has succeeded Commissioner Altman as Rehabilitator. For purposes of this brief, the term "Rehabilitator" refers to both Commissioner Altman and Acting Commissioner Humphreys as her successor.

of rehabilitation (herein, the "Plan"). The Plan's ultimate goal is to, *inter alia*, eliminate the Funding Gap by increasing premium revenue and modifying the existing terms of SHIP's 39,000 policies in force, including approximately 592 of said policies in New Jersey.[2]

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 (the "State Insurance Regulators"), appealed the Commonwealth Court's decision to approve the Plan. Because implementation of the Plan in New Jersey exposed SHIP policyholders to financial harm, Commissioner Caride joined 27 departments of insurance from other states as Amici Curiae to support the State Insurance Regulator's appeal. The Amici Curiae argued, *inter alia*, that the order approving the Plan violates the rate and form regulation statutes of the states as well as the comprehensive receivership and guaranty fund program enacted by each state for the protection of the policyholders. The Amici Curiae also argued that the Plan usurps: 1) the authority conferred upon and reserved to all states to regulate the business of insurance by both state and federal law and 2) the police power exercised by each jurisdiction's legislature for the protection of its citizens. The appeal remains pending.

Notwithstanding the appeal, Defendants have sought to implement the Plan in each jurisdiction, including New Jersey. Defendants mailed coverage election packages to New Jersey policyholders to require them to select of one of five options in the Plan. The options force the policyholders to reduce or drop coverage. The Rehabilitator's goal is not to honor SHIP's contractual obligations owed to policyholders, but rather to reduce SHIP's liabilities/deficit (namely the Funding Gap), by increasing premium revenue and reducing policyholder benefits. If

[2] As used herein, the term "New Jersey policyholders" refer to, collectively, SHIP policyholders who either reside in New Jersey or had their policy issued in New Jersey.

the Rehabilitator is permitted to follow through on that goal, New Jersey policyholders will be forced to make a difficult choice. They will have to decide whether to pay increased premiums for less coverage than when they initially purchased the policy, to accept significant downgrades in benefits for the same cost, or allow their long-term care policy to lapse by not making an election. As an additional harm, if SHIP goes into liquidation the policyholders who have made an election will receive reduced benefits from the guaranty association based on their selection under the Plan. The policyholders' reduction in benefits is irreversible.

Accordingly, to protect New Jersey policyholders from the financial consequences that arise from the Rehabilitator's implementation of the Plan, the immediate intervention of this court is required. First, DOBI and Commissioner Caride have more than a likelihood of success on the merits. As a matter of law, the Rehabilitator cannot unilaterally implement and impose on New Jersey policyholders increased rates and benefit changes on existing SHIP policies without the review and approval of DOBI. Second, as explained above, the irreparable harm to the New Jersey policyholders is certain. Without the immediate intervention of this court, the policyholders risk paying increased premiums, losing their contractually guaranteed benefits, and receiving reduced benefits from the New Jersey Life and Health Guaranty Association (LHIGA) if SHIP is ultimately placed into liquidation in Pennsylvania.

Therefore, DOBI requests this court to immediately enjoin Defendants' implementation of the Plan in New Jersey. This court should enjoin Defendants from undertaking any further communications with New Jersey policyholders and enter an order that voids any Plan elections that were previously made by the policyholders pursuant to SHIP's request. An injunction of this type will preserve the rights of the New Jersey policyholders as they existed before the

Rehabilitator's attempt to implement the Plan. The injunction should remain in place at least until the State Insurance Regulators' appeal is finally decided.

STATEMENT OF FACTS[3]

A. The Parties

Plaintiffs are Commissioner Caride and DOBI. *See* Certification of Gale Simon dated March 4, 2022 ("Simon Cert.") at ¶ 3. DOBI has the exclusive authority to regulate the business of insurance in New Jersey.

Defendants are former Commissioner Jessica K. Altman, Acting Commissioner Michael Humphreys, Special Deputy Rehabilitator Patrick H. Cantilo ("Cantilo"), and SHIP (collectively, "Defendants").

B. SHIP – Long-term Care Business

SHIP is a life and health insurance company domiciled in the Commonwealth of Pennsylvania that administers a closed block of long-term care insurance policies. SHIP commenced business on July 5, 1887, as the Home Beneficial Society. By the 1980's, SHIP was known as American Travelers Insurance Company and was primarily writing long-term care insurance policies. It was then acquired by, and merged into, CIHC, Inc., which was a wholly-owned subsidiary of Conseco, Inc. Ex. 1.

Upon information and belief, in 2002, Conseco filed a petition for bankruptcy protection, emerged from bankruptcy as CNO Financing Group. By 2003, CNO Financial Group's successor, Conseco Senior Health Insurance Company, ceased writing long-term care insurance policies.

[3] All facts are as set forth in Plaintiffs' Verified Complaint and the Certification of Gale Simon filed herewith. All letter exhibits are attached to the Verified Complaint. All numbered exhibits are attached to the Certification of G. Glennon Troublefield, Esq. filed herewith.

Conseco Senior Health Insurance Company has not sold any new policies since 2003. Id.

In October 2008, Conseco Senior Health Insurance Company changed its name to Senior Insurance Company of Pennsylvania (*i.e.* "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. At that time SHIP was transferred to the Senior Oversight Trust, SHIP had approximately 165,000 policyholders and approximately $3.2 billion in assets. Id.

SHIP was licensed in 46 states, including the State of New Jersey. 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. SHIP's policies are approximately thirteen percent (13%) home health care coverage, eighteen percent (18%) facility care coverage (inclusive of nursing homes and/or assisted living facilities), and sixty-nine percent (69%) comprehensive coverage. Upon information and belief, the average age of a SHIP long-term care policyholder is 89 years old and the average age of a policyholder claim is 89 years old. Id.

SHIP's financial condition deteriorated and required rehabilitation. By 2020, SHIP's assets were $1.4 billion and its liabilities were $2.6 billion, which created the Funding Gap.

C. SHIP's Rehabilitation Proceeding

On January 23, 2020, pursuant to Article V of the Insurance Department Act of 1921, Act of May 17, 1921, P.L. 789, as amended, ("Article V"), 40 P.S. § 221.1-221.63, and Rule 3774(c) of the Pennsylvania Rules of Appellate Procedure, Pa. R.A.P. 3774(c), the Rehabilitator filed an application for an order placing SHIP in rehabilitation. The application was filed in the Commonwealth Court of Pennsylvania and titled Jessica K. Altman, Insurance Commissioner of

the Commonwealth of Pennsylvania v. Senior Health Insurance Company of Pennsylvania, Docket No. 1 SHP 2020, (the "Rehabilitation Proceeding"). Ex. 1.

Among other grounds, the Rehabilitator asserted that SHIP committed one or more acts which constitute grounds for rehabilitation as set forth in 40 P.S. § 221.14 and 221.15, in that SHIP'S most recent annual statement demonstrated that it is statutorily insolvent as defined by 40 P.S. § 221.3 and that its most recent risk-based capital report ("RBC"), indicated that its total adjusted capital is substantially below its mandatory control level RBC, which triggered a "mandatory control level even" as that term is defined in 40 P.S. § 221.1A. SHIP's directors consented to being placed in rehabilitation. Id.

On January 29, 2020, the Commonwealth Court in the Rehabilitation Proceeding entered an Order of Rehabilitation and appointed the Rehabilitator. The Rehabilitator appointed Cantilo as Special Deputy Rehabilitator. Ex. 2.

On April 22, 2020, the Rehabilitator filed a proposed plan of rehabilitation and over the course of several months proposed two amended plans.

On August 24, 2021, the Commonwealth Court in the Rehabilitation Proceeding entered a Memorandum Opinion and Order approving the Plan. Ex. 3.

On September 21, 2021, the State Insurance Regulators filed a direct appeal to the Supreme Court of Pennsylvania of the Commonwealth Court's order approving the Plan. The appeal is titled In re: Senior Health Insurance Company of Pennsylvania (In Rehabilitation) - Appeal of: The Super Superintendent of Insurance of the State of Maine, Commissioner of Insurance of the Commonwealth of Massachusetts, and Insurance Commissioner of the State of Washington, Docket No. 71 MAP 2021. Ex. 4.

On October 1, 2021, the State Insurance Regulators filed a motion in the Rehabilitation Proceeding to stay implementation of the Plan pending the appeal. Ex. 7. The motion was denied.

On November 18, 2021, the State Insurance Regulators filed a motion in the Supreme Court of Pennsylvania for a stay pending appeal of, *inter alia* the Commonwealth Court's order approving the Plan. Ex. 8.

On December 22, 2021, Amici Curiae filed a brief in support of the State Insurance Regulators' appeal of the Commonwealth Court's order approving the Plan. Ex. 9.

On January 31, 2022, the Pennsylvania Supreme Court denied the State Insurance Regulator's motion for a stay pending appeal. Ex. 10.

D. Commissioner Caride's Authority

The New Jersey Legislature has expressly authorized the commissioner of insurance to be the administrator and chief executive officer of DOBI. N.J.S.A. 17:1-2 and 17:1-15. Among other duties and responsibilities, the commissioner of insurance has the exclusive authority to "perform, exercise, and discharge the functions, powers, and duties of the department through these divisions established by law or as the commissioner deems necessary." N.J.S.A. 17:1-15(c).

The New Jersey Legislature has also expressly authorized the commissioner of insurance to "determine all matters of policy within the commissioner's jurisdiction" and to "institute or cause to be instituted the legal proceedings or process necessary to enforce properly and give effect to any of the commissioner's powers or duties; and perform such other functions as may be prescribed by law in this act or by another other law." N.J.S.A. 17:1-15(f) and (g).

As to long-term care insurance, the New Jersey Legislature enacted the New Jersey Long-Term Care Insurance Act, N.J.S.A. 17B:27E-1, et seq. (the "Act"). The stated purpose of the Act is to "promote the public interest, to promote the availability of long-term care insurance policies,

to protect applications for long-term care insurance from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage." N.J.S.A. 17B:27E-1.

Commissioner Caride is empowered to enforce the Act in New Jersey.

E. Required Filing and Approval

Under Section 10 of the Act, long-term care policies, certificates, riders, or endorsements are required be filed with Commissioner Caride for approval. Section 10 of the Act provides:

> Every long-term care insurance policy or contract, including any application, certificate, rider, or endorsement to be issued or delivered in this State shall be filed with the commissioner for prior approval as provided in this section.

N.J.S.A. 17B:27E-10.

Similarly, Section 11 of the Act provides:

> An insurer providing long-term care insurance issued on an individual basis in this State shall file, for the commissioner's approval, its rates, rating schedule, and supporting documentation demonstrating that it is in compliance with the applicable loss ratio standards of this State. All filings of rates and rating schedules shall demonstrate that the benefits are reasonable in relation to the premium charged and that the rates are not excessive, inadequate, or unfairly discriminatory.

N.J.S.A. 17B:27E-11.

Under N.J.A.C. 11:4-34.17, premium and benefits under long-term care policies that are subject to the Act are required to be reviewed by Commissioner Caride:

> (a) This section applies to all rates for individual long-term care policies except those covered pursuant to N.J.A.C. 11:4–34.8 and 34.18.

> (b) Premiums and benefits under long-term care insurance policies whose rates are subject to this section shall meet the loss ratio requirements of N.J.A.C. 11:4–18.5.
>
> (c) Carriers shall include with each submission of new or revised rates for individual long-term care insurance an actuarial memorandum which includes anticipated loss ratio, methodology for calculating gross premiums, an explanation and documentation supporting the premium assumptions and the objective basis for any rate differentials . . .

N.J.A.C. 11:4-34.17.

F. SHIP's policies in New Jersey

As of January 12, 2021, SHIP has approximately 592 active long-term care policies in New Jersey. Of that group of policies, 17 policies were terminated, 523 policies are still in force, and approximately 49 policies are identified as being "NFO" – which means non-forfeiture option and no premium is due. Simon Cert., at ¶26

From approximately 2003 to 2019, either SHIP or one its successors and/or assigns submitted requests for rate increases for its long-term care policies issued to New Jersey policyholders. SHIP's requests were either approved, denied, or withdrawn. On August 26, 2019, SHIP filed its last application for a rate increase with DOBI. On March 13, 2020, SHIP withdrew that request. Ibid. at ¶27.

G. SHIP, The Rehabilitator and The Plan

SHIP is insolvent. Because SHIP is insolvent, a liquidation would inevitably result in the triggering of the state life and health insurance guaranty associations ("GA's") if SHIP cannot be successfully rehabilitated. Mandatory triggers of guaranty association benefits include an insurer being placed in liquidation with a finding of insolvency. Once "triggered", GA's commence the payment of policy benefits. The GA's generally provide for the continuation of insurance coverage

provided by the failed insurer, up to the statutory maximum coverage amounts. Unlike GA's in other states, New Jersey does not have a limit or "cap" on what benefits will be paid to policyholders. The benefits recoverable from GA's are subject to the policy limits. In addition, under the GA's, each provider receiving payments from the guaranty association must agree to a 20% discount pursuant to N.J.S.A. 17B:32A-3(e) as follows:

> A provider of health care services, in order to receive payment directly from the association upon a claim of the provider against an insured, shall agree to forgive the insured of 20% of the obligation which would otherwise be paid by the insurer had it not been insolvent. The obligations of solvent insurers to pay all or part of the covered claim are not diminished by the forgiveness provided in this paragraph. The association is not bound by an assignment of benefits executed with respect to the coverage provided by the insolvent insurer. The association may aggregate all claims owed health care providers when negotiating direct payment of claims of all covered individuals.

Simon Cert., ¶28.

After the GA's are triggered, the liquidator is required to deliver all of the assets in the insolvent estate not necessary for estate administration. GA's also receive all ongoing policy premiums once triggered. The GA's use the premium and estate assets to fulfill, in part, their obligations to policyholders. The GA's supplement those amounts by making assessments on their member insurance companies. Ibid. at ¶29.

In a liquidation, virtually all of SHIP's long-term care insurance policies would be covered by the state guaranty association system, subject to the individual state statutory conditions and limits. Thus, if SHIP is placed into liquidation because of its insolvency, the SHIP long-term care policies purchased by New Jersey residents would be covered by New Jersey's guaranty association. Because New Jersey does not have statutory limits on its guaranty association, New Jersey policyholders would be in a better position if SHIP is liquidated. Ibid. at ¶30.

Rather than consider SHIP insolvent, the Rehabilitator has proposed the Plan. Through the Plan, the burden of reducing the Funding Gap rests exclusively on SHIP's current policyholders who have not taken non-forfeiture options. The Plan does not involve guaranty associations. This strategy reflects a policy judgment by the Rehabilitator not to spread the burden of SHIP's insolvency through the guaranty association system. As result, SHIP policyholders will bear the entire Funding Gap through higher premiums or reduced benefits, even though they paid premiums for years which contractually guaranty their benefits under their policy. Id. at ¶31.

The Plan is implemented in three phases. Phase One, which began immediately upon the Commonwealth Court's approval of the Plan, is the principal phase through which the Rehabilitator seeks to reduce or eliminate the Funding Gap. Ex. 5.

In Phase One, policyholders whose premiums are below the "If Knew" premium level will be required to elect among options to modify premiums and/or benefits. 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. Policyholders whose current premium (including the premium they would be paying but for a premium waiver) falls below the If Knew Premium rate for the policy's benefits are required to select among five options. Option 1 ("downgrade") reduces benefits to the level supported by current premium on an If Knew Premium basis. Option 2 is a "basic policy endorsement" with reduced benefits. Option 2(a) is an "enhanced basic policy" with somewhat smaller benefit reductions. Option 3 is "non-forfeiture option" or "NFO" with reduced benefits and no future premium. Option 4 is the current policy with premiums increased to If Knew levels. Ibid. at ¶34.

Phase Two is intended to address the Funding Gap remaining after Phase One through further premium increases or benefit cuts largely based on Self-sustaining Premium. Phase Two will not affect policyholders who selected Options 2 or 3 in Phase One. Policyholders who choose Options 1 or 4 in Phase One face the possibility of additional substantial rate increases or benefit reductions in Phase Two. The substance of Phase Two is otherwise unknown, as the Plan does not specify all remedial measures that may be applied to policyholders in Phase Two and provides for an "alternative premium structure." The alternative premium structure is a "placeholder," and the Rehabilitator does not know what it would be. Ibid. at ¶35.

Phase Three will run-off the long-term care business in force. Ibid. at ¶36.

Policyholder elections under the Plan will be permanent. If SHIP is placed in liquidation after the Plan is implemented, the policies to which the guaranty association coverage will apply will be those as modified under the Plan. The modified policies will also be the basis for distribution from the liquidation estate. Accordingly, the total policy obligations will be reduced by the elections made by policyholders during implementation of the Plan. Ibid. at ¶37.

State insurance regulators other than Pennsylvania were given the option under the Plan to either 'opt in' or 'opt out'. Simon Cert., at ¶38. By letter dated September 30, 2021, the Rehabilitator communicated this option to Commissioner Caride. Ibid. at Ex. A. A state which opts out is one that elects to make its own determinations as to modifications of premium rates. If a state opts in, the state agrees that the Rehabilitator may make rate increases and benefit changes to that state's policyholders (pursuant to the Plan). If a state opts out, then the Rehabilitator will file a premium rate application for all policies below the If Knew premium. If a state denies the requested premium or approves only a lower premium, the Rehabilitator will then unilaterally adjust the benefits to the level that is determined to be appropriate. Ibid. at ¶38.

Commissioner Caride disagreed that the Rehabilitator had the unilateral right or ability to alter benefits or premium rates for New Jersey policyholders without her approval. By letter dated November 9, 2021, Commissioner Caride rejected the options presented to her by the Rehabilitator in the September 20, 2021 letter. Simon Cert., at ¶11, Ex. B. In her letter, Commissioner Caride stated:

> "[G]iven that rate regulation has long been reserved to the insurance commissioners of each state, the purpose of this letter is to notify you that (a) the Department will not respond to the Notice, and (b) the Department does not believe the Rehabilitator has authority to impose rate increases on our policyholders without the Department's approval."

Ibid. at ¶39.

Commissioner Caride further stated to the Rehabilitator that DOBI objects to the Plan, as expressed by State Insurance Regulators. Id.

In late January 2022, the Rehabilitator mailed "Coverage Election Packages" to New Jersey policyholders which contained the options referred to in the Plan. Ibid. at ¶41.

On February 2, 2022, the Rehabilitation Court approved SHIP's use of nationwide-premium rates for all states, including New Jersey. The "Coverage Election Packages" do not provide legally sufficient notice to New Jersey policyholders of SHIP's proposed rate increases, which have not been approved by Commissioner Caride. If a New Jersey policyholder does not make an option election by March 15, 2022, SHIP will on its own exercise the basic policy coverage option, resulting in a significant benefit reduction under a New Jersey insurance policy. Ex. 11.

Following its decision to implement the use of nationwide-rates, the State Insurance Regulators and non-intervening party insurance regulators objected to the Rehabilitator's plans

and took action. Several non-intervening party state insurance regulators issued administrative/regulatory cease and desist orders to Defendants. The cease and desist orders seek, *inter alia*, to enjoin Defendants from taking further action to implement the Plan in their particular state. Ex. 12. Other non-intervening party state insurance regulators commenced legal proceedings. Through those legal proceedings, the non-intervening party state insurance regulations obtained court ordered emergent temporary restraining orders or preliminary injunctions against Defendants to enjoin them from taking further action to implement the Plan in their particular state. Ex. 13.

Recognizing the growing nationwide litigation against Commissioner Altman's steps to implement the Plan, Commissioner Altman, before she resigned, and now Acting Commissioner Humphreys, as her successor in office, made proposals to reach an amical resolution. By letter dated March 8, 2022, Acting Commissioner Humphreys extended an offer to, *inter alia*, delay implementation of the Plan modifications until the earlier of October 1, 2022, or the date of the final order of the Pennsylvania Supreme Court. Ex. 14. Acting Commissioner Humphreys states in his letter that his team will continue to prepare for the modifications of SHIP policies under the Plan. He further states in his letter that he has directed "Pennsylvania's team to oppose any and all state administrative or legal actions directed against Pennsylvania and the Plan. Ibid.

As of March 8, 2022, based on Acting Commissioner's letter (Ex. 14), Defendants are in the midst of Phase One of the implementation of the Plan. Defendants have distributed Coverage Election Packages to around 20,000 policyholders and about two thirds of those particular policyholders who received the election package have selected options. Ibid.

ARGUMENT

POINT I

STANDARDS GOVERNING THE ISSUANCE OF PRELIMINARY INJUNCTIONS

The procedures by which a party may apply for the issuance of preliminary injunctions are set forth in R. 4:52, which provides that a plaintiff may apply for an order requiring the defendant to show cause as to why a preliminary injunction should not be granted pending final hearing of the action. The standards governing the issuance of injunctive relief are well settled. Injunctive relief will be granted where: (1) the applicant makes a preliminary showing of a reasonable probability of success on the merits; (2) the applicant is threatened with irreparable harm; (3) the legal right underlying the applicant's claim is settled; and (4) the equities are in favor of the applicant. Crowe v. DeGioia, 90 N.J. 126, 132-134 (1982); Citizens Coach Co. v. Camden Horse R.R. Co., 29 N.J. Eq. 299, 303-305 (E. & A. 1878). The purpose of a preliminary injunction is to prevent threatened irreparable harm until an opportunity is afforded for a full hearing on the merits. Outdoor Sports Corp. v. A.F. of L., Local 23132, 6 N.J. 217, 230 (1951).

The reasonable likelihood of success on the merits requirement is tempered by the principle that mere doubt as to the validity of the claim is not an adequate basis for refusing to maintain the status quo. Crowe, 90 N.J. at 132-34.

"An injury is irreparable when it cannot be adequately compensated in damages or when there exists no certain pecuniary standard for the measurement of the damages." Scherman v. Stern, 93 N.J. Eq. 626, 631 (E. & A. 1922). The inadequacy of damages as compensation may be due to the nature of the injury itself or the right or property injured. Id. It is well settled that acts that destroy a plaintiff's business, custom, or profits inflict irreparable harm upon that plaintiff and

warrant the issuance of a preliminary injunction. Id. Improper and wrongful actions which interfere with one's business is of a type which usually renders monetary damages inadequate and injunctive relief entirely appropriate. Silverstein v. Abco Vending Serv., 37 N.J. Super. 439, 446 (App. Div. 1955).

In considering the propriety of issuing an interlocutory injunction, the court must consider the respective hardships of the parties. Where the equities, when balanced, clearly favor the plaintiff, a preliminary injunction restraining the defendant pending a final hearing should issue. St. John's Evangelical Lutheran Church v. City of Hoboken, 195 N.J. Super. 419, 421 (Law Div. 1983). Importantly, to the extent that the defendant suffers any harm from a preliminary injunction, where this harm is a predictable and an unavoidable consequence of his willful breach of his duties and obligations, it is not the type of "undue" hardship from which a defendant should be protected.

It is axiomatic that equity would not permit a wrong to be suffered by an innocent party without affording the appropriate remedy. Graziano v. Grant, 326 N.J. Super. 328, 342 (App. Div. 1999). "Applying principles of fairness and justice, a judge sitting in a court of equity has a broad range of discretion to fashion the appropriate remedy in order to vindicate a wrong consistent with principles of fairness, justice, and the law." Ibid.

POINT II

PLAINTIFFS HAVE A REASONABLE LIKELIHOOD OF SUCCESS ON THE MERITS

A. Success on the merits

Commissioner Caride and DOBI have a reasonable likelihood of success. With the passage of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, in 1945, "Congress . . . declare[d] that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States." "The primary state insurance regulatory functions remain as they have been since the enactment of [the] McCarran-Ferguson [Act]. This allows . . . states to perform solvency oversight of the U.S. insurance industry and to regulate insurer behavior in the marketplace." See State Insurance Regulation, National Association of Insurance Commissioners (NAIC), Center for Insurance Policy and Research (CIPR) (2011), https://www.naic.org/documents/topics white paper hist ins reg.pdf.

"State legislatures are the public policymakers that establish . . . broad policy for the regulation of insurance by enacting legislation providing the regulatory framework under which insurance regulators operate. They establish laws which grant regulatory authority to regulators and oversee state insurance departments and approve regulatory budgets." Ibid. "State insurance regulatory systems are accessible and accountable to the public and sensitive to local, social, and economic conditions. State regulation has proven that it effectively protects consumers and ensures that promises made by insurers are kept. Insurance regulation is structured around several key functions, including insurer licensing, producer licensing, product regulation (review and approval

of rates (including benefits) and forms), market conduct, financial regulation, and consumer services." Ibid.

"State regulators protect consumers by ensuring that insurance policy provisions comply with state law, are reasonable and fair, and do not contain major gaps in coverage that might be misunderstood by consumers and leave them unprotected. The nature of the regulatory reviews of rates, rating rules, and policy forms varies somewhat among the states depending on their laws and regulations." Ibid.

The New Jersey State Legislature has properly delegated regulatory authority under the McCarran-Ferguson Act, 15 U.S.C. § 1011-1015, to DOBI, prescribing and approving detailed and extensive statutes and regulations governing long-term care policies and rates. Through the Act, the New Jersey Legislature declared that:

> [T]he purpose of this act is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

N.J.S.A. 17B:27E-1.

In furtherance of the New Jersey Legislature's scheme, the New Jersey Senate expressed that:

> [T]he bill contains a number of provisions intended to promote greater public understanding and comparison of long-term care coverage, protect applicants from unfair or deceptive sales practices, promote greater availability of long-term care coverage, and encourage the development of innovative long-term care products.

Sen. Commerce Comm. Statement to S. 2532, (June 12, 2003).

Accordingly, by statute, "[e]very long-term care insurance policy or contract, including any application, certificate, rider, or endorsement to be issued or delivered in this State shall be filed with the commissioner for prior approval as provided in this section." N.J.S.A. 17B:27E-10.

Pennsylvania's highest court has made clear that as a creature of statute, an insurance commissioner acting as a rehabilitator "can only exercise those powers which have been conferred upon it by the Legislature in clear and unmistakable language." Aetna Gas. and Sur. Co. v. Com., Ins. Dept., 638 A.2d 194 (Pa. 1994) (quoting Commonwealth, Human Relations Commission v. Transit Casualty Insurance Company, 478 Pa. 430, 438, 387 A.2d 58, 62 (1978)); see also Koken v. Legion Ins. Co., 831 A.2d 1196 (Pa. Commw. 2003), aff'd sub nom., Koken v. Villanova Ins. Co., 878 A.2d 51 (Pa. 2005). With that limited scope in mind, Defendants have only those powers conferred upon them by 40 Pa. Stat. Ann. § 221.1 et seq., which are limited and equivalent to those of new management, and they and insurance companies in rehabilitation, including SHIP, must therefore obey the Insurance Codes of each of the states in which they conduct the business of insurance. Id. (Rehabilitator has "full power to direct and mange" the insurer).

Nowhere in the Pennsylvania rehabilitation statutes is there "clear and unmistakable language" permitting a rehabilitator to unilaterally set new rates and policy terms in New Jersey. It defies logic that the Commonwealth Court would grant Defendants authority to impose rate increases or benefit changes of long-term care policies purchased by New Jersey residents. Likewise, it is illogical to assume that the New Jersey Legislature intended to abrogate the authority of Commissioner Caride and relinquish this court's subject matter jurisdiction to remedy violations of New Jersey insurance laws.

Defendants have expressed their intention not to obey New Jersey insurance laws and move forward in implementing the Plan in New Jersey. The first step to implement the Plan was the

Rehabilitator's September 30, 2021, letter to Commissioner Caride. Through that letter, the Rehabilitator attempted to assert regulatory authority over rate setting in New Jersey by offering Commissioner Caride the option to opt in or opt out of the policy rate structure of the Plan. The policy rate structure in the Plan was adopted by the Rehabilitator unilaterally. As a second step, the Rehabilitator communicated directly with New Jersey policyholders. The Rehabilitator mailed "Coverage Election Packages" to New Jersey policyholders, requesting that they select one of the five options in the Plan. Each of the options contain premium increases or benefit reductions adopted by the Rehabilitator. The Rehabilitator adopted the options in the Plan unilaterally.

The actions taken by the Rehabilitator violate applicable insurance laws. As a matter of federal law, the authority to control and regulate the business of insurance in a given state reside with insurance regulators of the state. Indeed, in addition to the McCarren-Ferguson Act, each state legislative body has the police power rights to regulate the business of insurance within its own borders.

As a matter of state law, the New Jersey Legislature adopted the Act which grants DOBI and Commissioner Caride the exclusive authority to regulate insurance with respect to long-term care policies. See N.J.S.A. 17B:27E-10 and -11. Likewise, under regulations applicable to long-term care policies, Commissioner Caride has the duty, and is empowered, to review any changes to rates, premiums, and benefits associated with long-term care policies sold in New Jersey. See N.J.A.C. 11:4-18.4 and 18.5 and N.J.A.C. 11:4-37.17. Contrary to the Act and its associated regulations, the Rehabilitator has unilaterally implemented increased premiums and/or reduced benefits on existing SHIP long-term care policies in New Jersey without Commissioner Caride's approval. The Rehabilitator's actions violate New Jersey law.

B. New Jersey is not alone

As further support of the strength of the likelihood of success on the merits, other states have successfully obtained injunctions or cease and desist orders against Defendants, thereby preventing Defendants form implementing the Second Amended Plan in their state. Courts in the States of Louisiana, South Carolina, Maine, Iowa, and North Dakota have entered orders restraining the actions of Defendants and Commissioners of Insurance in the states of Connecticut, Washington, D.C., and Maryland have issued cease and desist orders against Defendants in their respective jurisdictions. Ex. 10. The common thread running through the grants of injunctions or cease and desist orders in those states is based on the same set of circumstances and respective rate approval laws and policies that are analogous to those in New Jersey.

C. Conclusion

Based on the Rehabilitator's conduct which violates New Jersey insurance laws, DOBI and Commissioner Caride submit that they have more than a reasonable likelihood of success on the merits.

POINT III

IRREPARABLE HARM WILL OCCUR IF A PRELIMINARY INJUNCTION IS NOT ENTERED

The irreparable harm facing New Jersey policyholders (who have an average age of 89 years old), as a result of the Rehabilitator's implementation of the Plan in New Jersey is certain.

Senior citizens in New Jersey are a special class of residents. Although insurance laws are in place to protect all residents of New Jersey, particular consideration is paid to any conduct that would injure the elderly. Here, over 500 senior citizens of New Jersey purchased long-term care policies from SHIP over two decades ago. They paid premiums in fulfillment of their contractual obligation to pay for the long-term care benefits. They paid the premiums with the expectation that SHIP will fulfill its contractual obligations by delivering the long-term care benefits that the policyholders paid for. Some policyholders have lifetime benefits. Those lifetime benefits are now at risk due to the Rehabilitator's conduct.

The Rehabilitator's action to implement the Plan in New Jersey has dire financial consequences to New Jersey's senior citizens who are SHIP policyholders. One of the fundamental principles of insurance regulation is to ensure that companies fulfill and honor their policyholder obligations. Contrary to that fundamental principle, the Plan seeks to solve SHIP's financial hardship through the policyholders. Through implementation of the Plan, the burden of SHIP's insolvency shifts from the guaranty association system that was enacted to protect consumers in instances such as this to the policyholders. The policyholders are called up to make difficult financial choices if they want to keep part of their long-term care benefits under the plan. The Plan required policyholders to reduce or drop coverage. If the policyholders want to keep their coverage, they either have to pay increased premiums or accept reduced benefits. They are presented that

choice because the goal of the Rehabilitator is not to honor policyholder contractual obligations, but rather to reduce SHIP's liabilities, presumably before it goes into liquidation. If SHIP goes into liquidation, the policyholders who have selected one of the five options and had their benefits reduced, would receive reduced benefits from the guaranty associations. In other words, by making an election under the Plan, the policyholders lose the ability to keep their benefits if SHIP goes into liquidation, which is a realistic possibility in DOBI's view. Once an election is made and the benefits are reduced, the effect of the election is irreversible.

Accordingly, the New Jersey policyholders will suffer significant irreparable harm as a result of the implementation of the Plan. By making the election, policyholders will have lost the benefit of the bargain: they are required to pay increased premiums or receive reduced benefits and lose the ability to receive their contractually paid for benefits before SHIP's rehabilitation. That is patently unfair. It makes no difference that in Pennsylvania, the Rehabilitator is attempting to avoid triggering the funds from the guaranty associations. Defendants should not be permitted to salvage SHIP on the backs of innocent policyholders who are elderly and had purchased binding contractual policies with rates previously approved of in New Jersey.

Accordingly, the New Jersey policyholders will suffer irreparable harm if an injunction is not entered.

POINT IV

THE EQUITIES FAVOR PLAINTIFFS

Plaintiffs' hardships are indisputable. The authority of the Commissioner and DOBI was not followed, ignored, and has been used as a means for the Rehabilitator to implement the Plan. The unilateral decision to increase premiums and reduce benefits of New Jersey policyholders creates harm suffered by New Jersey policyholders that is unmatched by Defendants.

The Rehabilitator's implementation of the Plan is unfair. The Rehabilitator has proposed the Plan as a means of curing SHIP's insolvency. Through the Plan, the burden of reducing the Funding Gap rests exclusively on SHIP's current policyholders who have not taken non-forfeiture options, i.e. the premium paying policyholders. The Plan does not involve any financial assistance from guaranty associations. This strategy reflects a policy judgment by the Rehabilitator not to spread the burden of SHIP's insolvency through the guaranty association system but rather to place the burden solely on the backs of elderly policyholders through higher premiums or reduced benefits. The Rehabilitator has chosen to burden the elderly policyholders even though they paid premiums for years, which contractually guaranty their benefits under their policy and are supposed to be protected by guaranty association support in the event of company insolvency.

Due to their age, the elderly policyholders do not have the option to obtain a new long-term care policy from a different carrier. Their advanced age makes them uninsurable based on present industry standards associated with long-term care policy products offered in the life and health insurance market. As a result, the elderly policyholders have no choice but to either accept paying increased premiums or accept reduced benefits if they want to keep their long-term care policy from SHIP. That is patently unfair to the elderly policyholders. They faithfully paid their premiums over the course of 20 plus years and, frankly, did nothing wrong. Now, at the time when

they will need their contractually guaranteed long-term care policy, they have to accept less than what they paid for due to SHIP's mismanagement. Worst yet, even though the guaranty association system exists in each state, including New Jersey, to protect the interests of the elderly policyholders, the Rehabilitator has chosen to ignore that option. The Rehabilitator rather requires the elderly policyholders to pay more money or receive less coverage under the Plan for the sole purpose of curing the Funding Gap. The Rehabilitator would rather require the elderly policyholders to pay more money or receive less premiums under the Plan for the sole purpose of curing the Funding Gap. That is unfair to the elderly policyholders who have timely paid their premiums for over 20 years and unacceptable to DOBI.

Defendants will not suffer hardship by this. Defendants have their rights being pursued on appeal and still have the opportunity to submit the required forms to Commissioner Caride for review and approval. Defendants' election to not follow New Jersey law is a self-created hardship that Defendants have only themselves to blame. Thus, even if Defendants claim a hardship, it cannot rise to the level of undue hardship, because Defendants created their own predicament by implementing the Plan knowing that the Rehabilitator is acting contrary to the authority of state regulators across the Country. Jiffy Lube Int'l, Inc. v. Weiss Brothers, Inc., 834 F. Supp. 683, 693 (D.N.J. 1993) ("the harm which follows a defendant who willfully breaches [an obligation] is not a basis for denying a plaintiff the relief to which it is legally entitled."); see also J.H. Renarde, Inc. v. Sims, 312 N.J. Super. 195, 205 (Ch. Div. 1998) (holding that "self-inflicted hardship should not be considered or at best, should be given very little weight.").

POINT V

SCOPE OF THE RESTRAINTS

Due to the nature of Defendants' violation of the insurance laws of New Jersey, *see* Point II above, this court should enjoin Defendants from undertaking any further communications with New Jersey policyholders. Further communication from the Rehabilitator to the New Jersey policyholders will only cause more anxiety and confusion regarding the status of elderly New Jersey policyholders' long-term policy from SHIP. As to the group of New Jersey policyholders who have made an election, this court should declare those elections to be void. Those elections were made without approval by Commissioner Caride and were in contravention to the exclusive authority granted to Commissioner Caride over long-term care policies in New Jersey. Due to the elections being made contrary to applicable insurance laws of New Jersey, they should be rendered to be of no consequence and have no effect. Their full benefits should be restored to the point that they existed prior the Rehabilitator's implementation of the Plan.

Finally, restraints requested and injunctive relief should remain in place at least until the State Insurance Regulators' appeal is finally decided.

CONCLUSION

For all of the foregoing reasons, Plaintiffs respectfully request that their application for issuance of an Order to Show Cause and the entry of a Preliminary Injunction on the return date be granted in its entirety.

Respectfully yours,

Dated: March 9, 2022

CARELLA, BYRNE, CECCHI, OLSTEIN, BRODY & AGNELLO, P.C.

/s/ *G. Glennon Troublefield*
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Attorneys for Plaintiffs

MARLENE CARIDE, as Commissioner of the New Jersey Department of Banking and Insurance, and THE NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE, Plaintiffs, v. JESSICA K. ALTMAN, as Rehabilitator of Senior Health Insurance Company of Pennsylvania and her successors in office, in their capacity as Rehabilitator of Senior Health Insurance Company of Pennsylvania, PATRICK H. CANTILO, as Special Deputy Rehabilitator of Senior Health Insurance Company of Pennsylvania, MICHAEL HUMPHREYS, as Successor Rehabilitator of Senior Health Insurance Company of Pennsylvania, and SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, Defendants.	SUPERIOR COURT OF NEW JERSEY CHANCERY DIVISION GENERAL EQUITY PART MERCER COUNTY DOCKET NO. MER-C-_____22 Civil Action **CERTIFICATION OF G. GLENNON TROUBLEFIELD IN SUPPORT OF ORDER TO SHOW CAUSE**

I, G. GLENNON TROUBLEFIELD, hereby certify as follows:

1. I am an attorney at law of the State of New Jersey and member of the law firm of Carella, Byrne, Cecchi, Olstein, Brody & Agnello, P.C., counsel for Plaintiffs Marlene Caride, as

Commissioner of the New Jersey Department of Banking and Insurance, and The New Jersey Department of Banking and Insurance (collectively, "Plaintiffs") in connection with the above-captioned matter.

2. I am fully familiar with the facts as set forth below, unless otherwise indicated.

3. I make this certification in support of Plaintiffs' order to show cause and other relief against defendants Jessica K. Altman, as Rehabilitator of Senior Health Insurance Company of Pennsylvania ("Commissioner Altman" or the "Rehabilitator"), Patrick H. Cantilo, as Special Deputy Rehabilitator of Senior Health Insurance Company of Pennsylvania, Michael Humphreys, as Successor Rehabilitator of Senior Health Insurance Company of Pennsylvania, and Senior Health Insurance Company of Pennsylvania ("SHIP").

4. Attached hereto as Exhibit 1 is a true and accurate copy of the January 23, 2020 application on behalf the Rehabilitator for the entry of an order placing SHIP into rehabilitation, as filed In the Commonwealth Court of Pennsylvania, Docket No. 1 SHP 2020, titled Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania v. Senior Health Insurance Company of Pennsylvania (the "Rehabilitation Proceeding").

5. Attached hereto as Exhibit 2 is a true and accurate copy of the January 29, 2020 Order entered by the Commonwealth Court in the Rehabilitation Proceeding, placing SHIP into rehabilitation and appointing the Rehabilitator.

6. Attached hereto as Exhibit 3 is a true and accurate copy of the Rehabilitator's April 22, 2020 Application for Approval of the Plan of Rehabilitation for SHIP (without Exhibit A).

7. Annexed hereto as Exhibit 4 is a true and accurate copy of the Commonwealth Court's August 24, 2021 Memorandum Opinion and Order approving the Rehabilitator's Second Amended Rehabilitation Plan (the "Plan").

8. Attached hereto as Exhibit 5 is a true and accurate copy of the Plan, as approved on September 30, 2021.

9. Annexed hereto as Exhibit 6 is a true and accurate copy of excerpts of the September 21, 2021, notice of appeal filed by the Superintendent of Insurance of the State of Maine, Commissioner of Insurance of the Commonwealth of Massachusetts, and Insurance Commissioner of the State of Washington (the "State Insurance Regulators"), Docket No. 71 MAP 2021. The State Insurance Regulators filed a direct appeal to the Supreme Court of Pennsylvania of the Commonwealth Court's order approving the Plan. The appeal is titled In re: Senior Health Insurance Company of Pennsylvania (In Rehabilitation) - Appeal of: The Super Superintendent of Insurance of the State of Maine, Commissioner of Insurance of the Commonwealth of Massachusetts, and Insurance Commissioner of the State of Washington.

10. Annexed hereto as Exhibit 7 is a true and accurate copy of the State Insurance Regulators' October 1, 2021 Application for a Stay pending Appeal as filed in the Rehabilitation Proceeding.

11. Annexed hereto as Exhibit 8 is a true and accurate copy of the November 8, 2021 brief filed on behalf of the State Insurance Regulators' application for a stay pending appeal, as filed with the Pennsylvania Supreme Court.

12. Annexed hereto as Exhibit 9 is a true and accurate copy of the December 22, 2021 brief filed on behalf of Amici Curiae Insurance Regulators in support of the State Insurance Regulators' appeal.

13. Annexed hereto as Exhibit 10 is a true and accurate copy of the January 31, 2022 Order entered by the Pennsylvania Supreme Court denying the State Insurance Regulator's application for a stay pending appeal.

14. Annexed hereto as Exhibit 11 are true and accurate copies of the Rehabilitator's sample cover letter and sample coverage election forms, as mailed to New Jersey policyholders.

15. Annexed hereto as Exhibit 12 are true and accurate copies of cease and desist orders issued by State insurance regulators against the Rehabilitator and the other defendants in this action.

16. Annexed hereto as Exhibit 13 is a true and accurate copies of court orders from several jurisdictions entered against the Rehabilitator and the other defendants in this action.

17. Annexed hereto as Exhibit 14 is a true and accurate copy of a March 8, 2022 letter from Acting Insurance Commissioner Michael Humphreys to all state insurance regulators concerning the implementation of the Plan.

I hereby certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

/s/ G. Glennon Troublefield
G. GLENNON TROUBLEFIELD

Dated: March 9, 2022

EXHIBIT 1

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania,	:	
Plaintiff	:	Docket No. 1 SHP 2020
v.	:	
Senior Health Insurance Company of Pennsylvania 550 Congressional Boulevard, Suite 200, Carmel, IN 46032, NAIC Company Code 76325	:	
Defendant	:	

RECEIVED
COMMONWEALTH COURT
OF PENNSYLVANIA
2020 JAN 23 AM 9: 33

APPLICATION FOR ORDER PLACING SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA IN REHABILITATION

INTRODUCTION

Pursuant to Article V of the Insurance Department Act of 1921, Act of May 17, 1921, P.L. 789, *as amended.* ("Article V"), 40 P.S. §§ 221.1-221.63, and Rule 3774(c) of the Pennsylvania Rules of Appellate Procedure, Pa.R.A.P. 3774(c), Plaintiff, Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, files this Application for Order Placing Senior Health Insurance Company of Pennsylvania ("SHIP") in Rehabilitation (the "Application") seeking entry of an order directing her to rehabilitate SHIP, and in support thereof respectfully avers as follows:

SHIP has committed one or more acts which constitute grounds for rehabilitation as set forth in 40 P.S. § 221.14 (applicable to a petition for rehabilitation under 40 P.S. § 221.15). Specifically, SHIP's most recent annual statement demonstrates that the company is statutorily insolvent as defined in 40 P.S. § 221.3. Additionally, SHIP's most recent risk-based capital ("RBC") report indicates that the company's total adjusted capital is substantially below its mandatory control level RBC, thereby triggering a "mandatory control level event" as defined in 40 P.S. § 221.1-A. Finally, the Trustees of the Senior Health Care Oversight Trust ("Oversight Trust") and SHIP's directors have consented in a signed writing to the company being placed in rehabilitation and have waived the hearing contemplated by 40 P.S. §.221.15.

JURISDICTION

Jurisdiction over this case is founded upon 42 Pa.C.S. § 761(a) and Section 504(d) of Article V, 40 P.S. § 221.4(d).

PARTIES

1. Plaintiff is Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania ("Commissioner" or "Plaintiff"), acting in her official capacity. Plaintiff has her principal office at 1326 Strawberry Square, Harristown State Office Building No. 1, Harrisburg, Pennsylvania 17120.

2. Plaintiff is charged with the execution of the laws of the Commonwealth of Pennsylvania relating to insurance for the protection of policyholders, creditors, and the public generally.

3. Defendant, SHIP, is a domestic life and health insurance company organized pursuant to the laws of the Commonwealth of Pennsylvania and has its principal place of business at 550 Congressional Boulevard, Suite 200, Carmel, IN 46032.

4. SHIP was established to run off a closed block of long-term care insurance previously indirectly owned and administered by Conseco, Inc. Pursuant to an Order dated November 12, 2008 issued by then Insurance Commissioner Joel Ario, SHIP became wholly owned by the Oversight Trust.

5. The Oversight Trust is a Pennsylvania business trust designed and created with input and assistance from the Pennsylvania Insurance Department (the "Department") to provide, along with the Department, certain oversight of the runoff of SHIP business, as well as certain other activities specified in the Trust Agreement (as amended). The Oversight Trust is governed by a Board of Trustees ("Trustees") approved by the Department and is comprised of former insurance regulators and financial experts who also serve as members of the board of directors of SHIP.

6. At the time SHIP was transferred to the Oversight Trust, SHIP had approximately 165,000 policyholders and approximately $3.2 billion in assets.

Presently, SHIP has approximately 51,000 policyholders and approximately $2.2 billion in assets.

7. SHIP is the 100% owner and sole shareholder of Fuzion Analytics, Inc. ("Fuzion"), a Delaware Corporation that performs SHIP's operating functions, employs all the staff utilized by SHIP, and owns and operates all of the equipment and infrastructure through which SHIP operates.

8. SHIP is authorized to write the accident and health line of business under the Insurance Company Law of 1921, Act of May 17, 1921, P.L. 682, *as amended*, Section 202(c)(2), 40 P.S. § 382(c)(2). Specifically, SHIP has written long-term care insurance policies, including nursing home and assisted living facility stays and stand-alone home health care products, primarily for senior citizens. SHIP is, and at all material times has been, engaged solely in the long-term care line of insurance business. SHIP has not written any new insurance business since at least July 2003.

9. SHIP is, and at all material times has been, subject to examination by and to the jurisdiction of the Commissioner.

BACKGROUND

10. Paragraphs 1 through 9 above are incorporated herein by reference.

11. SHIP is required to file annual statements of its financial condition with the Commissioner. Annual statements are due March 1 of each year as to the prior year. *See* 40 P.S. § 443(a). On or about March 1, 2019, SHIP filed with the Commissioner

its 2018 Annual Statement. *See* Exhibit 1 - A true and correct copy of SHIP's annual financial statement for the year ended December 31, 2018 ("2018 Annual Statement") is attached as Ex. 1 to this Application and incorporated herein by reference. This Annual Statement reports that SHIP was insolvent by $466,872,975 on assets of $2,186,058,273 and liabilities, including capital stock, of $2,652,931,248 as of December 31, 2018.

12. SHIP's officers personally attested that its 2018 Annual Statement was a "full and true statement" of "all of the assets and liabilities and of the condition and affairs" of SHIP. *See* Ex. 1 at p. 1.

13. SHIP is required to file a Risk-Based Capital ("RBC") report with the Commissioner by March 1 of each year as to the preceding calendar year. On or about February 27, 2019, SHIP filed an RBC report with the Commissioner for the year ended December 31, 2018 (the "2018 RBC Report"). *See* Exhibit 2 - A true and correct copy of SHIP's 2018 RBC Report is attached as Ex. 2 to this Application and incorporated herein by reference. This report stated that at the time SHIP's required authorized control level Risk-Based Capital was $51,352,310. Capital of 70% or less of this amount ($35,946,617) would have placed SHIP in "mandatory control level." SHIP's actual total adjusted capital at the time was -$466,814,972, leaving SHIP far below mandatory control level.

14. On July 30, 2019 a majority of the Oversight Trust's Board of Trustees voted to give consent to the rehabilitation of SHIP and to waive the hearing contemplated by 40 P.S. § 221.15. *See* Exhibit 3 - A true and correct copy of the Lead Trustee's Certificate attaching resolutions adopted by the Board of Trustees of the Oversight Trust is attached as Ex. 3 to this Application and incorporated herein by reference.

15. On July 30, 2019, of SHIP's directors (which includes all of the Trustees of the Oversight Trust), a majority voted to give consent to the rehabilitation of SHIP and to waive the hearing contemplated by 40 P.S. § 221.15. *See* Exhibit 4 - A true and correct copy of the Secretary's Certificate attaching resolutions adopted by the Board of Directors of SHIP is attached as Ex. 4 to this Application and incorporated herein by reference.

FIRST GROUND FOR REHABILITATION: INSOLVENCY

16. Paragraphs 1 through 15 above are incorporated herein by reference.

17. Under 40 P.S. §§ 221.14, and 221.15, an order of rehabilitation may be entered if the insurer is insolvent. *See* 40 P.S. § 221.14(1) (order of rehabilitation may be issued based upon insurer's insolvency).

18. Under Section 503 of Article V, 40 P.S. § 221.3, an insurer is insolvent if its admitted assets do not exceed its liabilities plus the greater of its capital and surplus

required by law or its authorized and issued capital stock. *See* 40 P.S. § 221.3 (definition of "insolvency").

19. SHIP's minimum required capital and surplus is $1,000,000. *See* 40 P.S. § 386(a).

20. SHIP's authorized and issued capital stock is valued at $7,500,005, which amount is greater than its statutorily required capital and surplus. *See* Ex. 1, p. 3, lines 29 and 30; *see also* 40 P.S. § 221.3 (definition of "insolvency"); 40 P.S. § 386(a) (minimum capital stock and financial requirements to do business).

21. Based on actuarial projections of the longtail claim exposures, as of December 31, 2018, SHIP's liabilities, plus its authorized and issued capital stock, exceeded its admitted assets by more than $474 million:

	2018 Annual Statement
Admitted Assets	$ 2,186,058,273
Liabilities	$ 2,652,931,248
Authorized and Issued Capital Stock	$ 7,500,005
Liabilities + Authorized and Issued Capital Stock	$ 2,660,431,253
Total Insolvency (line 1 – line 4) (Admitted Assets minus sum of Liabilities plus Authorized and Issued Capital Stock)	($ 474,372,980)

22. Under Section 503 of Article V, SHIP is statutorily insolvent because, as it has reported in its 2018 Annual Statement, SHIP's admitted assets do not exceed its liabilities plus the greater of any capital and surplus required by law or its authorized and issued capital stock. *See* 40 P.S. § 221.3 (definition of "insolvency").

SECOND GROUND FOR REHABILITATION: MANDATORY CONTROL LEVEL EVENT

23. Paragraphs 1 through 22 above are incorporated herein by reference.

24. RBC is a tool developed by the National Association of Insurance Commissioners to assist state insurance regulators in identifying insurers in a weak or deteriorating capital position and to authorize regulatory action based solely on RBC results to avoid or minimize the impact of insolvencies.

25. Under 40 P.S. § 221.2-A, every domestic insurer must submit to the Commissioner a report of its RBC levels, as of the end of the immediately preceding calendar year, on or before March 1 of each year.

26. Under 40 P.S. § 221.9-A(2), the filing of an RBC report that indicates that an insurer's total adjusted capital is less than its mandatory control level RBC provides an independent and sufficient basis for the entry of an order of liquidation. 40 P.S. § 221.1-A (definition of "mandatory control level event"); 40 P.S. § 221.9-A(2) (mandatory control level event "shall be deemed sufficient grounds" for entry of order of rehabilitation under 40 P.S. § 221.14).

27. On or about February 27, 2019, SHIP filed an RBC report with the Department for the year ending December 31, 2018 ("2018 RBC Report"). *See* Exhibit 2.

28. SHIP's officers personally represented that its 2018 RBC Report was a "true and fair representation of the company's affairs and has been completed in accordance with the [National Association of Insurance Commissioners ("NAIC")] instruction according to the best of their information, knowledge and belief." *See* Ex. 2, p. LR001.

29. SHIP's 2018 RBC Report indicated that its total adjusted capital of -$466,814,972 was less than its mandatory control level RBC of $35,946,617, thereby triggering the occurrence of a mandatory control level event. *See* Ex. 2, p. LR033, ln. 1, 5; LR034, ln. 12.

30. SHIP has not provided the Commissioner a corrective action plan that restores the company's RBC above mandatory control level, let alone above company action level, which would be 43% higher.

THIRD GROUND FOR REHABILITATION: CONSENT

31. Paragraphs 1 through 30 above are incorporated herein by reference.

32. As documented in Exhibits 3 and 4, a majority of the Trustees of the Oversight Trust and SHIP's directors have consented to the placement of SHIP in rehabilitation and to waiving the hearing contemplated in 40 P.S. § 221.15.

REHABILITATION

33. SHIP's financial condition is dire. The Commissioner's staff and consultants have spent some time working with the Trustees and SHIP management to obtain as accurate as possible a financial picture of SHIP's affairs. They have advised the Commissioner that it may be possible to devise and implement a plan for the rehabilitation of SHIP that would produce for policyholders a result no less beneficial than would be produced by a liquidation, and perhaps materially better than that.

34. Because of the gravity of SHIP's financial difficulties, there can be no assurance that the rehabilitation efforts will be successful. Nonetheless, in cooperation with SHIP's staff, the Trustees, and consultants, the Commissioner's representatives have begun the development of a plan for addressing the Company's financial difficulties that can only be implemented with the assistance of this Court in the context of court-ordered rehabilitation under Article V.

35. It is probable that the plan, when implemented, will require modification of existing contracts, premium rate increases, and other measures that in combination will reduce or eliminate SHIP's deficit.

36. To that end, the Commissioner requests that this Court enter an Order placing SHIP in rehabilitation, enabling her to develop a rehabilitation plan for this Court's approval, modification, or rejection after notice and hearing, and providing her the tools necessary for the development of that plan.

CONCLUSION

37. Under 40 P.S. § 221.14, SHIP's insolvency, by itself, is sufficient grounds for the Commissioner's requested relief. There is no good faith dispute that SHIP is insolvent.

38. Under 40 P.S. § 221.9-A(2), SHIP's RBC ratio is below the mandatory control level, which by itself, is sufficient grounds for the Commissioner's requested relief. There is no good faith dispute that SHIP's RBC ratio is below the mandatory control level.

39. Under 40 P.S. § 221.14, SHIP's consent, by itself, is sufficient grounds for the Commissioner's requested relief. The consent of the Oversight Trust's Trustees and SHIP's directors is documented in Exhibits 3 and 4.

40. It is evident that ample grounds exist to place SHIP in rehabilitation or liquidation. By this application, the Commissioner seeks to enlist the aid of this Court in attempting to salvage SHIP's business as much as possible and to avoid its liquidation.

RELIEF

WHEREFORE, Plaintiff Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, respectfully requests that this Court enter the attached Order of Rehabilitation.

Respectfully submitted,

AMY G. DAUBERT (ID #62064)
Chief Counsel

JODI A. FRANTZ (ID #84727)
Deputy Chief Counsel

KATHRYN MCDERMOTT SPEAKS (ID #77238)
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Counsel for the Pennsylvania Insurance Department, Commonwealth of Pennsylvania

DATED: January 23, 2020

EXHIBIT 2

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

ORDER OF REHABILITATION

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

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

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

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

(a) Inform all banks, investment banks, and other financial institutions or persons with custody of SHIP assets to identify and report these assets to the Rehabilitator and advise these institutions not to disburse, transfer, hypothecate or encumber such assets without the prior written consent of the Rehabilitator.

(b) Inform all banks and other financial institutions with SHIP accounts that checks or other payments that have been processed and transmitted may be honored without prejudice to the ability of the Rehabilitator to recover said amounts from the recipient or payee in accordance with applicable law.

(c) Inform all insurance producers, agents, managing general agents, brokers or other persons who have collected premiums on behalf of SHIP to account for all earned and unearned premiums and commissions to the Rehabilitator at the offices of SHIP within thirty (30) days of the date of this Order and that premium monies owed to SHIP must be remitted to the Rehabilitator.

(d) Inform all attorneys employed or retained by SHIP that within thirty (30) days of this Order they must report to the Rehabilitator the name of the case or claim they are handling; the claim or docket number, if one is assigned; the status of each such case; and, further, that the Rehabilitator will not make payment for any unsolicited reports.

(e) Inform all vendors providing claims or data processing services to SHIP that they shall continue such services unless and until instructed to the contrary by the Rehabilitator.

(f) Inform all vendors with custody or control of any data processing information and electronic records belonging to SHIP to preserve these electronic files and information and to transfer the data to the control of the Rehabilitator upon request.

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

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

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

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

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

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

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

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

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

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

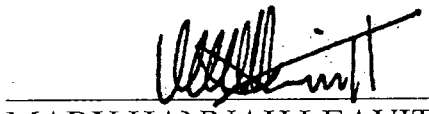
13. The Rehabilitator is directed to review all litigation pending outside the courts of the Commonwealth of Pennsylvania and petition these other courts or tribunals for a ninety (90) day stay of litigation where necessary to protect the estate of SHIP.

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

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

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

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



MARY HANNAH LEAVITT, Judge

Certified from the Record

JAN 29 2020

And Order Exit

EXHIBIT 3

Received 4/22/2020 8:37:52 PM Commonwealth Court of Pennsylvania

Filed 4/22/2020 8:37:00 PM Commonwealth Court of Pennsylvania
1 SHP 2020

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

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

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

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

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

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

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

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

a) reduction of the Funding Gap by appropriately increasing, maintaining and, in some instances, reducing premium rates to more accurately reflect the cost of benefits;

b) allowing policyholders to elect to maintain or reduce the level of benefits from their policy;

c) allowing policyholders to choose between Option One, Option Two, Option Three and Option Four relating to the premium paid and level of benefit received;

d) implementation of the corrective action in three distinct phases;

e) the suspension of payments of commissions to Agents;

f) investigation and analysis of the past operations and business dealings of the Company; and

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

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

VI. OTHER MATTERS

A. ABOUT SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

B. LONG-TERM CARE INSURANCE

C. FINANCIAL CONDITION

D. REHABILITATION PROCEEDING

E. SENIOR HEALTHCARE OVERSIGHT TRUST

F. FUZION ANALYTICS

G. LTCG, INC.

L. REINSURANCE

M. COMMISSIONS

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

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

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

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

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

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

Respectfully submitted,

/s/James R. Potts

James R. Potts
Attorney I.D. No. 73704
Dexter R. Hamilton
Attorney I.D. No. 50225
Michael Broadbent
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VERIFICATION

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

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

Patrick H. Cantilo

Patrick H. Cantilo
Special Deputy Rehabilitator

Dated: April 22, 2020

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EXHIBIT A

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

REHABILITATION PLAN
SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA, IN REHABILITATION

Wednesday, April 22, 2020

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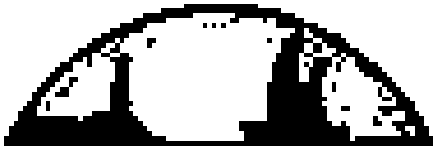

SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, *IN REHABILITATION* REHABILITATION PLAN

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

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HOW TO PROVIDE COMMENTS AND OBJECTIONS

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

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

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

IMPORTANT NOTICE

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

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

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

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

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

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

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

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

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REHABILITATION PLAN DOCUMENT

I. BASIC INFORMATION ABOUT THE PLAN

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

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

1. Enable policyholders and interested parties to understand, provide meaningful comments about, and formal objections if any to, the Plan, and

2. Enable the Commonwealth Court to determine whether to approve, modify and approve, or disapprove the Plan.

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

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

A. SUMMARY DESCRIPTION OF THE PLAN

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

1. GOAL AND PHASES OF THE PLAN

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

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

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

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

2. POLICYHOLDER ELECTIONS

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

a. Option One will be to continue paying the Current Premium but (if it is less that the If Knew Premium) have benefits reduced so that the premium for the reduced benefits on an If Knew Premium basis is equal to the Current Premium. The benefit reductions will be selected automatically by the Plan.

b. Option Two will be to select certain policy endorsements that in most cases provide greater benefits than Option One but at a lower premium than Option Four. This Option, of which an enhanced version will also be available, will not be subject to further rate increases or benefit reductions in Phase Two of the Plan. This Option is designed to provide reasonable coverage at reasonable premium rates.

c. Option Three will be a ***Non-forfeiture Option*** through which the policyholder will receive a Reduced Paid-up (RPU) policy providing limited benefits but for which no future premiums will be charged. Under the Plan, this Option will include more generous benefits than the typical industry non-forfeiture option or reduced paid-up policy, most notably in that it will offer as much as a 30 month benefit period unless the current policy has a shorter benefit period. Moreover, policyholders who select this option will never have to pay additional premiums and this policy will never lapse.

d. Option Four will be to retain the current policy benefits and pay the corresponding If Knew Premium (unless equal to or lower than the Current Premium that the policyholder is paying). For many policyholders this may require a very large increase in premiums.

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

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

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

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

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

B. KEY CONSIDERATIONS FOR POLICYHOLDERS

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

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

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

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

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

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

C. TIMELINE

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

D. RATIONALE FOR THE PLAN

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

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

1. The Plan gives policyholders more control over their fates, allowing each to elect the path best suited to his or her circumstances.

2. All policyholders will have at least one option for preserving their current coverage and at least one option for preserving their Current Premium.

3. Target premiums under the Plan take rate increase history and product differences into account, improving the equity of the premium rate structure. Generally, policyholders whose policies were issued in states that have approved comparatively more rate increases over preceding years will face lower premium increases or benefit reductions under the Plan.

4. In every case, unless their policies are already below Guaranty Association limits, policyholders will have at least one option (Option Two) calibrated to Guaranty Association limits to provide outcomes no less favorable than liquidation.

5. The revenue from rate increases under the Plan will go to pay claims and expenses of implementing the Plan whereas, in liquidation, Guaranty Association rate increases are used to reduce assessment burdens for member insurers and not to increase the ability to pay claims.

6. Though certainly not guaranteed, the Plan structure inherently creates the possibility of greatly reducing, if not eliminating, the Company's deficit.

II. GENERAL PLAN DETAILS AND TECHNICAL INFORMATION

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

A. PLAN PHASES

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

B. POLICYHOLDER CATEGORIES

1. For Plan implementation purposes, policyholders are sorted into eight main categories, four each in Phase One and in Phase Two:

    (1) Active - premium paying;
    (2) Active - <u>not</u> premium paying (further segregated between lifetime or dual Premium Waiver);
    (3) Disabled - premium paying; and
    (4) Disabled - <u>not</u> premium paying.

2. There may be some policyholders who do not fit neatly into the Plan's defined policyholder categories in each Phase, though none have yet been identified. If so, those will be addressed on an *ad hoc* basis.

C. POLICYHOLDER OPTIONS

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

a. ***Option One*** - Keep the Current Premium (or Premium Waiver) and downgrade to specified reduced benefits in a manner determined automatically by the Plan. The ***Downgrade Process*** is explained beginning at page 30. This will be solely a benefit reduction option;

b. ***Option Two*** - Elect ***Basic Policy Endorsements*** (making the policy one designed to provide reasonable benefits and premiums - see Section III.A.2.d, page 36) at If Knew Premium (as defined below) in Phase One or at Self-sustaining Premium if elected in Phase Two. This option may entail both premium increases and benefit reductions for many policyholders, but premium increases will always be lower than under Option Four. For some policyholders it may entail a premium reduction. Policyholders will be offered two variations of this option, a standard version and an enhanced alternative. As explained below, policyholders who select this option in Phase One will not be asked to make Policy Modifications in Phase Two;

c. ***Option Three*** - Elect a Non-forfeiture Option on which no additional premium will ever be paid (see Section III.A.3, page 37); or

d. ***Option Four*** - Keep the current policy benefits and accept a premium increase. The new premium will be (as defined below) the ***Phase One Premium*** in Phase One and the ***Self-sustaining Premium*** in Phase Two. This will be solely a premium increase option.

2. Thus, policyholders whose Current Premiums are below the If Knew Premium for their policies will be able to: (a) keep their current premium with downgraded benefits, (b) choose Basic Policy Endorsements, (c) take a NFO, or (d) to keep their current benefits and pay additional premium.

   a. The Basic Policy Endorsements modify the existing policy to one with generally more affordable premiums than would be charged for the current policy benefits on an If Knew basis and more limited benefits when compared to the current policy, but generally richer than those in Option One, the downgrade. Details of its provisions are laid out in Section III.A.2.d, page 36, below. As noted, to maximize policyholder choice, two variations of this option will be offered, standard and enhanced.

   b. The NFO is a reduced paid up policy more fully described in Section III.A.3, page 37, below. No more premium is ever due on the NFO and it will never lapse.

3. These will be the only options available under the Plan. Other options that are sometimes available in particular states in response to approved rate increases are not offered under the Plan.

4. In Phase One, policyholders whose Current Premium on the Determination Date (see page 92) is at or above the If Knew Premium for the benefits offered by their policies need not modify their policies, and their policies would not be changed by selecting Option One or Option Four. Such policyholders may do nothing or they may select Option Two or Option Three if they wish to do so to accommodate their individual circumstances, for example to reduce their premiums or to avoid the possibility of a Phase Two rate increase. The Default Option for these policyholders will be that their policies remain unchanged.

5. Subject to the orders of the Commonwealth Court of Pennsylvania (***Commonwealth Court*** - which is the rehabilitation court), the Plan contemplates that Basic Policy Endorsements elected in Phase One (Option Two) will be immune from Phase Two changes unless the Company is placed in liquidation. Policyholders who elect this option in Phase One generally will not face premium rate increases or additional benefit reductions in Phase Two of the Plan.

6. However, certain policyholders paying the lower ***Phase One Differential Premium*** or ***If Knew Differential Premium*** due to a Premium Waiver may be required to begin paying the full Phase One Premium or If Knew Premium if the Premium Waiver no longer applies (for example because a policyholder on claim recovers). Similarly, in Phase Two certain policyholders paying the ***Self-sustaining Differential Premium*** due to a Premium Waiver may be required to begin paying the full Self-sustaining Premium if the Premium Waiver no longer applies (for example because a policyholder on claim recovers). See Section III.A.2.c, page 35.

7. Non-forfeiture Options elected in Phase One will not be subject to change thereafter, including in Phase Two or if the Company is placed in liquidation.

8. It is important to note, and policyholders will be advised before making such elections, that policies for which Options One or Option Four are chosen in Phase One may be subject to additional modifications in Phase Two. Moreover, the timing and details of the modifications that may be required in Phase Two will not be known to policyholders when they make their Phase One elections. In particular, policyholders will be advised that options to retain benefits that generate low premium rate increases in Phase One may result in premium rate increases or benefit reductions in Phase Two due to differences in the methodologies used to calculate premium rates in each phase.

9. The exceptions to this possibility of changes in Phase Two are the election of Basic Policy Endorsements or NFO (Options Two and Three, respectively) in Phase One. As noted below (see Section III.A.2.c, page 35), so long as the Plan remains in effect, and unless the Commonwealth Court orders otherwise, the Basic Policy Endorsements elected in Phase One will be immune from Phase Two changes except that (as explained above in Section II.C.5)

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

10. The approximately 10,500 policyholders who have already chosen to replace their policies with Non-forfeiture Options before the Plan is implemented will not be asked, or have the ability, to make any changes to their policies as part of the Plan.

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

D. CLAIM STATUS

For purposes of Policyholder Elections:

1. After the Plan is approved, a policyholder will be deemed to be on claim if he or she is receiving health care services that would be reimbursable by the Company were it not for an ***Elimination Period*** (EP) that has not been satisfied. Such a policyholder will be expected to begin receiving indemnity or reimbursement payments as soon as the EP is satisfied.

2. The Company may also determine that a policyholder has been on claim as of an earlier date when that policyholder has been receiving health care services reimbursable by the Company but has not reported such services to the Company. Such a policyholder is expected to be reimbursed for prior covered services when they are reported to the Company, subject to policy terms and conditions and applicable law.

E. PREMIUM RATE DETERMINATIONS

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

2. The **If Knew Premium** rate is the rate that, if charged from inception, would have produced the greater of the initial target loss ratio or the minimum loss ratio applicable to the policy form. For the sake of simplicity, this will be assumed to be 60%. If Knew Premium rates are intended to price policies adequately on a lifetime basis, but not to recoup losses due to inadequate pricing in the past.

3. For each policy for which the Current Premium is more than the If Knew Premium, the Current Premium will be the Phase One Premium required to maintain the current benefits. In short, that policyholder can (but is not required to) retain the current policy at Current Premium without change in Phase One. Correspondingly, for policies with a Phase One Premium higher than the Current Premium (which in this case would be the same as the If Knew Premium), the downgrade required to maintain the Current Premium will be a reduction in benefits to a level that produces an If Knew Premium equal to the Current Premium as explained beginning on page 29.

4. ***Self-sustaining Premium*** is the premium calculated by determining the amount of premium required to eliminate a policy's ***Shortfall Amount***.

   a. The Shortfall Amount is the difference between its ***Projected Benefit Amount*** (PBA) and its ***Projected Credit Amount*** (PCA) where the difference is more than zero. The Shortfall Amount can also be expressed as a policy's ***Gross Premium Reserve*** (GPR) less its ***Allocated Assets***. If the difference is zero or less there is no shortfall and the policy is Self-sustaining.

   b. The PBA is the present value as of the valuation date of the sum of (1) unpaid expected policy benefits and (2) unpaid expected policy expenses. For purposes of this determination "expected" consists of best estimate assumptions.

   c. The PCA is the sum of (1) the present value as of the valuation date of expected premiums, adjusted for future premium increases reasonably expected to be put into effect and (2) the assets allocated to that policy as described below in subparagraph II.E.4.e, page 17. Again, for purposes of this determination "expected" consists of best estimate assumptions.

   d. ***Total Allocable Assets*** is a notional determination consisting of the Company's invested assets less reserves for costs of administration, contingencies, and certain debts of higher priority. ***Active Allocable Assets*** is a notional determination consisting of the Company's Total Allocable Assets less the amount required to fund fully the Claims Reserves for Disabled Lives under the Plan. For the purpose of these calculations, NFO policies will be treated as Disabled Lives and their GPR will be included with Claims Reserves for Disabled Lives. ***Disabled Allocable Assets*** is a notional allocation consisting of the product of the Active Asset Premium Ratio

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

e. **Allocated Assets** are the portion of the Company's Allocable Assets notionally allocated to a particular policy in accordance with the terms of, and solely for the purposes of calculations described in, the Plan. Such asset allocations are nominal and do not give a policyholder a right to any Allocated Assets or any particular sum of money. Allocated Assets are determined separately for active lives and disabled lives.

(1) For each Active Policy, Allocated Assets is the portion of Active Allocable Assets equal to the percentage of total Accumulated Premium for active lives represented by that policy's Accumulated Premium.

(2) For a policy on claim, the Allocated Assets is the portion of Disabled Allocable Assets equal to the percentage of total Accumulated Premium for policies on claim represented by that policy's Accumulated Premium.

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

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

5. For policyholders on claim in Phase Two, the Self-sustaining Premium will be determined as if they were not on claim. For this purpose, assets will be allocated notionally to policies on claim as explained above.

6. In certain instances the Plan uses a ***Differential Premium***, which in each case is the difference between the target rate (Phase One Premium, If Knew Premium, or Self-sustaining Premium, depending on the option elected and whether this occurs in Phase One or Phase Two) and the Current Premium the policyholder would be paying if not on waiver. Differential Premium can never be less than zero. In cases in which the Current Premium is higher than the target rate, there would be no Differential Premium.

   a. Thus, in Phase One the Plan requires policyholders not paying premium, who elected Option Four (retain current benefits), to pay the Phase One Differential Premium consisting of the Phase One Premium less the Current Premium they would be paying if they were not on waiver (but not less than zero).

   b. Policyholders not paying premium who chose Option Two (Basic Policy Endorsements) in Phase One and whose current (waived) premium before making that election was lower than the If Knew Premium for the Basic Policy Endorsements will be required to pay the If Knew Differential Premium. This is the difference between the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements and the Current Premium for the policy, both of which are set as if the policyholder did not have a Premium Waiver in effect.

   c. Similarly, in Phase Two the Plan requires policyholders not paying premium who selected Option Two (Basic Policy Endorsements) or Option Four (retain current benefits) to pay the Self-sustaining Differential Premium consisting of the Self-sustaining Premium less the Current Premium they would be paying if they were not on waiver (but not less than zero).

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

F. PREMIUM WAIVERS

1. SHIP LTC policies may contain one or more ***Premium Waiver*** provisions under which a policyholder is permitted to discontinue paying premiums and maintain the policy in force during a period of covered care or under circumstances specified in the policy.

   a. Under a ***Claim Waiver of Premium*** (WOP) provision, a policyholder who receives benefits under his or her policy for a specified period of time (such as 90 days) is no longer required to pay premiums for coverage after that time period as long as the policyholder remains eligible for benefits and/or receives a specified level of care. Once the policyholder's eligibility for benefits ends, the policyholder is required to recommence paying premiums in order to keep the policy in force.

   b. Under a ***Dual Waiver of Premium*** (DWOP) provision, also called "Spousal Waiver of Premium", a policyholder may suspend premium payments during the time that a spouse qualifies for waiver of premium.

   c. The ***Lifetime Waiver of Premium*** provision permits suspension of premium payments upon the death of a covered spouse after a qualifying period (typically five, seven, or ten years). The Lifetime Waiver of Premium provision, as the name implies, is permanent.

2. The Plan affects these Waiver of Premium provisions in specific ways. Policyholders who took a Non-forfeiture Option before the Plan became effective, or who do so under the Plan, do not pay premium and are not affected by Waiver of Premium provisions.

   a. **Claim Waiver of Premium.** Policyholders on Claim Waiver of Premium on the

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

(1) If such policyholders elect Option One, which does not entail a premium increase, the Current Premium remains waived and no Differential Premium is applicable. If such policyholders recover, their Current Premium must again be paid but their policies will remain downgraded.

(2) If such policyholders make an election under the Plan that increases their premiums (Option Two or Option Four, see page 12), the waiver does not apply to the increase and they will be required to pay Differential Premium consisting of the difference between the Current Premium and the premium under the elected Plan Option. When such policyholders recover and the Claim Waiver of Premium terminates, they must begin paying the full Plan premium. If such policyholders go on claim again following a specified period of recovery and their policy retains the Claim Waiver of Premium provision, the full ***Plan Premium*** (Phase One Premium, If Knew Premium, or Self-Sustaining Premium, depending on the circumstances) is waived while they are on claim.

(3) Policyholders who elect Option Three, the NFO, are unaffected by Premium Waiver provisions because they do not pay premium.

b. **Dual Waiver of Premium.** Policyholders whose premiums are waived under a Dual Waiver of Premium (DWOP) provision will be treated in the same way as policyholders under a Claim Waiver of Premium. However, it is the status of the spouse on claim that determines whether they pay the Differential Premium or the full Plan premium when they select Option Two or Option Four.

(1) If a policyholder has selected Option One, is not paying any premium due to the waiver, and his or her spouse recovers, he or she must begin paying the Current Premium but his or her policy will remain downgraded.

(2) If a policyholder has selected Option Two, is paying only the If Knew Differential Premium due to the waiver, and his or her spouse recovers, such a policyholder must begin paying the full If Knew Premium. Of course, if the If Knew Differential Premium for that policyholder is zero, he or she need not pay any additional premium.

(3) If a policyholder has selected Option Four, is paying only the Phase One Differential Premium due to the waiver, and his or her spouse recovers, such policyholder must begin paying the full Phase One Premium.

(4) If a policyholder is on Dual Waiver, has a policy with Claim Waiver of Premium, selects Option Two or Option Four, is paying Phase One Differential Premium or If Knew Differential Premium, and goes on claim after the Effective Date, the Differential Premium will then be waived under the Claim Waiver of Premium provision so that the policyholder will not have to pay any premium while on claim, even if the spouse recovers during that period. Once the policyholder recovers, he or she will be required to resume paying the Differential Premium if the spouse remains on claim and the dual waiver of premium is still effective. If the spouse has also recovered or the dual waiver of premium is otherwise no longer effective, the policyholder will be required to pay the full Phase One Premium or If Knew Premium upon recovery. If both policies with Dual Waiver select Option Four, and one goes on claim after the Effective Date, the full Phase One Premium for both policies would be waived.

c. **Lifetime Waiver of Premium.** Policyholders who are on Lifetime Waiver of Premium on the Policyholder Election Date will retain that waiver after the Plan Effective Date.

(1) If such a policyholder makes an election under the Plan that increases his or her premiums (Option Two or Option Four), the Lifetime Waiver of Premium does not apply to the increased portion of the premium and he or she will be required to pay Differential Premium consisting of the difference between the Current Premium and the premium under the elected Plan Option.

(2) If a policyholder is on lifetime waiver, has a policy with Claim Waiver of Premium benefit, selects Option Four, and goes on claim after the Effective Date, the Differential Premium will then be waived under the Claim Waiver of Premium provision so that the policyholder will not have to pay any premium while on claim.

G. CERTAIN "NON-CORE" POLICY BENEFITS

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

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

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

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

H. RATE APPROVALS

1. Rate increases and Policy Modifications will be submitted to Commonwealth Court of Pennsylvania for approval as part of the Plan. The Rehabilitator will not seek separate approval of rate increases or Benefit reductions.

2. The rate increases will not necessarily be limited by, or adhere to, filed rate cards. Rate cards are issued by insurers and approved by regulators to describe the premium rates applicable under specified circumstances or for specific types of coverage. They are inapplicable to the Plan.

3. Premium increases and Policy Modifications will not be submitted to individual insurance departments for approval. This is consistent with the established insurance rehabilitation practice in the U.S. under which the domiciliary regulator as domiciliary rehabilitator may, with only rehabilitation court approval and no approval from individual states, modify or terminate insurance policies issued by the delinquent insurer throughout the country. If its premium rates were subject to approval in each state, the Plan could not meet its goal of eliminating "subsidies" by having policyholders with substantially similar policies generally pay substantially similar premium regardless of the state in which the policyholder resides or in which the policy was issued. Moreover, the delay and expense of state-by-state rate approval would make the Plan unfeasible. Finally, the state-by-state approval process might perpetuate or increase the nation-wide premium rate variations the Plan strives to eliminate.

I. NFOs AND PAID-UP POLICIES

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

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

J. PARTNERSHIP-QUALIFIED POLICIES

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

K. PLAN TIMING

1. The Plan is designed for implementation of Phase One as rapidly as possible, with more time available for implementation of Phase Two. At the conclusion of Phase One and continuously thereafter its results will be evaluated and, in due course, a determination will be made as to whether and, if so how, Phase Two should be implemented.

2. The anticipated timeline provides for a fair opportunity for policyholders and interested parties to evaluate and object to, or comment upon, the Plan if they choose to do so. The Rehabilitator may suggest modifications of the Plan as a result of those comments and objections, if any. Illustration 4 provides a high-level sequence for the Plan.

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

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

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

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

(2) The ***Policyholder Election Package*** (containing the information required for

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

(3) Except as noted below in Section II.K.3, page 25, the Policyholder Elections must be made by the ***Policyholder Election Date*** and will be collected and evaluated by the Company as received.

(4) On the ***Initial Plan Effective Date*** all the Policyholder Elections, other than those addressed in Section II.K.3.c, below, will be implemented and the premium and policy changes will take effect.

(5) The Initial Plan Effective Date may vary from policyholder to policyholder. For each policyholder the Initial Plan Effective Date will be the policy's ***Monthiversary Date*** occurring during the ***Initial Plan Effective Month***. See definitions, pages 95 and 97.

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

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

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

b. Policyholders who have been deemed eligible for benefits, but the benefits are pending and they have therefore not yet gone on claim, will be treated as if they were on claim and be required to elect from among the options available to policyholders on claim, including the availability of Premium Waiver. Note that during the

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

c. Policyholders who, during the Policyholder Transition Period,

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

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

L. POLICYHOLDER INFORMATION

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

2. Phase Two - Before being required to make any elections in Phase Two of the Plan, each policyholder eligible to make elections in this Phase will receive a ***Phase Two Policyholder Election Package*** that includes notice and details of Phase Two of the Plan. These details will include the premium amount and/or benefit reductions that will apply to the policyholder's specific policy under each applicable option of the Plan in Phase Two.

M. CALCULATION NOTES

1. The assets allocated on an Accumulated Premium basis for determination of Self-sustaining Premium will be those remaining after provision is made for administrative costs and contingencies as more fully explained above at Section II.E.4.d, page 16.

2. Whenever the Plan calls for adjustment of the ***Maximum Benefit Period*** (MBP) it will be calculated in increments of whole days.

3. Whenever the Plan calls for matching an existing premium rate, it may be by rounding the premium to the nearest dollar.

4. In calculating the Phase One Premium, the If Knew Premium, and other Plan provisions, periods on claim (including those followed by recovery) prior to the Initial Plan Effective Date will be taken into account and reduce the remaining benefit period. The operative benefit period for the policy will be what remains on the Determination Date. Thus, a policyholder whose initial Maximum Benefit Period was eight years when the policy was issued, but who has used five years of benefits (whether in one or more periods on claim) that were not restored or eligible for restoration and therefore has three years remaining as of the Determination Date, will be deemed to have a Maximum Benefit Period of three years for Plan calculation purposes. The Phase One Premium and If Knew Premium will be calculated using the remaining benefit period without regard to prior periods on claim. Thus, for this hypothetical policyholder the premium will be calculated for a policy with a three year MBP.

5. In calculating reductions of the Maximum Benefit Period, for policies with two different pools of money, one (typically of two years) for Home Health Care and one (typically longer, part of which may have been utilized) for Assisted Living Facility Care or Nursing Home Care:

    a. The Plan will treat the policy as having a single benefit period equal to the longer of those provided by the pools. The benefit periods provided by the pools will not be aggregated. Thus, the Maximum Benefit Period for Assisted Living Facility Care cannot be increased by adding the unused benefit period for Home Health or *vice versa*.

    b. Benefits paid under the policy regardless of site of care, will reduce the new single benefit period.

    c. Pools shorter than four years will not be adjusted by the Plan. If benefits have reduced the benefit period below four years as of the Effective Date, it will remain at that level for Plan calculation purposes.

6. Policies that share a pool of benefits before the Policyholder Election Date, so that a policyholder whose benefit period is exhausted may continue receiving benefits under the shared pool until it is exhausted, will be treated for purposes of calculating premiums under the Plan as having a benefit period equal to the sum of the policy's benefit period and half of the shared pool's benefit period. Such policies will continue sharing a pool after the Plan and elections made under the Plan will affect only the policy's benefit period, not the value of the shared pool. When such a policyholder goes on claim after the applicable Plan Effective Date, the claim will reduce the policy's benefit period first and then the shared pool. Policyholders sharing a pool need not make the same elections under the Plan.

   a. For a policyholder who elects Option One, the downgrade will affect only the policy's benefit period (which cannot be reduced below four years unless it is already below that) and not the shared pool.

   b. For a policyholder who elects Option Two, the policy's benefit period may be reduced but it will retain the possibility of benefits under the shared pool.

   c. Thus, the premium for such a policyholder who elects Option Four will be calculated as if the policy had a benefit period equal to the sum of the policy's current benefit period plus half of the shared pool.

7. A policy with an unlimited benefit period will be deemed to have an unlimited ***Maximum Policy Value*** (MPV - the product of a policy's ***Maximum Benefit Period*** times its ***Maximum Daily Benefit*** - MDB).

8. The Plan contemplates that the minimum premium for Basic Policy Endorsements in Phase Two will be 110% of the If Knew Premium to discourage delaying the selection of Basic Policy Endorsements to Phase Two. See Sections IV.B.2.c, IV.C.1.b, IV.C.2.b.(4), IV.E.2.b, and IV.D.1.b.

9. Premium paying modalities (*i.e.,* monthly or quarterly payments) in effect before the Plan will be unchanged by the Plan unless necessary to give effect to a policyholder's election. If a policyholder is not paying premium prior to the applicable Plan Effective Date due to a waiver, and under the Plan he or she must begin paying a premium (such as a differential premium), the premium modality in effect prior to the waiver becoming effective will apply to the premium under the Plan.

10. Fees charged before commencement of the rehabilitation to premium payments based on modality (such as additional fees for monthly premiums) will continue to apply to premiums paid under the Plan on the same basis.

N. DRAFTING NOTES

1. As endorsements are drafted to implement policy changes, provisions not intended to be substantively affected will be left unchanged unless editing is necessary to implement the modifications selected.

2. As a result, for example, if a policy has an unlimited benefit period and a Restoration of Benefit provision, shortening the benefit period will not remove the Restoration of Benefit provision. However, the Restoration of Benefits provision cannot extend the benefit period beyond the newly shortened Maximum Benefit Period. Similarly, policies with limits in terms of days-of-care will remain so and not be converted to pool-of-money policies except by operation of the Downgrade Process or if the Basic Policy Endorsement is elected.

3. Replacement language to implement modifications will strive to eliminate ambiguities and add clarity.

4. If the language of the current policy does not differentiate clearly between Nursing Home and Assisted Living Facilities (ALF) coverage so that SHIP is now covering ALF care within the Nursing Home provision in those policies, electing the Basic Policy Endorsements will not eliminate ALF coverage but Maximum Daily Benefits for ALF care will be limited to 75% of the policy's MDB.

III. DETAILS OF PHASE ONE OF THE PLAN

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

1. OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS.

   a. Policyholders can keep their Current Premium but will have policy benefits reduced if the Current Premium is less than the If Knew Premium for their policy benefits.

   b. The target premium for this Option is the Phase One Premium, which is the higher of the Current Premium and the If Knew Premium. For policyholders whose Current Premiums equal or exceed the If Knew Premium for their policies, no downgrade will be necessary because they are already paying the target premium and Options One and Four will produce the same result - no change in their policies. For other policyholders (those whose Current Premiums are lower than the If Knew Premium for their current policies), the benefit reductions applied to each policyholder who elects this option will be calibrated to produce benefits for which the premium on an If Knew Premium basis will be within 2% of the Current Premium, determined as follows:

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

TABLE 4: IS DOWNGRADE NECESSARY?

IF:	CASE 1	CASE 2
1. THE CURRENT PREMIUM IS	$3,000	$3,200
and		
2. THE IF KNEW PREMIUM FOR THE CURRENT BENEFITS IS	$2,800	$5,000
THEN:		

IN CASE 1, SINCE THE IF KNEW PREMIUM IS LOWER THAN THE CURRENT PREMIUM, THERE WILL BE NO BENEFIT REDUCTIONS.

IN CASE 2, SINCE THE IF KNEW PREMIUM IS MORE THAN THE CURRENT PREMIUM, BENEFITS WILL BE REDUCED 36% TO THE CURRENT PREMIUM.

c. DOWNGRADE PROCESS: A single combination of one or more of the benefit reductions described in Section III.A.1.f, page 32 below, will be selected by the Rehabilitator in accordance with the Plan provisions to reduce the policy's benefits to a combination with an If Knew Premium within 2% of the Current Premium. Policyholders will not have the option of electing specific benefit reductions.

(1) Not all of the benefit reductions on the list below will be applicable to all policies. For example, eliminating inflation protection features would not be applicable to a policy that has no such benefits. Similarly, shortening the Maximum Benefit Period would not be applicable to a policy with a benefit period that does not exceed four years. Thus, the list of potentially applicable benefit reductions may vary from policy to policy.

(2) Each benefit reduction option is expected to have a materially different effect on premiums, some reducing the If Knew Premium more than others. The result of a particular benefit reduction may vary among different policies. Benefit reductions will be selected sequentially, beginning with the first potentially applicable benefit reduction for the policy in question. However, in some cases the Rehabilitator may skip over one or more possible benefit reductions (for example, because they are inapplicable, produce too large a reduction, or are non-scalable) in order to produce the If Knew Premium closest to the Current Premium.

(3) The Rehabilitator may also scale a potentially applicable scalable benefit reduction up or down to simplify the process, for example by enabling fewer benefit reductions to be effected to achieve the desired premium level. For the sake of simplicity, efforts will be made to minimize the number of benefit reductions effected.

(4) Benefits will not be scaled above or below Plan Limits (a range of four to six years for MBP and $300 to $600 for MDB) unless current benefits already fall short of or exceed these limits.

d. The default mode will be to evaluate the potentially applicable benefit reductions in the order in which they are included in the Plan.

(1) If the first potentially applicable benefit reduction produces an If Knew Premium that is higher than 98% of the Current Premium it will be selected. If it produces a premium lower than 98% of the Current Premium, it would implement too deep a benefit reduction and would not be selected.

(a) If that first potentially applicable benefit reduction produces an If Knew Premium that is between 98% and 102% of the Current Premium, that will be the only benefit reduction and downgrade necessary for the policy in order to implement Option One.

(b) If the benefit reduction produces an If Knew Premium above 102 % of the Current Premium, is scalable, and can be scaled down sufficiently to produce an If Knew Premium no higher than 102% of the Current Premium without going below Plan Limits for MDB and MBP, then it will be scaled down sufficiently to achieve that result and that will be the only benefit reduction for the policy.

(2) If the first potentially applicable benefit reduction will not suffice (with or without scaling, if applicable) to reach an If Knew Premium within 2% of the Current Premium, the next potentially applicable benefit reduction will then be evaluated in the same manner, taking into account the effect of the previously selected potentially applicable benefit reduction.

(3) If the result is still an If Knew Premium that is higher than 102% of the Current Premium, that reduction will also be selected and the next potentially applicable benefit reduction will then be evaluated, again taking into account the effects of the previously selected potentially applicable benefit reductions.

(4) This process will continue until the resulting If Knew Premium is within 2%

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

(5) If the benefit reductions selected, in combination, produce an If Knew Premium that is lower than 98% of the Current Premium, the policy's MDB and MBP can be increased (subject to Plan Limits) to produce (in combination with previously selected benefit reductions) an If Knew Premium within 2% of the Current Premium. If raising the MBP and MDB (in combination with previously selected benefit reductions) still does not produce an If Knew Premium within 2% of the Current Premium, the policy's premium can be reduced so that the resulting If Knew Premium is within 2% of the Current Premium.

(6) If all of the benefit reductions selected in combination produce an If Knew Premium that is higher than 102% of the Current Premium, then in addition, the Maximum Benefit Period will be shortened (but not below Plan Limits) to the extent necessary to produce an If Knew Premium within 2% of the Current Premium.

(7) If the resulting If Knew Premium is still higher than 102% of the Current Premium, then the Maximum Daily Benefit will be reduced (but not below Plan Limits) to the extent necessary to produce an If Knew Premium within 2% of the Current Premium.

(8) In the unlikely event that after all these steps the If Knew Premium for the reduced benefits remains higher than 102% of the Current Premium, there will be no further reductions and those will be the downgraded benefits and the premium charged for those benefits will be the Current Premium.

e. Each policyholder will only receive one downgrade option, calculated as described in this Section. The Rehabilitator may develop algorithms, tables or other tools that will facilitate implementation of this process through classification of the existing policies. Policy provisions not identified in this Section will not be affected by the Downgrade unless necessary to implement the specified option.

f. ***Possible Active Benefit Reductions*:**

(1) ***Benefit Reduction One*:** Adjustment of the "recovery period" for Restoration of Benefits provisions so that to be eligible for the benefit period restoration the policyholder must not be eligible for health benefits during a continuous and uninterrupted period of not less than six months. This is a binary and

non-scalable benefit reduction.

(2) ***Benefit Reduction Two:*** For policies with less restrictive triggers, adoption of the TQ Trigger. See Section III.A.2.d.(8), page 36. This is a binary and non-scalable benefit reduction.

(3) ***Benefit Reduction Three:*** Elimination of Return of Premium (ROP) provisions. However, accrued ROP benefits, for policies which provide that they accrue over several years and are then paid, will not be lost and will be calculated as of the applicable Plan Effective Date and repaid within a reasonable time after that date or when due. This is a binary and non-scalable benefit reduction.

(4) ***Benefit Reduction Four*:** Removal of inflation and "locking" of MDB at their current levels. This is a scalable benefit reduction because the MDB can be increased or decreased within Plan Limits as necessary.

(5) ***Benefit Reduction Five*:** Conversion of indemnity to reimbursement. See Section VI.B.1.f, page 71. This is a binary and non-scalable benefit reduction.

(6) ***Benefit Reduction Six*:** Reduction of MBP to no more than four years (from the applicable Plan Effective Date). If the current MBP is less than four years it will not be modified. As long as the resulting MBP is above the lesser of (a) the current period, or (b) four years, this is a scalable benefit reduction.

(7) ***Benefit Reduction Seven*:** Extension of the EP to 90 days. If the current EP is 90 days or more it will not be modified. The EP will apply to each period of care. This will be treated as a binary and non-scalable benefit reduction.

(8) ***Benefit Reduction Eight*:** Reduction of the policy's MDB to $300. This is a scalable benefit reduction (that can be increased or decreased) so long as the resulting MDB is within Plan Limits. For comprehensive policies, this benefit reduction will also reduce the MDB available for Assisted Living Facilities to 75%, and for Home Health Care to 50% of the nominal MDB.

(9) ***Benefit Reduction Nine*:** Elimination of all Waiver of Premium provisions. For purposes of the Plan this is a binary and non-scalable benefit reduction. The Plan will not allow elimination of fewer than all available Premium Waiver provisions.

(10) ***Benefit Reduction Ten*:** Elimination of Restoration of Benefits (ROB) provisions. This is a binary and non-scalable benefit reduction.

(11) ***Benefit Reduction Eleven:*** Removal of Alternative Plan of Care (APOC) provisions. This is a binary and non-scalable benefit reduction.

(12) ***Benefit Reduction Twelve:*** Convert to pool of money and reduce maximum benefit amount to amount required to achieve the Current Premium subject to Plan Limits.

g. The Downgrade is generally the Default Option for policyholders on Premium Waiver. However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than the benefits offered by the NFO, the NFO will be the Default Option.

TABLE 5: DOWNGRADE PROCESS

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

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

2. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT CORRESPONDING IF KNEW PREMIUM.

   a. Policyholders will have the option to have their current policy endorsed to provide benefits substantially similar to a newly designed Basic Policy.

   b. The new premium for the policy will be the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements.

   c. **THIS OPTION WILL BE IMMUNE FROM PHASE TWO CHANGES. Policyholders who elect this option will not face premium rate increases or**

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

d. Key provisions of the Basic Policy Endorsements are:

(1) MBP equal to the lesser of (a) the current benefit period, and (b) four years (beginning on the applicable Plan Effective Date);

(2) Minimum EP equal to the longer of (a) 90 calendar days, or (b) the current EP;

(3) Minimum 6-month Recovery Period;

(4) Removal of Return of Premium (ROP) benefit. However, accrued ROP benefits, for policies which provide that it accrues over several years and is then paid, will not be lost and will be calculated as of the applicable Plan Effective Date and repaid within a reasonable time after that date or when due.

(5) Reduction of Inflation to 1.5% for policies with inflation above that level;

(6) Initial MDB set at lesser of 80% of current level or $300;

(7) Adjusting MDB by site of care: 100% of MDB available for Nursing Home Care, 75% of MDB available for Assisted Living Facility Care, and 50% of MDB available for Home Health Care;

(8) Adopting ***Tax Qualified*** (TQ) Triggers. Tax Qualified or TQ Triggers require that a person 1) be expected to require care for at least 90 days, and be unable to perform 2 or more Activities of Daily Living (ADL - eating, dressing, bathing, transferring, toileting, and continence) without substantial assistance (hands on or standby); or 2) for at least 90 days, need substantial assistance due to a severe cognitive impairment. In either case a licensed healthcare professional must certify a plan of care;

(9) Conversion of reimbursement policies to indemnity;

(10) Removal of Restoration of Benefits (ROB) provisions;

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

(12) Elimination of all Premium Waivers.

e. This will be the Default Option for policyholders in this category (active, paying premium) whose Current Premium is lower than the If Knew Premium.

f. Unless the benefits of their current policies are lower, policyholders will also be offered an "Enhanced Basic Policy Endorsement" with the terms described above but caps at a five-year benefit period and 2% inflation at higher If Knew Premium. In Phase Two the premium for the Enhanced Basic Policy Endorsements will be at Self-sustaining Premium rates. For a policyholder whose current policy has a Maximum Benefit Period of less than five years but inflation above 2%, the Enhanced Basic Policy Endorsements will only affect the inflation benefit. For a policyholder whose current policy has a inflation below 2% but a Maximum Benefit Period of more than five years, the Enhanced Basic Policy Endorsements will only affect the Maximum Benefit Period.

g. With the exception of the change from reimbursement to indemnity, benefits in the Basic Policy Endorsements (even in the Enhanced Basic Policy Endorsements) cannot exceed those in the current policy. If a particular component of the Basic Policy Endorsements provides more coverage than the current policy's corresponding provision, that provision of the current policy will not be modified by endorsement. Thus, for example, if the MBP of the current policy is three years, the Basic Policy Endorsements for that policy will incorporate a Maximum Benefit Period of three, not four or five years.

h. For those policies with an MPV that is currently above their applicable Guaranty Association (GA) limits, the endorsed policy's MPV will be adjusted so that it is at least equal to the applicable GA limit. The adjustment will be made by lengthening the MBP.

3. OPTION THREE - NFO.

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

b. No additional premiums will be due for this policy and it will never lapse.

c. This policy is much more generous than traditional NFOs. It cannot be upgraded later.

d. The selection of indemnity, rather that reimbursement, modality for Options Two and Three is expected to be of significant value to policyholders.

4. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY PHASE ONE PREMIUM.

a. Policyholders can elect to keep their current benefits and their premiums will increase to the Phase One Premium. See Section II.E.1, page 15, above. Policyholders whose Current Premiums equal or exceed the If Knew Premium for their policies will continue to pay their Current Premiums. For those policyholders, this option, like Option One, does not result in any change.

b. Policyholders selecting this option may also face substantial rate increases or Benefit reductions in Phase Two.

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

1. LIFETIME WAIVER - Policyholders not paying premium due to Lifetime Waiver of Premium (because of the death of a spouse) will have essentially the same four options as premium paying active lives (see Section, III.A, page 29) with the following modifications:

a. OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS. If the Current (waived) Premium is equal to or greater than the If Knew Premium, there will be no downgrade and Options One and Four will produce the same result - no change in their policies. If the Current Premium is less than the If Knew Premium the policy will be downgraded as follows.

(1) Due to the Premium Waiver the policyholder will continue not paying premium.

(2) The Downgrade Process will be the same as for premium-paying active lives (see Section III.A.1.c, page 30, above).

(3) The specific possible benefit reductions will be the ones described in Section III.A.1.f, page 32, above.

(4) The benefit reductions will be calibrated to the Current Premium as explained

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

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

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

(1) The If Knew Differential Premium for this option is the difference between the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements and the Current Premium for the policy, both of which are set as if the policyholder did not have a Premium Waiver in effect. If the If Knew Differential Premium is less than zero, the policyholder will not be required to pay any additional premium for the Basic Policy Endorsements.

(2) Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher If Knew Premiums. See Section III.A.2.f, page 37.

(3) Policyholders who elect this option in Phase One will not face premium rate increases or additional benefit reductions in Phase Two of the Plan.

(4) The Guaranty Association floor on benefit reductions will be applied to these policyholders as described in Section III.A.2.h, page 37.

c. OPTION THREE - NFO (see Section III.A.3, page 37).

d. OPTION FOUR - KEEP THE CURRENT BENEFITS AND PAY PHASE ONE DIFFERENTIAL PREMIUM.

(1) The If Knew Differential Premium for this option is the difference between the If Knew Premium and the Current Premium for the policy, both of which are set as if the policyholder did not have a Premium Waiver in effect. If the If Knew Differential Premium is less than zero, the policyholder will not be required to pay any additional premium.

(2) Policyholders who elect this Option may also face substantial rate increases in Phase Two.

2. DUAL WAIVER - The options for a policyholder not on claim but not paying premium due

to a Dual Waiver (because his or her spouse is on claim) will be the same as for a policyholder not on claim with a Lifetime Waiver except that the premium he or she must pay will be determined in part by the spouse's claim status. The default for these policyholders will be Option One (Downgrade). However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, Option Three, the NFO, will be the Default Option.

a. OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS. The policyholder will retain the Current Premium Waiver. If the Current Premium the policyholder would be paying in the absence of waiver is equal to or greater than the If Knew Premium the policy will not be downgraded. If the If Knew Premium is greater than the Current Premium the policyholder would be paying in the absence of waiver, the policy will be downgraded as follows:

(1) The Downgrade Process will be as described in Section III.A.1.c, page 30 subject to the following provisions.

(2) The Possible Active Benefit Reductions will apply, as described in Section III.A.1.f, page 32. Benefit reductions for each policyholder to whom this option applies will be calibrated to produce an If Knew Premium within 2% of the Current Premium for the policy (see Section III.A.1.b, page 29). However, because of the waiver, the policyholder will not be required to pay any premium.

(3) If the disabled spouse resumes paying premiums, the active spouse will also be required to resume paying premiums at the premium rate he or she would be paying if not on waiver, but if the policy has been downgraded it will remain downgraded.

b. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT IF KNEW DIFFERENTIAL PREMIUM.

(1) The policy will be modified through the Basic Policy Endorsements (See Section III.A.2.d, page 36). The policyholder will be required to pay the If Knew Differential Premium. The If Knew Differential Premium for this Option is the difference between the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements and the Current Premium for the policy, both of which are set as if the policyholder did not have a Premium Waiver in effect. If the If Knew Differential Premium is less than zero, the policyholder will not be required to pay any additional premium for the Basic Policy Endorsements.

(2) Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher If Knew Premiums. See Section III.A.2.f, page 37.

(3) The Guaranty Association floor on benefit reductions will be applied to these policyholders as described in Section III.A.2.h, page 37.

(4) Policyholders who elect this option in Phase One will not face premium rate increases or additional benefit reductions in Phase Two of the Plan, except as noted below.

(5) If the disabled spouse recovers, the active spouse will be required to begin paying the full If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements.

c. OPTION THREE - NFO.

(1) The policyholder can select a NFO. See Section III.A.3.

d. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY PHASE ONE DIFFERENTIAL PREMIUM: The policyholder will retain the current policy benefits and pay the Phase One Differential Premium (see Section II.E.6.b, page 18). However, if the disabled spouse recovers, the active spouse will be required to begin paying the full Phase One Premium. As noted, if the Current Premium is equal to or greater than the If Knew Premium, the policyholder will not be required to pay a Differential Premium.

C. DISABLED LIVES PAYING PREMIUM (*ON CLAIM - PAYING*)

Policyholders on claim, who are paying premiums, will have the same options as active lives paying premiums (see Section III.A, page 29), subject to the following conditions:

1. OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS.

a. Policyholders will preserve their Current Premium. For policyholders whose Current Premiums equal or exceed the If Knew Premium for their policies, no downgrade will be necessary because they are already paying the target premium and Options One and Four will produce the same result - no change in their policies. However, if the Current Premium is less than the If Knew Premium, the policy will be downgraded using the Downgrade Process described in Section III.A.1.c, page 30, above, subject to the following provisions.

b. The following ***Possible on Claim Benefit Reductions*** will apply instead of the Possible Active Benefit Reductions:

(1) ***Benefit Reduction One***: Removal of inflation and locking of MDB at current level. This reduction will be implemented as describe in Section III.A.1.f.(4), page 33, above.

(2) ***Benefit Reduction Two:*** Conversion of indemnity policies to reimbursement policies.

(3) ***Benefit Reduction Three:*** Reduction of MBP to no more than four years (from the applicable Plan Effective Date). If the current MBP is less than four years, the policy will retain its current MBP.

(4) ***Benefit Reduction Four:*** Elimination of Restoration of Benefits provision.

(5) ***Benefit Reduction Five:*** Reduction of the policy's MDB to $300 if it is above $300. This is a scalable benefit reduction (that can be increased or decreased) so long as the resulting MDB is within Plan Limits.

c. The reductions will be calibrated to produce an If Knew Premium within 2% of the Current Premium for the policy (see Section III.A.1.b, page 29).

d. Note that the Downgrade Process does not change the premium being paid prior to the downgrade.

e. If the policyholder regains active status, for future periods of care:

(1) The EP will be no less than 90 days. If the current EP is more than 90 days the policy will retain the current EP;

(2) The EP will apply to each period of care; and

(3) TQ triggers will apply. See Section III.A.2.d.(8), page 36.

2. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT IF KNEW PREMIUM. The policy will be endorsed as described in Section III.A.2.d, page 36, at If Knew Premium.

a. For those policies with an MPV that is currently above their applicable GA limits, the endorsed policy's MPV will be adjusted to be at least equal to the applicable Guaranty Association limits. The adjustment will be made by lengthening the MBP.

b. Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher If Knew Premiums. See Section III.A.2.f, page 37.

c. Changes in EP and benefit trigger would apply to subsequent periods of care following recovery. This will be the default for these policyholders if their Current Premium is lower than the If Knew Premium.

3. OPTION THREE - NFO. See Section III.A.3.

4. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY PHASE ONE PREMIUM. Policyholders can elect to keep their current benefits and their premiums will increase to the Phase One Premium. Policyholders whose Current Premiums equal or exceed the If Knew Premium for their policies will continue to pay their Current Premiums. Policyholders who elect this Option may also face substantial rate increases in Phase Two.

5. In some cases, options like the downgrade or Basic Policy Endorsements may result in a reduction of the benefits being received by the policyholder on claim at the time of the election. It is also possible that the If Knew Premium for the Basic Policy Endorsements will be lower than the policyholder's Current Premium.

D. DISABLED LIVES NOT PAYING PREMIUM (*ON CLAIM - WAIVER*)

1. OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS.

a. These policyholders will preserve their Premium Waiver but, if the Current Premium they would be paying in the absence of waiver is less than the If Knew Premium, the policies will be downgraded. The Downgrade Process will be as described in Section III.A.1.c, page 30, but the Possible on Claim Benefit Reductions described in Section III.C.1.b, page 41 will apply.

b. This is the Default Option for policyholders on claim with waiver of premium in Phase One. However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, the NFO (Option Three) will be the Default Option.

c. The reductions will be calibrated to produce an If Knew Premium within 2% of the Current Premium for the policy (see Section III.A.1.b, page 29). However, because of the waiver, the policyholder will not be required to pay any premium.

d. If the policyholder resumes paying premiums, the premiums will be at the rate the policyholder would be paying if not on waiver, but the policy will remain downgraded. Note that the Downgrade Process does not change the premium being paid prior to the downgrade.

e. If the policyholder regains active status, for future periods of care:

(1) The EP will be no less than 90 days. If the current EP is more than 90 days, the policy will retain the current EP;

(2) The EP will apply to each period of care; and

(3) TQ Triggers will apply. See Section III.A.2.d.(8), page 36.

2. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT IF KNEW DIFFERENTIAL PREMIUM.

a. The policyholder will have the option to have the current policy endorsed to provide benefits substantially similar to a newly designed Basic Policy. See Section III.A.2.d, page 36, above.

b. Policyholders will also be offered an "Enhanced Basic Policy Endorsement"at higher If Knew Premiums. See Section III.A.2.f, page 37.

c. Changes in EP and benefit trigger would apply to subsequent periods of care following recovery.

d. With the exception of the change from reimbursement to indemnity, no component of the endorsed policy can be richer than the current policy.

e. If the Current Premium the policyholder would be paying but for the waiver is less than the If Knew Premium for this policy, the policyholder must begin paying the If Knew Differential Premium. The If Knew Differential Premium for this option is the difference between the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements and the current premium for the policy, both of which are set as if the policyholder did not have a premium waiver in effect. As noted, if the If Knew Differential Premium is less than zero, the policyholder will not be required to pay any additional premium for the Basic Policy Endorsements.

f. If the disabled policyholder recovers, the waiver of premium benefit will no longer be applicable or available in the future, and he or she will be required to begin paying the full If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements, even if it is lower than the current waived premium.

g. Except upon recovery, policyholders who elect this option in Phase One will not face

premium rate increases or additional benefit reductions in Phase Two of the Plan.

h. For those policies with an MPV that is currently above their applicable GA limits, the endorsed policy's MPV will be adjusted to be at least equal to the applicable Guaranty Association limits. The adjustment will be made by lengthening the MBP.

3. OPTION THREE - NFO. Policyholders can elect a Non-forfeiture Option (NFO). See Section III.A.3.

4. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY PHASE ONE DIFFERENTIAL PREMIUM. If the Current Premium the policyholder would be paying in the absence of waiver is equal to or greater than the If Knew Premium, the policyholder will not be required to pay a Differential Premium.

a. Policyholders on claim with Premium Waiver can keep their current policy benefits.

b. Their Premium Waiver (including Lifetime and Dual) will apply only to the Current Premium they would be paying absent the waiver. If the Current Premium the policyholders would be paying but for the waiver is less than the If Knew Premium for this policy, they will be required to begin paying the corresponding Phase One Differential Premium, if any. (See Section II.E.6.b, page 18).

c. If the policyholders recover, they will be required to begin paying the full Phase One Premium.

IV. DETAILS OF PHASE TWO OF THE PLAN

A. APPLICATION

1. Throughout the period that follows implementation of Phase One the Company's financial condition will be monitored with emphasis on projected changes in the Company's deficit.

2. The evaluation of the Company's condition will include a determination of the magnitude of additional remedial measures required to eliminate any projected remaining deficit. The evaluation will include projections of the effect of Phase One over time.

3. A decision will then be made as to whether, when, and how Phase Two should be implemented.

4. Phase Two adjustments will only be made to policies that:

a. Are not Fully Covered by the applicable Guaranty Association limits (*i.e.,* have

Uncovered Benefits),

b. Are not Self-sustaining (because the sum of projected benefits and expenses exceeds the sum of allocated assets and projected premium), and

c. Did not elect Option Two (Basic Policy Endorsements) or Option Three (NFO) in Phase One.

5. Phase Two adjustments will be calculated after the results of Phase One adjustments have been incorporated.

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

1. OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS.

a. Policyholders not on claim paying premium can elect in Phase Two to keep the premium rate resulting from Phase One and reduce benefits to eliminate the policy shortfall.

b. The benefit reduction process and options will be the same as in Phase One (see Section III.A.1.c page 30) but the current benefits will be reduced so that they produce a Self-sustaining Premium that is within 2% of the policyholder's Current Premium.

c. As in Phase One, each policyholder will only receive one downgrade option, calculated as described in Section III.A.1.c.

2. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING PREMIUM.

a. Policyholders can choose to have their current policy endorsed to provide benefits substantially similar to a newly designed Basic Policy. See Section III.A.2.d, page 36.

b. This is the Default Option for premium paying active lives in Phase Two.

c. Premiums will be set to the corresponding Self-sustaining Premium level. The premium for this option will be no less than 110% of the If Knew Premium for this policy reflecting the cost of delay in making this election in Phase Two.

d. Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 37.

e. With the exception of the change from reimbursement to indemnity, post-endorsement benefits cannot exceed those in the current policy. If a particular component of the Basic Policy Endorsements provides more coverage than the current policy's corresponding provision, that provision of the current policy will not be modified by endorsement.

f. For those policies with an MPV that is currently above their applicable GA limits, the endorsed policy's MPV will be adjusted to be at least equal to the applicable Guaranty Association limits. The adjustment will be made by lengthening the MBP.

3. OPTION THREE - NFO. Policyholders can elect a Non-forfeiture Option. See Section III.A.3.

4. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING PREMIUM.

a. The policyholder can elect to maintain the current policy benefits but will be required to pay Self-sustaining Premiums.

b. The ***Self-sustaining Premium*** is the premium calculated to eliminate any shortfall in the policy. The shortfall is the excess of the sum of projected benefits and expenses (the PBA) over the sum of projected premiums and assets allocated on an accumulated premium basis (the PCA). See Section II.E.4, page 16, above.

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

1. LIFETIME WAIVER - Policyholders on lifetime waiver (due to the death of a spouse) will have essentially the same four options as premium paying policyholders not on claim (See Section IV.B, page 46) with the following modifications:

a. OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS. This will be the Default Option for these policyholders. However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, the NFO (Option Three) will be the Default Option.

(1) Due to the Premium Waiver the policyholder will continue not paying premium.

(2) The Downgrade Process will be the same as for premium-paying active lives in Phase One (see Section III.A.1.c, page 30, above).

(3) The specific possible benefit reductions will be the ones described in Section III.A.1.f, page 32, above,

(4) In this case the benefit reductions will be calibrated such that the projected benefits and expenses (the PBA) is equal to the assets allocated to the policy on an accumulated premium basis (the PCA).

b. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING DIFFERENTIAL PREMIUM. The Guaranty Association floor on benefit reductions will be applied to these policyholders as described in Section III.A.2.h, page 37.

(1) The Self-sustaining Premium used for the calculation for this option will be no less than 110% of the If Knew Premium for this policy reflecting the cost of delay in making this election in Phase Two.

(2) Policyholders will also be offered an "Enhanced Basic Policy Endorsement". See Section III.A.2.f, page 37 at higher Self-sustaining Premiums.

c. OPTION THREE - NFO (see Section III.A.3, page 37).

d. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING DIFFERENTIAL PREMIUM. The new premium will be the Self-sustaining Differential Premium described in the next paragraph.

e. The ***Self-sustaining Differential Premium*** is the difference between (1) the corresponding Self Sustaining Premium set as if the policyholder were not on claim and (2) the Current Premium the policyholder would be paying if he or she were not on Premium Waiver. Because these policies are not Self-sustaining the Self-sustaining Differential Premium will never be less than zero.

2. DUAL WAIVER - The options for a policyholder not on claim but not paying premium due to a dual waiver (because his or her spouse is on claim) will be the same as for a policyholder not on claim with a lifetime waiver except that the premium he or she must pay will be determined in part by the spouse's claim status. The default for these policyholders will be Option One (Downgrade). However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, the NFO (Option Three) will be the Default Option.

a. OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS. The policyholder will retain the Current Premium Waiver but the policy

will be downgraded.

(1) The Downgrade Process will be as described in Section III.A.1.c, page 30 subject to the following provisions.

(2) The Possible Active Benefit Reductions will apply, as described in Section III.A.1.f, page 32. Benefit reductions for each policyholder to whom this option applies will be calibrated to produce a Self-sustaining Premium equal to the premium the policyholder would be paying if not on waiver. However, because of the waiver, the policyholder will not be required to pay any premium.

(3) If the disabled spouse resumes paying premiums, the active spouse will also be required to resume paying premiums at the premium rate he or she would be paying if not on waiver, but the policy will remain downgraded.

b. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING DIFFERENTIAL PREMIUM.

(1) The policy will be modified through the Basic Policy Endorsements (See Section III.A.2.d, page 36). The policyholder will be required to pay the Self-sustaining Differential Premium.

(2) The Guaranty Association floor on benefit reductions will be applied to these policyholders as described in Section III.A.2.h, page 37.

(3) Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 37.

(4) The Self-sustaining Premium used for the calculation for this option will be no less than 110% of the If Knew Premium for this policy, reflecting the cost of delay in making this election in Phase Two

(5) If the disabled spouse recovers the active spouse will be required to begin paying the full Self-Sustaining Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements.

c. OPTION THREE - NFO. The policyholders can elect a Non-forfeiture Option. See Section III.A.3.

d. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING DIFFERENTIAL PREMIUM. The policyholder will retain the current policy

benefits and pay the Self-sustaining Differential Premium (see Section IV.C.1.e, page 48).

(1) If the disabled spouse recovers the active spouse will be required to begin paying the full Self-sustaining Premium.

(2) Because these policies are not Self-sustaining, the Current Premium will always be lower than the Self-sustaining Premium and the Self-sustaining Differential Premium will always be greater than zero.

D. DISABLED LIVES PAYING PREMIUM (*ON CLAIM - PAYING*)

1. Policyholders on claim who are paying premiums will have the same options as active lives paying premiums (see Section IV.B, page 46) subject to the following conditions:

a. OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS. Keep the Current Premium rates but accept specified downgrades. The Downgrade process will be as described in Section III.A.1.c, page 30. The Possible on Claim Benefit Reductions described in Section III.C.1.b, page 41 will apply, but the benefits will be reduced so that they produce a Self-Sustaining Premium within 2% of the Current Premium.

b. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING PREMIUM. The policy will be endorsed as described in Section III.A.2.d, page 36, at Self-sustaining Premium

(1) The Self-sustaining Premium used for the calculation for this option will be no less than 110% of the If Knew Premium for this policy reflecting the cost of delay in making this election in Phase Two.

(2) Changes in EP and benefit trigger would apply to subsequent periods of care following recovery.

(3) For those policies with an MPV that is currently above their applicable GA limits, the endorsed policy's MPV will be adjusted to be at least equal to the applicable GA limits. The adjustment will be made by lengthening the MBP.

(4) This will be the default for these policyholders.

(5) Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 37.

c. OPTION THREE - NFO. See Section III.A.3.

d. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING PREMIUM. The Self-sustaining Premium will be set as if the policyholder were not on claim. However, in so doing assets will be allocated to the policyholders according to the method previously described for Disabled Lives.

2. In some cases, options like the downgrade or Basic Policy Endorsements may result in a reduction of the benefits being received by the policyholder on claim at the time of the election.

E. DISABLED LIVES NOT PAYING PREMIUM (*ON CLAIM - WAIVER*)

1. OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS.

a. This is the Default Option for policyholders on claim with Premium Waiver in Phase Two. However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, the NFO (Option Three) will be the Default Option.

b. Policyholders may preserve their Premium Waiver and the policy will be downgraded. The Downgrade Process will be as described in Section III.A.1.c, page 30. The Possible on Claim Benefit Reductions will apply as explained in Section III.D.1, page 41 but benefits will be reduced so that they produce a Self-sustaining premium that is within 2% of the Current Premium.

c. If the policyholder resumes paying premiums, the premiums will be at the rate the policyholder would be paying if not on waiver, but the policy will remain downgraded. Note that the Downgrade Process made that premium equal to the Self-sustaining Premium for the downgraded policy at the time of implementation of Phase Two.

d. If the policyholder regains active status, for future periods of care:

(1) The EP will be no less than 90 days. If the current EP is more than 90 days, the policy will retain the current EP;

(2) The EP will apply to each period of care; and

(3) TQ Triggers will apply. See Section III.A.2.d.(8), page 36.

2. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING DIFFERENTIAL PREMIUM.

   a. The policyholder will have the option to have the current policy endorsed to provide benefits substantially similar to a newly designed Basic Policy. See Section III.A.2.d, page 36.

   b. The policyholder must begin paying the Self-sustaining Differential Premium corresponding to the Self-sustaining premium for the Basic Policy Endorsements set as if the policyholder were not on claim. The Self-sustaining Premium used for the calculation for this option will be no less than 110% of the If Knew Premium for this policy reflecting the cost of delay in making this election in Phase Two.

   c. With the exception of the change from reimbursement to indemnity, no component of the endorsed policy can be richer than the current policy.

   d. For those policies with an MPV that is currently above their applicable GA limits, the endorsed policy's MPV will be adjusted to be at least equal to the applicable Guaranty Association limits. The adjustment will be made by lengthening the MBP.

   e. Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 37.

   f. Changes in EP and benefit trigger would apply to subsequent periods of care following recovery.

   g. If he or she recovers, the policyholder will be required to begin paying the full Self-sustaining Premium.

3. OPTION THREE - NFO. Policyholders can elect a Non-forfeiture Option. See Section III.A.3.

4. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING DIFFERENTIAL PREMIUM.

   a. A policyholder on claim with Premium Waiver can keep the current policy benefits.

   b. The Premium Waiver (including lifetime and dual) will apply only to the Current Premium. The policyholder will be required to begin paying the corresponding Self-sustaining Differential Premium (see Section IV.C.1.e, page 48). If the policyholder recovers he or she will be required to begin paying the full Self-sustaining Premium.

TABLE 6: POLICYHOLDER OPTIONS		
	PHASE ONE	**PHASE TWO**
ACTIVE PAYING	1. KEEP PREMIUM - DOWNGRADE 2. BASIC POLICY - IF KNEW PREMIUM* 3. NFO 4. KEEP BENEFITS - PHASE ONE PREMIUM	1. KEEP PREMIUM - DOWNGRADE 2. BASIC POLICY - SELF SUSTAINING PREMIUM* 3. NFO 4. KEEP BENEFITS - SELF-SUSTAINING PREMIUM
ACTIVE WAIVER	1. DOWNGRADE - RETAIN PREMIUM WAIVER*‡ 2. BASIC POLICY - IF KNEW DIFFERENTIAL PREMIUM 3. NFO 4. KEEP BENEFITS - PHASE ONE DIFFERENTIAL PREMIUM DUAL WAIVER PREMIUM GOVERNED IN PART BY SPOUSE'S STATUS	1. DOWNGRADE - RETAIN PREMIUM WAIVER*‡ 2. BASIC POLICY - SELF SUSTAINING DIFFERENTIAL PREMIUM† 3. NFO 4. KEEP BENEFITS - SELF SUSTAINING DIFFERENTIAL PREMIUM† DUAL WAIVER PREMIUM GOVERNED IN PART BY SPOUSE'S STATUS
ON CLAIM PAYING	1. KEEP PREMIUM - DOWNGRADE 2. BASIC POLICY - IF KNEW PREMIUM* 3. NFO 4. KEEP BENEFITS - PHASE ONE PREMIUM	1. KEEP PREMIUM - DOWNGRADE 2. BASIC POLICY - SELF SUSTAINING PREMIUM*† 3. NFO 4. KEEP BENEFITS - SELF SUSTAINING PREMIUM†
ON CLAIM WAIVER	1. DOWNGRADE - RETAIN PREMIUM WAIVER*‡ 2. BASIC POLICY - IF KNEW DIFFERENTIAL PREMIUM 3. NFO 4. KEEP BENEFITS - PHASE ONE DIFFERENTIAL PREMIUM	1. - DOWNGRADE - RETAIN PREMIUM WAIVER*‡ 2. BASIC POLICY - SELF-SUSTAINING DIFFERENTIAL PREMIUM† 3. NFO 4. KEEP BENEFITS - SELF SUSTAINING DIFFERENTIAL PREMIUM†

***Default Option. †Self-sustaining premium calculated as if policyholder not on claim. ‡If the NFO provides greater benefits, that will be the Default Option. In Phase One, policyholders whose Current Premium is not less than the If Knew Premium need not change premiums or benefits.**

POLICY ILLUSTRATIONS

The following twelve examples illustrate how these options work for some representative policies. The policies selected are actual in-force SHIP policies. The SHIP SAMPLE POLICY TABLE describes the key attributes of each of the twelve sample policies, enabling the reader to locate easily the samples most similar to a particular policy. They were selected to provide a representative variety of policy features. Reviewing sample policies resembling a particular policy will provide an indication of how the Plan will result in modifications to that policy. Because of the differences among the features in the sample policies, it may be helpful to review several sample policies to see how particular features are affected by the Plan.

SHIP SAMPLE POLICY TABLE

ILLUSTRATION	1	2	3	4	5	6	7	8	9	10	11	12
Gender	F	F	F	F	F	M	M	F	F	F	M	F
Issue Age	56	56	63	67	62	64	60	64	57	64	65	60
Issue Year	1992	1988	1997	1995	1996	1997	1990	1995	1988	2001	1993	1991
Attained Age	80	88	86	88	86	87	50	89	89	83	92	89
State Resident	IN	TX	IL	TX	PA	OK	NE	OH	PA	FL	SD	TX
State Issue	IN	TX	IL	TX	PA	Ok	NE	OH	PA	PA	SD	Ok
Guaranty Association Coverage Limit	300k	300k	300k	300k	300k	300k	300k	300k	300k	300k	300k	300k
Premium Paying Status	PP	FP	PP	LW	PF	PP	CW	PP	PP	FP	LW	PP
Disability Status	Active	Active	Active	Active	Active	Active	Disabled	Active	Active	Active	Disabled	Active
CODE	32329	37446	12223	19570	09746	18588	33210	05005	00002	03255	01285	02561
Nursing Home: Reimbursement Method	I	I	I	R	I	I	I	I	N/A	R	I	I
Nursing Home: Benefit Period (years)	U	4.0	3.0	3.0	3.0	5.0	U	3.0	N/A	4.0	5.0	U
Nursing Home: Current Maximum Daily Benefit[1]	$212	580	5234	560	5307	$205	5203	5323	N/A	5246	5159	5133
Nursing Home: Elimination Period[2] (days)	N/A	0	100	0	0	0	0	0	N/A	0	0	180
Home Health Care: Reimbursement Method	N/A	N/A	N/A	R	R	R	N/A	N/A	R	R	R	R
Home Health Care: Benefit Period (years)	N/A	N/A	N/A	3.0	3.0	5.0	N/A	N/A	2.0	4.0	5.0	U
Home Health Care: Current Maximum Daily Benefit[1]	N/A	N/A	N/A	560	5307	5205	N/A	N/A	$160	5246	5159	$133
Home Health Care: Elimination Period[2] (days)	N/A	N/A	N/A	0	0	0	N/A	N/A	0	0	0	180
Assisted Living Facility: Reimbursement Method	N/A	N/A	R	R	R	R	N/A	R	N/A	N/A	R	R
Assisted Living Facility: Benefit Period (years)	N/A	N/A	3	3.0	3.0	5.0	N/A	3	N/A	N/A	5.0	U
Assisted Living Facility: Current Maximum Daily Benefit[1]	N/A	N/A	5234	560	5307	$205	N/A	5323	N/A	N/A	5159	$133
Assisted Living Facility: Elimination Period[2] (days)	N/A	N/A	100	0	0	0	N/A	0	N/A	N/A	0	180
Daily Benefit Annual Inflation	0.0%	0.0%	5.0%	0.0%	5.0%	5.0%	5.0%	5.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	Yes	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	Yes	Yes	Yes	No	No	No	No	Yes	Yes
Return of Premium Coverage[3]	No	No	No	No	No	No	No	Yes	No	No	Yes	Yes
Benefit Trigger	TQ	TQ	TQ	NTQ	TQ	NTQ	TQ	TQ	TQ	TQ	TQ	TQ
Maximum Policy Value[4]	U	117k	256k	65,700	336k	374k	U	353k	117k	357k	251k	U
Annual Premium[5]	3,089	1,193	2,216	0	2,642	2,995	0	6,306	529	2,614	0	4,116
Active Life Reserve (if applicable)	101k	26,142	61,254	16,972	78,126	45,601	N/A	113k	25 553	79,333	N/A	67,820

PP = Premium paying
I = Indemnity
U = Unlimited

TQ = Tax Qualified
R = Reimbursement
LW = Lifetime waiver

NTQ = Not Tax Qualified
CW = Claim waiver
S OMITTED

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ILLUSTRATION NO. 1

Gender	F
Issue Age	56
Issue Year	1992
Attained Age	84
State Resident	IN
State Issue	IN
Guaranty Association Coverage Limit	$300,000
Premium Paying Status	Premium paying
Disability Status	Active

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 32324)

Option Number	**N/A**	**1**	**2**	**2a**	**3**	**4**
Option Name	**Current**	**Downgrade**	**Basic Policy Endorsement (Standard)**	**Basic Policy Endorsement (Enhanced)**	**NFO**	**Phase I premium**
Nursing Home: Reimbursement Method	Indemnity	Reimbursement	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	Unlimited	4.0	4.0	5.0	2.5	Unlimited
Nursing Home: Current Maximum Daily Benefit[1]	$212	$261	$170	$170	$170	$212
Nursing Home: Elimination Period[2] **(days)**	0	0	90	90	90	0
Home Health Care: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Current Maximum Daily Benefit[1]	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Elimination Period[2] **(days)**	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Current Maximum Daily Benefit[1]	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Elimination Period[2] **(days)**	N/A	N/A	N/A	N/A	N/A	N/A
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	Yes	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	No	No	No
Return of Premium Coverage[3]	No	No	No	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value[4]	Unlimited	$381,060	$247,931	$309,914	$154,957	Unlimited
Annual Premium[5]	$3,089	$3,089	$1,431	$1,537	$0	$3,967

1 Current Maximum Daily Benefits reflects inflation (if applicable) through 11 30 2019

2 Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

3 The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

4 Maximum Policy Value is as of 11 30 2019. Maximum Policy Value will increase for policies with inflation provisions

5 Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

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ILLUSTRATION NO. 2

Gender	F
Issue Age	56
Issue Year	1988
Attained Age	88
State Resident	TX
State Issue	TX
Guaranty Association Coverage Limit	$300,000
Premium Paying Status	Premium paying
Disability Status	Active

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium **(CODE 37446)**

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Indemnity	Indemnity	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	4.0	4.0	4.0	4.0	2.5	4.0
Nursing Home: Current Maximum Daily Benefit[1]	$80	$80	$64	$64	$64	$80
Nursing Home: Elimination Period[2] (days)	0	0	90	90	90	0
Home Health Care: Reimbursement Method	N A	N A	N A	N A	N A	N A
Home Health Care: Benefit Period (years)	N A	N A	N A	N A	N A	N A
Home Health Care: Current Maximum Daily Benefit[1]	N A	N A	N A	N A	N A	N A
Home Health Care: Elimination Period[2] (days)	N A	N A	N A	N A	N A	N A
Assisted Living Facility: Reimbursement Method	N A	N A	N A	N A	N A	N A
Assisted Living Facility: Benefit Period (years)	N A	N A	N A	N A	N A	N A
Assisted Living Facility: Current Maximum Daily Benefit[1]	N A	N A	N A	N A	N A	N A
Assisted Living Facility: Elimination Period[2] (days)	N A	N A	N A	N A	N A	N A
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	Yes	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	No	No	No
Return of Premium Coverage[3]	No	No	No	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value[4]	$116,800	$116,800	$93,440	$93,440	$58,400	$116,800
Annual Premium[5]	$1,198	$1,198	$508	$508	$0	$1,198

1 Current Maximum Daily Benefits reflects inflation (if applicable) through 11-30-2019

2 Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

3 The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

4 Maximum Policy Value is as of 11-30-2019. Maximum Policy Value will increase for policies with inflation provisions

5 Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

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Gender	F
Issue Age	63
Issue Year	1997
Attained Age	86
State Resident	IL
State Issue	IL
Guaranty Association Coverage Limit	$300,000
Premium Paying Status	Premium paying
Disability Status	Active

ILLUSTRATION NO. 3

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 12220)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Indemnity	Reimbursement	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	3.0	3.0	3.0	3.0	2.5	3.0
Nursing Home: Current Maximum Daily Benefit[1]	$234	$234	$187	$187	$187	$234
Nursing Home: Elimination Period[2] (days)	100	100	100	100	100	100
Home Health Care: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Current Maximum Daily Benefit[1]	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Elimination Period[2] (days)	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Assisted Living Facility: Benefit Period (years)	3.0	3.0	3.0	3.0	2.5	3.0
Assisted Living Facility: Current Maximum Daily Benefit[1]	$234	$176	$187	$187	$187	$234
Assisted Living Facility: Elimination Period[2] (days)	100	100	100	100	100	100
Daily Benefit Annual Inflation	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
Claim Waiver of Premium Coverage	Yes	No	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	No	No	No
Return of Premium Coverage[3]	No	No	No	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value[4]	$256,274	$256,230	$205,019	$205,019	$170,849	$256,274
Annual Premium[5]	$2,216	$2,216	$2,102	$2,137	$0	$3,029

1 Current Maximum Daily Benefits reflects inflation (if applicable) through 11 30 2019

2 Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

3 The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

4 Maximum Policy Value is as of 11 30 2019. Maximum Policy Value will increase for policies with inflation provisions

5 Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

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ILLUSTRATION NO. 4

Gender	F
Issue Age	67
Issue Year	1999
Attained Age	88
State Resident	TX
State Issue	TX
Guaranty Association Coverage Limit	$300,000
Premium Paying Status	Lifetime waiver
Disability Status	Active

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 19570)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Nursing Home: Benefit Period (years)	3.0	3.0	3.0	3.0	2.5	3.0
Nursing Home: Current Maximum Daily Benefit[1]	$60	$60	$48	$48	$48	$60
Nursing Home: Elimination Period[2] (days)	0	0	90	90	90	0
Home Health Care: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Home Health Care: Benefit Period (years)	3.0	3.0	3.0	3.0	2.5	3.0
Home Health Care: Current Maximum Daily Benefit[1]	$60	$60	$48	$48	$48	$60
Home Health Care: Elimination Period[2] (days)	0	0	90	90	90	0
Assisted Living Facility: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Assisted Living Facility: Benefit Period (years)	3.0	3.0	3.0	3.0	2.5	3.0
Assisted Living Facility: Current Maximum Daily Benefit[1]	$60	$60	$48	$48	$48	$60
Assisted Living Facility: Elimination Period[2] (days)	0	0	90	90	90	0
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	Yes	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	Yes	Yes	No	No	No	Yes
Return of Premium Coverage[3]	No	No	No	No	No	No
Benefit Trigger	Non Tax Qualified	Non Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Non Tax Qualified
Maximum Policy Value[4]	$65,700	$65,700	$52,560	$52,560	$43,800	$65,700
Annual Premium[5]	$0	$0	$0	$0	$0	$0

1 Current Maximum Daily Benefits reflects inflation (if applicable) through 11 30 2019

2 Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

3 The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

4 Maximum Policy Value is as of 11 30 2019. Maximum Policy Value will increase for policies with inflation provisions

5 Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

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ILLUSTRATION NO. 5

Gender	F
Issue Age	62
Issue Year	1996
Attained Age	86
State Resident	PA
State Issue	PA
Guaranty Association Coverage Limit	$300,000
Premium Paying Status	Premium paying
Disability Status	Active

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 09746)

Option Number	**N/A**	**1**	**2**	**2a**	**3**	**4**
Option Name	**Current**	**Downgrade**	**Basic Policy Endorsement (Standard)**	**Basic Policy Endorsement (Enhanced)**	**NFO**	**Phase I premium**
Nursing Home: Reimbursement Method	Indemnity	Reimbursement	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	3.0	3.0	3.0	3.0	2.5	3.0
Nursing Home: Current Maximum Daily Benefit[1]	$307	$312	$246	$246	$246	$307
Nursing Home: Elimination Period[2] **(days)**	0	90	90	90	90	0
Home Health Care: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Home Health Care: Benefit Period (years)	3.0	3.0	3.0	3.0	2.5	3.0
Home Health Care: Current Maximum Daily Benefit[1]	$307	$312	$150	$150	$150	$307
Home Health Care: Elimination Period[2] **(days)**	0	90	90	90	90	0
Assisted Living Facility: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Assisted Living Facility: Benefit Period (years)	3.0	3.0	3.0	3.0	2.5	3.0
Assisted Living Facility: Current Maximum Daily Benefit[1]	$307	$312	$225	$225	$225	$307
Assisted Living Facility: Elimination Period[2] **(days)**	0	90	90	90	90	0
Daily Benefit Annual Inflation	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
Claim Waiver of Premium Coverage	Yes	Yes	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	Yes	Yes	No	No	No	Yes
Return of Premium Coverage[3]	No	No	No	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value[4]	$336,340	$341,640	$269,072	$269,072	$224,227	$336,340
Annual Premium[5]	$2,642	$2,642	$1,934	$1,965	$0	$3,799

1 Current Maximum Daily Benefits reflects inflation (if applicable) through 11 30 2019

2 Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

3 The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

4 Maximum Policy Value is as of 11 30 2019. Maximum Policy Value will increase for policies with inflation provisions

5 Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

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ILLUSTRATION NO. 6

Gender	M
Issue Age	64
Issue Year	1997
Attained Age	87
State Resident	OK
State Issue	OK
Guaranty Association Coverage Limit	$300,000
Premium Paying Status	Premium paying
Disability Status	Active

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 13538)

Option Number	**N/A**	**1**	**2**	**2a**	**3**	**4**
Option Name	**Current**	**Downgrade**	**Basic Policy Endorsement (Standard)**	**Basic Policy Endorsement (Enhanced)**	**NFO**	**Phase I premium**
Nursing Home: Reimbursement Method	Indemnity	Indemnity	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	5.0	5.0	4.0	5.0	2.5	5.0
Nursing Home: Current Maximum Daily Benefit[1]	$205	$205	$164	$164	$164	$205
Nursing Home: Elimination Period[2] (days)	0	0	90	90	90	0
Home Health Care: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Home Health Care: Benefit Period (years)	5.0	5.0	4.0	5.0	2.5	5.0
Home Health Care: Current Maximum Daily Benefit[1]	$205	$205	$150	$150	$150	$205
Home Health Care: Elimination Period[2] (days)	0	0	90	90	90	0
Assisted Living Facility: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Assisted Living Facility: Benefit Period (years)	5.0	5.0	4.0	5.0	2.5	5.0
Assisted Living Facility: Current Maximum Daily Benefit[1]	$205	$205	$164	$164	$164	$205
Assisted Living Facility: Elimination Period[2] (days)	0	0	90	90	90	0
Daily Benefit Annual Inflation	5.0%	5.0%	1.5%	2.0%	0.0%	5.0%
Claim Waiver of Premium Coverage	Yes	Yes	No	No	No	Yes
Dual Premium Waiver Coverage	Yes	Yes	No	No	No	Yes
Survivorship Premium Waiver Coverage	Yes	Yes	No	No	No	Yes
Return of Premium Coverage[3]	No	No	No	No	No	No
Benefit Trigger	Non Tax Qualified	Non Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Non Tax Qualified
Maximum Policy Value[4]	$373,724	$374,125	$239,183	$298,979	$149,489	$373,724
Annual Premium[5]	$2,995	$2,995	$1,171	$1,232	$0	$2,995

1 Current Maximum Daily Benefits reflects inflation (if applicable) through 11 30 2019

2 Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

3 The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

4 Maximum Policy Value is as of 11 30 2019. Maximum Policy Value will increase for policies with inflation provisions

5 Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

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Gender	M
Issue Age	64
Issue Year	1994
Attained Age	90
State Resident	NE
State Issue	NE
Guaranty Association Coverage Limit	$300,000
Premium Paying Status	Claim waiver
Disability Status	Disabled

ILLUSTRATION NO. 7

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 33210)

Option Number	**N/A**	**1**	**2**	**2a**	**3**	**4**
Option Name	**Current**	**Downgrade**	**Basic Policy Endorsement (Standard)**	**Basic Policy Endorsement (Enhanced)**	**NFO**	**Phase I premium**
Nursing Home: Reimbursement Method	Indemnity	Indemnity	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	Unlimited	Unlimited	4.0	5.0	2.5	Unlimited
Nursing Home: Current Maximum Daily Benefit[1]	$203	$212	$163	$163	$163	$203
Nursing Home: Elimination Period[2] **(days)**	0	0	90	90	90	0
Home Health Care: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Current Maximum Daily Benefit[1]	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Elimination Period[2] **(days)**	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Current Maximum Daily Benefit[1]	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Elimination Period[2] **(days)**	N/A	N/A	N/A	N/A	N/A	N/A
Daily Benefit Annual Inflation	5.0%	5.0%	1.5%	2.0%	0.0%	5.0%
Claim Waiver of Premium Coverage	Yes	Yes	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	No	No	No
Return of Premium Coverage[3]	No	No	No	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value[4]	Unlimited	Unlimited	$237,314	$296,643	$148,321	Unlimited
Annual Premium[5]	$0	$0	$0	$0	$0	$0

1 Current Maximum Daily Benefits reflects inflation (if applicable) through 12/30/2019

2 Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

3 The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

4 Maximum Policy Value is as of 12/30/2019. Maximum Policy Value will increase for policies with inflation provisions

5 Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

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ILLUSTRATION NO. 8

Gender	F
Issue Age	61
Issue Year	1995
Attained Age	89
State Resident	OH
State Issue	OH
Guaranty Association Coverage Limit	$300,000
Premium Paying Status	Premium paying
Disability Status	Active

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 05000)

Option Number	**N/A**	**1**	**2**	**2a**	**3**	**4**
Option Name	**Current**	**Downgrade**	**Basic Policy Endorsement (Standard)**	**Basic Policy Endorsement (Enhanced)**	**NFO**	**Phase I premium**
Nursing Home: Reimbursement Method	Indemnity	Reimbursement	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	3.0	3.1	3.0	3.0	2.5	3.0
Nursing Home: Current Maximum Daily Benefit[1]	$323	$600	$258	$258	$258	$323
Nursing Home: Elimination Period[2] **(days)**	0	90	90	90	90	0
Home Health Care: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Current Maximum Daily Benefit[1]	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Elimination Period[2] **(days)**	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Assisted Living Facility: Benefit Period (years)	3.0	3.1	3.0	3.0	2.5	3.0
Assisted Living Facility: Current Maximum Daily Benefit[1]	$323	$450	$225	$225	$225	$323
Assisted Living Facility: Elimination Period[2] **(days)**	0	90	90	90	90	0
Daily Benefit Annual Inflation	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
Claim Waiver of Premium Coverage	Yes	No	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	No	No	No
Return of Premium Coverage[3]	Yes	No	No	No	No	Yes
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value[4]	$353,148	$679,800	$282,519	$282,519	$235,432	$353,148
Annual Premium[5]	$6,306	$6,306	$2,988	$3,012	$0	$11,166

1 Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

2 Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

3 The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

4 Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

5 Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

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ILLUSTRATION NO. 9

Gender	F
Issue Age	57
Issue Year	1988
Attained Age	89
State Resident	PA
State Issue	PA
Guaranty Association Coverage Limit	$300,000
Premium Paying Status	Premium paying
Disability Status	Active

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium **(CODE 00002)**

Option Number	**N/A**	**1**	**2**	**2a**	**3**	**4**
Option Name	**Current**	**Downgrade**	**Basic Policy Endorsement (Standard)**	**Basic Policy Endorsement (Enhanced)**	**NFO**	**Phase I premium**
Nursing Home: Reimbursement Method	N A	N/A	N/A	N A	N A	N/A
Nursing Home: Benefit Period (years)	N A	N A	N A	N A	N A	N A
Nursing Home: Current Maximum Daily Benefit[1]	N A	N/A	N/A	N/A	N A	N/A
Nursing Home: Elimination Period[2] (days)	N A	N A	N/A	N A	N A	N A
Home Health Care: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Home Health Care: Benefit Period (years)	2.0	2.0	2.0	2.0	2.0	2.0
Home Health Care: Current Maximum Daily Benefit[1]	$160	$80	$128	$128	$128	$160
Home Health Care: Elimination Period[2] (days)	0	90	90	90	90	0
Assisted Living Facility: Reimbursement Method	N A	N A	N/A	N A	N A	N A
Assisted Living Facility: Benefit Period (years)	N A	N A	N/A	N A	N A	N A
Assisted Living Facility: Current Maximum Daily Benefit[1]	N A	N A	N A	N A	N A	N A
Assisted Living Facility: Elimination Period[2] (days)	N A	N A	N A	N A	N A	N A
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	No	No	No	No	No	No
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	No	No	No
Return of Premium Coverage[3]	No	No	No	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value[4]	$116,800	$58,400	$93,440	$93,440	$93,440	$116,800
Annual Premium[5]	$529	$529	$593	$593	$0	$761

1 Current Maximum Daily Benefits reflects inflation (if applicable) through 11-30-2019

2 Elimination Period does not account for claim status (requirements may have already been met), and different period may be applicable for waiver of premium benefits

3 The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3).

4 Maximum Policy Value is as of 11-30-2019. Maximum Policy Value will increase for policies with inflation provisions

5 Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

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ILLUSTRATION NO. 10

Gender	F
Issue Age	64
Issue Year	2001
Attained Age	83
State Resident	FL
State Issue	PA
Guaranty Association Coverage Limit	$300,000
Premium Paying Status	Premium paying
Disability Status	Active

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium **(CODE 03255)**

Option Number	**N/A**	**1**	**2**	**2a**	**3**	**4**
Option Name	**Current**	**Downgrade**	**Basic Policy Endorsement (Standard)**	**Basic Policy Endorsement (Enhanced)**	**NFO**	**Phase I premium**
Nursing Home: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Nursing Home: Benefit Period (years)	4.0	4.0	4.0	4.0	2.5	4.0
Nursing Home: Current Maximum Daily Benefit[1]	$246	$246	$197	$197	$197	$246
Nursing Home: Elimination Period[2] **(days)**	0	90	90	90	90	0
Home Health Care: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Home Health Care: Benefit Period (years)	4.0	4.0	4.0	4.0	2.5	4.0
Home Health Care: Current Maximum Daily Benefit[1]	$246	$123	$150	$150	$150	$246
Home Health Care: Elimination Period[2] **(days)**	0	90	90	90	90	0
Assisted Living Facility: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Current Maximum Daily Benefit[1]	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Elimination Period[2] **(days)**	N/A	N/A	N/A	N/A	N/A	N/A
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	No	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	No	No	No
Return of Premium Coverage[3]	No	No	No	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value[4]	$356,829	$357,192	$285,463	$285,463	$179,398	$356,829
Annual Premium[5]	$2,614	$2,614	$3,031	$3,031	$0	$6,208

1 Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

2 Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

3 The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

4 Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

5 Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

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ILLUSTRATION NO. 11

Gender	M
Issue Age	65
Issue Year	1993
Attained Age	92
State Resident	SD
State Issue	SD
Guaranty Association Coverage Limit	$300,000
Premium Paying Status	Lifetime waiver
Disability Status	Disabled

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Plan features and premium **(CODE 01285)**

Option Number	**N/A**	**1**	**2**	**2a**	**3**	**4**
Option Name	**Current**	**Downgrade**	**Basic Policy Endorsement (Standard)**	**Basic Policy Endorsement (Enhanced)**	**NFO**	**Phase I premium**
Nursing Home: Reimbursement Method	Indemnity	Reimbursement	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	5.0	4.0	4.0	5.0	2.5	5.0
Nursing Home: Current Maximum Daily Benefit[1]	$159	$159	$127	$127	$127	$159
Nursing Home: Elimination Period[2] **(days)**	0	0	90	90	90	0
Home Health Care: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Home Health Care: Benefit Period (years)	5.0	4.0	4.0	5.0	2.5	5.0
Home Health Care: Current Maximum Daily Benefit[1]	$159	$159	$127	$127	$127	$159
Home Health Care: Elimination Period[2] **(days)**	0	0	90	90	90	0
Assisted Living Facility: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Assisted Living Facility: Benefit Period (years)	5.0	4.0	4.0	5.0	2.5	5.0
Assisted Living Facility: Current Maximum Daily Benefit[1]	$159	$159	$127	$127	$127	$159
Assisted Living Facility: Elimination Period[2] **(days)**	0	0	90	90	90	0
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	Yes	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	Yes	Yes	No	No	No	Yes
Return of Premium Coverage[3]	Yes	Yes	No	No	No	Yes
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value[4]	$290,522	$232,140	$185,934	$232,417	$116,209	$290,522
Annual Premium[5]	$0	$0	$0	$0	$0	$2,183

1 Current Maximum Daily Benefits reflects inflation (if applicable) through 11-30-2019

2 Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

3 The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

4 Maximum Policy Value is as of 11-30-2019. Maximum Policy Value will increase for policies with inflation provisions

5 Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

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ILLUSTRATION NO. 12

Gender	F
Issue Age	60
Issue Year	1991
Attained Age	89
State Resident	TX
State Issue	OK
Guaranty Association Coverage Limit	$300,000
Premium Paying Status	Premium paying
Disability Status	Active

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Plan features and premium (CODE 00561)

Option Number	N/A	1	2	2a	3	4
Option Name	**Current**	**Downgrade**	**Basic Policy Endorsement (Standard)**	**Basic Policy Endorsement (Enhanced)**	**NFO**	**Phase I premium**
Nursing Home: Reimbursement Method	Indemnity	Reimbursement	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	Unlimited	4.0	4.0	5.0	2.5	Unlimited
Nursing Home: Current Maximum Daily Benefit[1]	$133	$467	$106	$106	$106	$133
Nursing Home: Elimination Period[2] **(days)**	100	100	100	100	100	100
Home Health Care: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Home Health Care: Benefit Period (years)	Unlimited	4.0	4.0	5.0	2.5	Unlimited
Home Health Care: Current Maximum Daily Benefit[1]	$133	$234	$106	$106	$106	$133
Home Health Care: Elimination Period[2] **(days)**	100	100	100	100	100	100
Assisted Living Facility: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Assisted Living Facility: Benefit Period (years)	Unlimited	4.0	4.0	5.0	2.5	Unlimited
Assisted Living Facility: Current Maximum Daily Benefit[1]	$133	$350	$106	$106	$106	$133
Assisted Living Facility: Elimination Period[2] **(days)**	100	100	100	100	100	100
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	No	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	Yes	No	No	No	No	Yes
Return of Premium Coverage[3]	Yes	No	No	No	No	Yes
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value[4]	Unlimited	$681,820	$154,959	$193,698	$96,845	Unlimited
Annual Premium[5]	$4,116	$4,116	$1,172	$1,242	$0	$7,269

1 Current Maximum Daily Benefits reflects inflation (if applicable) through 11 30 2019

2 Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

3 The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

4 Maximum Policy Value is as of 11 30 2019. Maximum Policy Value will increase for policies with inflation provisions

5 Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

V. PHASE THREE

Following implementation of Phase One and Phase Two, SHIP will continue managing its LTCI in a run-off mode. If the company has improved to the point of having excess assets, the Plan provides for distributions to policyholders and creditors. While some aspects of Phase Three will be developed in the future, one component will be distributions to policyholders on account of benefits they eliminated through Policy Modifications under the Plan. As more fully explained at Section VI.H, page 77, as part of the Plan some of SHIP's policies will be restructured in a way that identifies these eliminated benefits separately. These amounts, called ***Unfunded Benefit Liabilities*** (UBL), will be tracked by the Rehabilitator. To the extent assets are available in Phase Three, they will be applied to the UBL along with other unpaid liabilities, such as agent commissions. It is possible that in Phase Three SHIP will not be able to pay off all remaining liabilities in full. In that event, it is likely that it will then be placed in Liquidation in accordance with Article V. To the extent that at that time some policy benefits may remain unfunded, the Guaranty Associations may be triggered to assist in the resolution of those remaining policy liabilities. See Section VI.J, page 78.

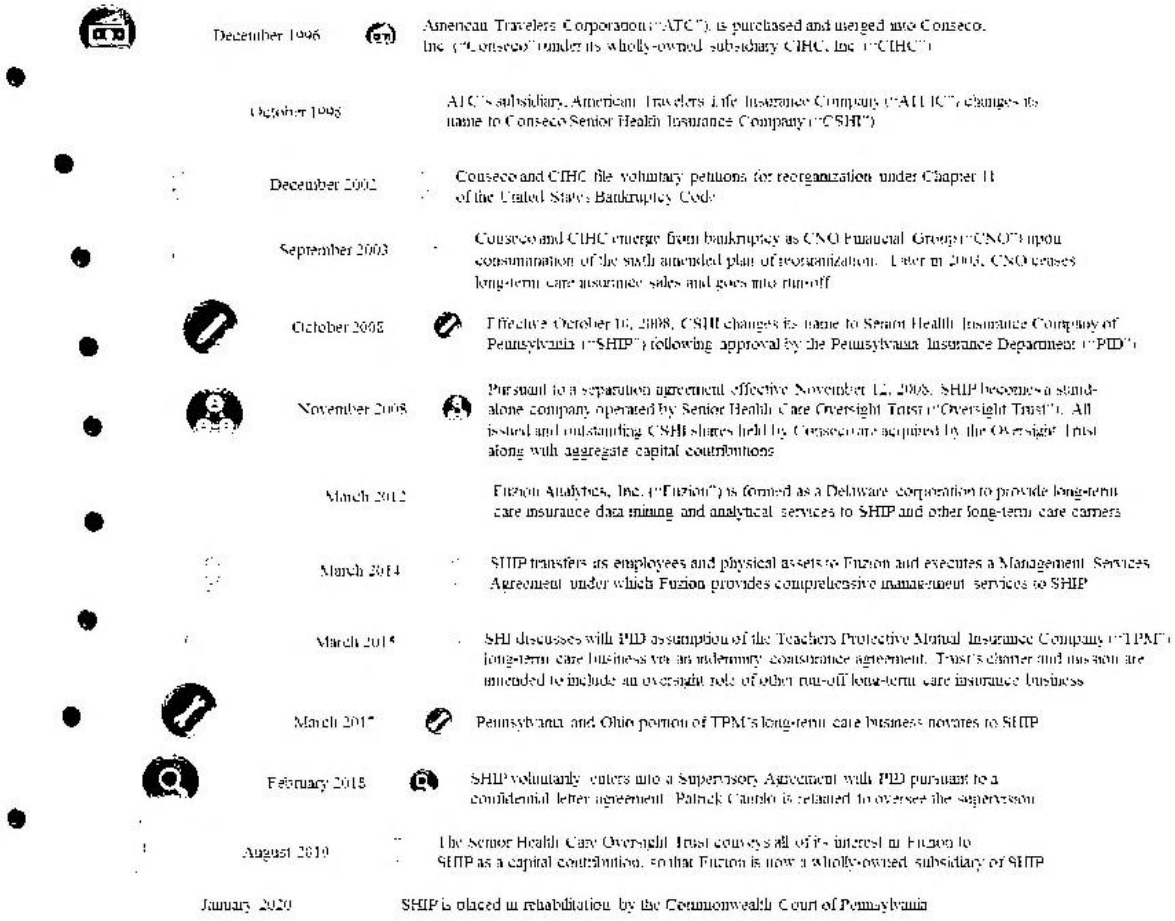
VI. OTHER MATTERS

A. ABOUT SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

SHIP commenced business on July 5, 1887, as the Home Beneficial Society. It underwent many transactions and transformations in the ensuing century, culminating in the adoption of the current name in October 2008, when it was transferred by its then owner, Conseco, to the newly formed, nonprofit, *Senior Health Care Oversight Trust* (the "Trust" - see page 75) so it could continue running off its long-term care insurance ("LTCI") business independently. At the time, SHIP had 152,000 policies in force. As of year-end 2019 that number was down to close to 45,000. It is a Pennsylvania life and health insurance company. Prior to Rehabilitation, SHIP was licensed in 46 states (excluding Connecticut, New York, Rhode Island, and Vermont), the District of Columbia, and the U.S. Virgin Islands. Since SHIP's creation in 2008, it has utilized an outsourcing model for select functions, specifically: Long Term Care Group ("LTCG") for lower-level claims administration functions; Milliman for rate increase analyses and valuations; Conning (and recently now New England Asset Management) for investment services; KPMG for tax services; and external law firms for specific legal issues. Beginning in 2018, the Company engaged Ernst & Young for internal audit services.

Table 7 summarizes the Company's corporate history.

TABLE 7



B. LONG-TERM CARE INSURANCE

At the time this proposed Rehabilitation Plan is filed, the insurance business of SHIP consists entirely of LTCI, much of it issued many decades ago, and none issued any later than 2003, when the Company ceased writing new business. Of approximately 645,000 LTCI policies sold by SHIP and its predecessors since the late 1970s, fewer than 50,000 remain in force. The key characteristic of this remaining "legacy" block of LTCI policies as a group is that the premiums being paid, when added to the Company's assets, are projected to be grossly insufficient to pay the benefits expected to be due under those policies. This anticipated "Funding Gap" led to the Company being placed in Rehabilitation on January 29, 2020, and is the key challenge sought to be addressed by the Plan.

SHIP's long-term care insurance policies cover long-term care services, including confinement to nursing facilities and assisted living facilities, as well as home health care and adult day care for individuals who meet specified requirements. These requirements vary among the Company's policies but typically include things like the policyholder requiring care for at least 90 days, and being unable to perform 2 or more Activities of Daily Living (eating, dressing, bathing, transferring, toileting, and continence) without substantial assistance (hands on or standby).

The Company's business is comprised of both LTCI policies written by the Company and assumed reinsurance. For the policies written by the Company, average LTC policyholder age is 86 and the average claimant is 89 years old. SHIP's policies are approximately 13% Home Health Care coverage, 18% Facility Care coverage (nursing home and/or assisted living facility), and 69% Comprehensive coverage covering multiple levels of care. The following paragraphs provide a general description of certain terms and features that are included in many of the Company's LTC Policies:

a. Tax Qualified v. Non-Tax Qualified - In order to trigger coverage under a policy, the policyholder generally must satisfy certain needs-based tests that vary depending on whether the policy is Tax Qualified or Non-Tax Qualified. Under Section 213 of the Internal Revenue Code ("IRC"), premiums paid for a Tax Qualified LTC policy are deductible medical expenses. According to Section 7702B of the IRC, a Tax Qualified policy is one that:

   (1) provides insurance coverage only for qualified LTC services;

   (2) does not pay or reimburse expenses that are reimbursable under Medicare;

   (3) is guaranteed renewable;

   (4) does not provide for a cash surrender value or other money that can be paid, assigned or pledged as collateral for a loan, or borrowed;

   (5) provides that all refunds of premiums (other than refunds on the death of the insured or on a complete surrender or cancellation of the policy, which cannot exceed the aggregate premiums paid under the policy) and the policyholder dividends, or similar amounts, are applied as a reduction of future premiums or to increase future benefits; and

   (6) satisfies certain consumer protection requirements as well as disclosure and nonforfeitability requirements.

b. "Qualified long-term care services" are defined as necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and other rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual and are provided pursuant to a plan of care prescribed by a licensed health care practitioner. A "chronically ill individual" is defined as one who has been

certified within the previous twelve (12) months by a licensed health care provider as:

(1) being unable to perform (without substantial assistance from another individual) at least two (2) Activities of Daily Living (eating, toileting, transferring, bathing, dressing and continence) for a period of at least 90 days due to a loss of functional capacity;

(2) having a level of disability similar to the level of disability described in the clause above, as determined by the Internal Revenue Service in consultation with the Department of Health and Human Services; or

(3) requiring substantial supervision to protect such an individual from threats to health and safety due to severe cognitive impairment.

c. A Non-Tax Qualified Policy generally contains eligibility standards, such a Medical Necessity, which is a lower threshold to trigger coverage. For example, some policy forms contain the following conditions for eligibility:

(1) Your Physician certifies Your care to be Medically Necessary; or

(2) You are unable to perform two (2) or more Activities of Daily Living without assistance or supervision; or

(3) You are afflicted with Cognitive Impairment.

Approximately 85% of the Company's policies are Non-Tax Qualified policies, and approximately 66% of the in-force policies are eligible to qualify for care through the Medical Necessity provision.

d. Daily Benefit Amount - The Company's LTC policies are subject to a Maximum Daily Benefit that was selected by the policyholder when he or she purchased the coverage. The Maximum Daily Benefit available ranged from $10 to $300 per day, with many policies subject to annual percentage increases. Some policies, known as "indemnity", pay the full Maximum Daily Benefit, regardless of actual expenses incurred. With the annual percentage increases, in some cases the Maximum Daily Benefit has accumulated to over $700. The Company's average Maximum Daily Benefit for in-force policyholders is $173.

e. Inflation Benefit - Some of the Company's LTC policies were issued with an inflation benefit (referred to as "Inflation Protection"). Inflation Protection may increase a policy's Maximum Daily Benefit by a fixed percentage, often 3% or 5% each year, and inflate the Maximum Lifetime Benefit or Benefit Account Value proportionately. The inflation may be simple (increase by the fixed percentage of the original benefit each year) or compound (increase by the fixed percentage of the current benefit each year). The duration of the inflation may be limited to 20 years, or until a policyholder attained age of 85, but many policies have Inflation Protection

for the life of the policy. Approximately 32% of the in-force policyholders have lifetime 5% compound inflation.

f. Indemnification - Indemnity and reimbursement denote the method by which the Maximum Daily Benefit will be paid out. Some policies provide coverage for the actual expenses of care (reimbursement), while others pay the full daily benefit amount regardless of actual expenses incurred (indemnity) much like disability insurance policies. The payment method can vary on comprehensive policies, between Assisted Living Facility Care or Home Health Services. Approximately 63% of in-force policyholders have the indemnity benefit for their main coverage.

g. Benefit Period - Most of the Company's LTC policies are subject to a Maximum Benefit Period. The Maximum Benefit Periods range from one year to six years. Some policies, however, have an unlimited benefit period ("lifetime policies") while others are subject to a maximum dollar amount. Approximately 72% of the in-force policyholders have a limited benefit period while approximately 29% of policyholders have lifetime policies.

h. Elimination Period - Some of the Company's LTC policies have an Elimination Period, which is a period of time during which the Company is not required to pay benefits to an otherwise eligible policyholder receiving covered care or services. Some policies were issued with a zero-day Elimination Period. Approximately 66% of the in-force policyholders have a zero-day Elimination Period.

i. Waiver of Premium - Approximately 99% of the Company's LTC policies provide that a policyholder who receives benefits under his or her policy for a specified period of time (such as 90 days) is no longer required to pay premiums for coverage after that time period as long as the policyholder remains eligible for benefits and/or receives a specified level of care. Once the policyholder's eligibility for benefits ends, the policyholder is required to recommence paying premiums. Approximately 14% of policyholders who otherwise would pay premiums are currently receiving the Waiver of Premium benefit.

j. Restoration of Benefits - The Restoration of Benefits ("ROB") provision provides that the policy's Maximum Benefit Period will restore to the original Maximum Benefit after receiving some or all claim benefits if the policyholder does not need or receive care during a specified period of time such as 180 days. In most instances, partial benefits were utilized prior to the restoration period. Some policies may restore an unlimited number of times, while others are restricted in the number of times the policy can be restored. Approximately 76% of the in-force policyholders have a ROB benefit.

k. Return of Premium - Approximately 5% of the Company's LTC policies were issued with a Return of Premium ("ROP") benefit. This benefit provides for the return of a percentage of premium paid by the policyholder if the policyholder does not have

a claim or has a limited amount of benefits paid under the policy. The ROP typically occurs upon termination or upon ten-year incremental anniversaries. Since 2011, over $53 million has been returned through the ROP benefit.

C. FINANCIAL CONDITION

The Company has been in a declining financial condition for many years. Its reported surplus is reflected in the following table:

TABLE 8: FINANCIAL CONDITION (IN DOLLARS)

YEAR	ASSETS	LIABILITIES	CAPITAL & SURPLUS/ (DEFICIT)
2009	3,251,994,962	3,058,545,856	193,449,106
2010	3,317,023,144	3,139,706,226	177,314,918
2011	3,161,093,979	3,046,696,672	114,397,307
2012	3,080,745,346	2,975,278,318	105,467,028
2013	2,985,938,782	2,887,736,889	98,201,892
2014	2,906,965,242	2,826,959,318	80,005,924
2015	2,879,794,716	2,824,037,145	55,757,570
2016	2,744,535,287	2,716,512,099	28,023,187
2017	2,688,468,510	2,675,819,343	12,649,166
2018	2,186,058,273	2,652,931,248	(466,814,972)
2019	1,907,181,137	2,823,279,366	(915,731,212)

It is estimated that SHIP's Funding Gap is between $500 million and $1 billion. That is to say, based on Current Premium payments and the current value of SHIP's assets, in the absence of rehabilitation, by the time all of SHIP's policies terminate about twenty to twenty-five years from now, it will have incurred liability for covered benefits costing between $500 million and $1 billion more than the money that will be available to pay for those benefits. It is important to note that these are estimates or projections for events that will occur over a long period of time. Any of a multitude of factors can change during that time affecting materially the accuracy of those projections.

There are many reasons that SHIP finds itself in this dilemma, some understood better than others. The Rehabilitator will be conducting thorough and exhaustive investigations and analyses

of the reasons for SHIP's current financial condition. The areas of investigation and analysis will include, but not be limited to, industry wide challenges, common industry practices, volatility in the financial markets and the conduct of SHIP's management, business partners, consultants and other service providers. The Rehabilitator, in consultation with her advisors and experts, will determine how these forces may have contributed to SHIP's current financial condition. Actions will be taken as appropriate.

Industry wide challenges may have played a role. The LTCI industry or line of insurance business is relatively young, significant numbers of such policies being sold for the first time in the late 1970s and early 1980s. When the products were first designed, there did not exist a robust data base of historical LTCI experience of the type on which actuaries rely to calculate what benefits will cost, how the policies will "behave" over time, and what level of premium will be required to make them financially safe. There was insufficient historical data on which to base expectations about benefit costs and required premiums. The industry therefore referred to experience in other lines of insurance, such as life and disability, to make such projections. Soon, the industry came to understand that the characteristics of LTCI policies are materially different in key respects from those in other lines of insurance. For example, many fewer policyholders voluntarily surrender their LTCI policies before expiration than is true of other types of insurance. Similarly, the length of time during which LTCI policyholders will require benefits is materially longer than had been projected. In short, many factors affecting projected liabilities turned out materially different from what had been assumed when the policies were first issued and premium rates set for them.

This problem was compounded by a decision by the industry to structure these policies as level-premium guaranteed-renewable contracts. In summary, this meant that, as long as the policyholders paid their premiums, the policies could not be cancelled despite changes in age, health condition, and other circumstances. Moreover, the premiums could only be increased if they were increased by the same percentage for all policyholders who had the same type of policy, and then only if the state insurance regulator approved the increase. Over time, a large percentage of these policies were found to be substantially underpriced in that the premiums paid for a given group of such policies could be projected to fall far short of what the company would need for the benefits due under the policies for that group. Obtaining the required approval for rate increases from state regulators proved difficult over time, resulting in two key problems. First, for many LTCI companies, the entire block of such policies were projected to create liabilities far in excess of what the companies would be able to pay. In fact, for many companies like SHIP, this became a serious threat or contributing cause of insolvency. Second, because of differences in the responses by different states to requests for authorization to increase premium rates, over time there emerged wide divergence in the premiums policyholders holding similar policies would pay in different states. Some critics characterized this phenomenon as resulting in policyholders in rate-increase-approving states subsidizing those in states that rejected such requests. All of this can be contrasted with typical health insurance policies that generally last only a year or less, and the premiums for which are adjusted at least annually.

Adding to these challenges were material changes in the economic environment in which these policies were required to perform. For example, when early LTCI policies were sold, there did not exist a robust assisted living facility ("ALF") or continuing care retirement center ("CCRC") industry. When one became incapable of caring for oneself, the principal choices were internment in a nursing home, widely viewed as undesirable unless absolutely necessary, or (at much lower cost) having family or hired help care for one at home. However, as LTCI policies began becoming more popular and provided a funding source for other alternatives, there emerged a vibrant industry of desirable retirement homes providing varying level of care, but typically in much more enticing surroundings and with attractive amenities. These ALFs and CCRCs increased the cost of caring for those who qualified for long-term care benefits but preferred not to remain at home to be cared for by their families or hired care-givers. In many other ways, the cost of caring for those who could not fend for themselves also increased beyond what had been projected by some companies and their consultants when early LTCI policies were priced.

Another major development affected a different key source of funding for future benefits. LTCI policies are designed to generate far more premium than needed to pay benefits in their early years, with those amounts to be invested and generate a material investment income that will be added to the premium and be used in later years when benefit costs are expected to exceed premiums being collected at that later time. In short, the notion is that the company will build-up a fund of premium and investment income that will suffice to pay the large claims expected in the future. In addition to premium being inadequately low when first set, and claims costing more than expected, income earned on the invested premium has also turned out to be much less than anticipated. Changes in the capital market and the broader economy, especially the "great recession" of 2008, dramatically suppressed investment returns below expectations. Current economic circumstances are exacerbating this problem. Many LTCI insurers have amassed billions of dollars in invested premiums. A decline of 1% in yield on each $1 billion of invested premium amounts to a loss every year of $10 million in funds to be reinvested and be available for future claims. It is not hard to see how a decline in market yields of even just 3% for five years for a company with $2 billion in invested assets could be a major event. That would entail a loss of at least $300 million! This is the nature of lost investment income experienced by SHIP and the rest of the LTCI industry, but on more invested assets for many more years. As a point of reference, the Wall Street Journal Prime Rate was at: 8.25% on March 5, 1975; **17.25%** on March 4, 1980; 10% on January 8, 1990; 9% on March 22, 2000; 5.75% on March 22, 2005; 3.25% on December 16, 2008; 5.50% on December 20, 2018; and back down to 3.25% on April 10, 2020.

These and other challenges faced by SHIP over the eleven years since it was separated from Conseco have combined to create the Funding Gap described above. The purpose of the Plan is to narrow or eliminate that Funding Gap by a combination of an increase in revenue through rate increases and a reduction in liabilities through benefit modifications.

D. REHABILITATION PROCEEDING

Since the fall of 2008, SHIP has been owned and overseen by the Senior Health Care Oversight Trust ("Trust" - see paragraph VI.E, page 75) and its Trustees. As SHIP's domiciliary regulator, the Pennsylvania Insurance Department ("PID") regulates SHIP's affairs and monitors its financial condition. On May 7, 2015, the PID concluded a financial examination of SHIP for the five-year period ending on December 31, 2013. The results were detailed in the Report of Examination dated as of that date, which concluded that, as of December 31, 2013, SHIP had capital & surplus of $98,201,892 and made no recommendations.

As surplus continued to decline (see Table 7, at page 72, above), the PID became substantially concerned about SHIP's financial situation. The Department engaged in an intense regulatory focus aimed in part at encouraging management and the Trustees to review and revise the actuarial and other assumptions on which they were basing their financial projections and reports of SHIP's financial condition. In 2017 the PID commenced a limited examination of SHIP's affairs and engaged an independent consulting actuary to assist, especially, in evaluation of the adequacy of the Company's reserves. This work, though continuing, revealed a number of areas of concern and the PID appointed a Special Representative to work with SHIP management, the Trustees, and consultant for both the Company and the PID, to ascertain SHIP's financial condition and to determine whether it would be able to fulfill the contractual promises inherent in the LTCI block the Company was running off. As this work progressed it became evident that SHIP was in a more hazardous financial condition even than suggested by the 2017 statutory annual statement filed in March 2018, which reported a decline in surplus to just over $12.6 million from over $28 million a year earlier and almost twice that the year before.

SHIP and its consultants, in communication with the PID and its representatives and advisors, re-evaluated their underlying assumptions, and, in early 2019, SHIP completed an annual statement for 2018 that reported a $467 million deficit. Management was provided an opportunity to develop a corrective action plan to eliminate this deficit and restore the Company's surplus to acceptable levels but failedto do so. On January 29, 2020, at the request of Pennsylvania Insurance Commissioner Jessica K. Altman, and with the consent of a majority of the Trustees and SHIP's directors, the Commonwealth Court of Pennsylvania entered an order (the "Rehabilitation Order") placing SHIP in rehabilitation and appointing Commissioner Altman as Rehabilitator. The order directed the Rehabilitator to file a preliminary plan for SHIP's rehabilitation on or before April 22, 2020. Commissioner Altman appointed Patrick H. Cantilo as Special Deputy Rehabilitator (SDR) to comply with the Court's requirement. This Plan Document is the plan required by the Court.

E. SENIOR HEALTH CARE OVERSIGHT TRUST

As mentioned above, SHIP had been a subsidiary of Conseco, Inc. ("Conseco") until 2008 when it agreed with PID's approval to transfer it to a newly created independent nonprofit trust. For that purpose the Senior Health Care Oversight Trust (the Trust) was formed as a Pennsylvania

business trust and the following served as its trustees (the "Trustees") as of the date the Company was placed in Rehabilitation and for at least seven years before that date:

1. Julianne Marie Bowler (Chair), since 2009 the Chief Underwriting Officer, and also the Chief Compliance and Administrative Officer, of Narragansett Bay Insurance Company. Ms. Bowler had served as the Massachusetts Insurance Commissioner from 2002 to 2007;

2. Cecil Dale Bykerk, President of CDBykerk Consulting, LLC, a life and health insurance consulting actuary;

3. Thomas Edward Hampton, Senior Advisor to Dentons US LLP, a Certified Public Accountant and former commissioner of the District of Columbia Department of Insurance, Securities, and Banking;

4. John Martin Morrison, senior Partner at Morrison, Sherwood, Wilson, Deola, PLLP, and former Montana State Auditor and Insurance Commissioner; and

5. Gregory Vincent Serio, Partner and Managing Director of New York lobbying firm Park Strategies, and former New York Superintendent of Insurance.

The transaction transferring SHIP to the Trust was memorialized in an August 1, 2008, Transfer Agreement between Conseco and the Trust. The Trust has been (and continues to be) governed by the board of trustees identified above, who have also served as directors of SHIP and Fuzion, along with certain senior officers of the companies. Their authority to oversee the Company has been effectively suspended by the rehabilitation proceedings.

F. FUZION ANALYTICS

Fuzion Analytics, Inc. ("Fuzion"), is a Delaware corporation formed in 2012 as a subsidiary of the Senior Health Care Oversight Trust ostensibly to provide LTCI data mining, analytical and other services to long-term care insurers, including SHIP. Beginning in 2012, SHIP entered into several agreements with Fuzion under which, over time, it paid Fuzion millions of dollars. In 2014, SHIP conveyed essentially all of its infrastructure to Fuzion in exchange for agreed-upon cash consideration consisting initially of a payment of $367,806. In due course, Fuzion began providing SHIP all of the services necessary to administer SHIP's affairs, other than those being performed by other vendors. Since that conveyance, SHIP has had no facilities or employees, relying instead on Fuzion to perform all of the functions necessary to run-off SHIP's LTCI business. On August 20, 2019, the Senior Health Care Oversight Trust conveyed all of its interest in Fuzion to SHIP as a capital contribution, so that Fuzion is now a wholly owned subsidiary of SHIP. In addition to the services provided to SHIP, Fuzion continues to provide Fraud Waste and Abuse and other services to customers in the long-term care industry.

G. LTCG, INC.

In 2008 SHIP entered into a Master Services Agreement with Univita for a broad array of claims and administrative services, excluding complaints. Univita has since become the Long Term Group ("LTCG") and continues providing these services to SHIP.

H. POLICY RESTRUCTURING

Before the Effective Date and potentially again after Phase One, the Rehabilitator will determine which of SHIP's policies are Impaired Policies (under priced and/or Non-self-sustaining). For purposes of implementing the Plan, the Rehabilitator will request that the Court deem SHIP's Impaired Policies to have been restructured first as of the Effective Date and before giving effect to Policyholder Elections or modifications under the Plan, and potentially again between Phase One and Phase Two. However, these restructurings will not affect the elections available to or made by policyholders. The restructuring will be for the purpose of separating the liabilities arising under those policies that SHIP is projected to have sufficient assets to fund from those that it is projected to be unable to fund in the absence of the Plan. This initial restructuring will consist of reducing the liability arising under each such policy (equal to its GPR) to its Initial Funded Restructured Policy Value (IFRPV), being the amount of that liability that the Company can be reasonably expected to fund before it is further modified under the Plan. The Company will retain indebtedness to the policyholders for the amount by which the liabilities have been reduced, *i.e.*, the Unfunded Benefit Liability (UBL). It is possible that realization by SHIP of additional assets could reduce its aggregate UBL. In any case, as explained below, the Rehabilitator will take steps so that the portion of SHIP's UBL that it will not be able to fund will be discharged as part of the Plan.

Allocated Assets and premiums paid as to each policy determined under the Plan as described in Section II.E.4.e, page 17, will suffice to enable the Company to fund its IFRPV. As a result, after the Effective Date SHIP will have assets at least equal to the funded liabilities (or IFRPVs) remaining under the Restructured Policies. Further, SHIP will also have indebtedness to policyholders for the UBL created by the restructuring process described in this Section. The modification of Impaired Policies under the Plan will result in contractual changes to eliminate liabilities that had been converted to UBL in the initial restructuring. That UBL will be equal to the difference between the policy's GPR before modification and its GPR after such modification. SHIP will retain indebtedness to the policyholder equal to that UBL. In due course, however, that UBL will be paid or be discharged by the Court. Because SHIP is unable to fund the UBL, the Rehabilitator will request that, in due course, the Court's Order approving the Plan discharge SHIP's liability for any unpaid UBL.

I. GAUGING PLAN PERFORMANCE

During the pendency of the Plan, the Company's financial condition will be monitored closely with emphasis on changes in the projected deficit. Elections by policyholders to increase

premiums and reduce benefits in the aggregate are expected to have a material effect on that projected deficit. Various aspects of the Plan are also expected to have material effects on key trends such as average claim cost, claim incidence, claim duration and policy terminations. Most of these are heavily dependent on policyholder behavior that is difficult to predict with certainty. As time passes following implementation of each phase of the Plan, however, changes in these key trends will become more evident and the effects of the Plan as a whole will be more susceptible of quantification.

J. GUARANTY ASSOCIATIONS

This is a general summary of the state Guaranty Association system. Readers must review the individual state laws to understand how individual Guaranty Associations operate in each jurisdiction and the protections they afford. The Plan does not contemplate involvement by Guaranty Associations in the Plan's operations. This information is provided solely in the interest of addressing anticipated questions.

All U.S. states and the District of Columbia have legislatively established entities, commonly referred to as "Insurance Guaranty Associations," which protect policyholders of licensed insurance companies in the event their insurance company fails. These Guaranty Associations generally are required to provide for the continuation of the life and health insurance coverage provided by the failed insurer, in most cases up to statutory maximum coverage amounts and subject to specified conditions.

Virtually all of SHIP's LTC insurance policies would be covered under the state Guaranty Association system, subject to individual state statutory maxima and conditions, if SHIP were placed into liquidation with a finding that it is insolvent. Policies held by residents of countries other than the U.S. may not be covered by Guaranty Associations.

In most states, Guaranty Association benefits can be "triggered" in one of several ways. Some "triggers" are permissive, authorizing the Guaranty Association to guarantee, assume or reinsure, or cause to be guaranteed, assumed, or reinsured, the covered contractual obligations arising under the insurer's policies or contracts (or to provide loans or other assistance). Other "triggers" are mandatory, requiring the Guaranty Association to take such measures. When triggered, the Guaranty Associations generally provide such protections to the residents of their states, though the contracts may have been issued in other states. In most states, the permissive trigger can be used when an insurer is deemed "impaired" but has not been found insolvent or ordered liquidated. As the term implies permissive triggers are optional with the Guaranty Associations and very rarely used.

Mandatory triggers generally include an insurer not paying claims on time and being placed in liquidation with a finding of insolvency. These provisions vary somewhat among the several states. The Rehabilitator has concluded that SHIP does not now qualify for mandatory triggers

largely because there has not been an order of liquidation with a finding of insolvency and it is currently paying claims on time. However, though SHIP is currently paying claims on time as required by the Rehabilitation Order, its financial condition is so dire that it is a virtual certainty that it cannot continue paying claims in full and on time for as long as required by its LTC insurance contracts without remedial measures. In the absence of a rehabilitation plan, the continuation of full benefit payments to current claimants virtually assures that policyholders who go on claim in the future will not be able to receive full, or in some cases any, benefits from SHIP.

Generally, if a policyholder is entitled to receive benefits from the Guaranty Association of his or her state of residence no further inquiry is necessary to determine which Guaranty Association is responsible for his or her policy. However, when that is not the case, it may be necessary to determine whether the Pennsylvania Life and Health Insurance Guaranty Association (PLHIGA) may be required to provide such benefits because SHIP is domiciled in Pennsylvania. It is important to note that the conditions and limits of Guaranty Association protection typically apply to each policyholder, not to each policy. Thus, in a state in which such benefits are limited to $300,000 (the majority of states), that limit will apply to all of a policyholder's policies issued by the same Company combined. The laws of each specific jurisdiction should be reviewed carefully to determine how these conditions and limits apply in particular cases.

It is important to note that the amount of statutorily promulgated Guaranty Association coverage limits is not directly comparable to a policy's GPR. GPR is the present value as of the valuation date of expected benefits unpaid, expected expenses unpaid, and unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect and including provision for moderately adverse developments. It measures the present value of benefits and expenses less the present value of premiums. The Guaranty Association coverage limits are stated nominally (that is the total to be paid over time, no matter how long that time) and not at present value. The GPR equivalent of stated Guaranty Association Limit depends on factors individual to each policyholder, mostly related to the expected timing and amount of benefit and premium payments. Thus, a $300,000 Guaranty Association limit may equate to a GPR of $270,000 or some other amount less than $300,000 for a given policyholder.

Neither the Rehabilitator nor SHIP would be responsible for coverage decisions of the Guaranty Associations. Each Guaranty Association evaluates its own liability and makes its own coverage determinations in accordance with applicable law. Those laws vary to some degree among the states and benefits available in some states may differ from those available in others. For example, in some states the Guaranty Associations do not provide coverage for any portion of a policy or contract to the extent that the rate of interest on which it is based exceeds a specified rate, typically set by reference to Moody's Corporate Bond Yield Average over a specified time. These interest rate limitations often apply retrospectively (to interest earned pre-liquidation) and prospectively (to interest earned after liquidation), though perhaps in different ways. Other states have adopted legislation making such provisions inapplicable to LTCI.

As noted above, Guaranty Association benefits are subject to statutory conditions and limits. For example, PLHIGA is not obligated to provide more than $300,000 in benefits to a covered individual. In some states that limit can be significantly higher. However, the fact that applicable limits may be higher in another state does not entitle Pennsylvania residents to the higher protection afforded by the Guaranty Association of another state. In addition, the Guaranty Association statutes contain certain residency and other requirements that must be met in order to receive benefits. Some of SHIP's policyholders may have aggregate claims in excess of these limits or which do not qualify for Guaranty Association benefits for other reasons (Uncovered Benefits).

The methods by which Guaranty Associations discharge their statutory responsibilities vary from case to case but normally involve assumption by a Guaranty Association or an insurer of the contractual obligations created by the policies issued by the failed insurer, up to statutorily prescribed limits and subject to statutory conditions. Policyholders are required to continue paying their premiums without interruption in order to preserve their insurance coverage, unless those premiums have been suspended by Premium Waiver provisions in their policies. However, once benefits paid by the Guaranty Association reach the applicable statutory limit (and those benefits are therefore discontinued), the policyholder will no longer be required by the Guaranty Association to continue making premium payments.

As noted, SHIP has not been placed in liquidation and Guaranty Association coverage and associated limits are therefore not applicable to SHIP policies. While it is hoped that it will not be necessary to place SHIP in liquidation, and no specific plans exist to do so, past experience provides guidance about some likely aspects of such an eventuality. Specifically, it is probable that if the Guaranty Associations are "triggered" for a SHIP liquidation they would seek to raise rates to If Knew Premium levels. To the extent that the Plan does so now, it should reduce or eliminate the need for the Guaranty Associations to do so if that were to occur.

K. JURISDICTION OF COMMONWEALTH COURT

The Commonwealth Court has exclusive *in rem* jurisdiction over SHIP and all of its assets. That means it is the only court with jurisdiction over SHIP's assets and business. Note by way of distinction that other courts may have *in personam* jurisdiction over SHIP, its policyholders and claimants. The Commonwealth Court has authority to approve a rehabilitation plan for the company. 40 P.S. § 221.16 expressly authorizes the rehabilitator to "prepare a plan for the reorganization, consolidation, conversion, reinsurance, merger, or other transformation of" SHIP. Without going into detail, that statute gives the rehabilitator broad discretion to develop a plan to correct the conditions that led to the need to place SHIP's in rehabilitation, including changing the Company's policies (and rates) as part of the Plan. So long as all affected parties (including other state insurance departments) are provided an opportunity to object, they will be bound by the Court's approval of the Plan, and its modification of policies and premium rates as part of the Plan.

Some concern has been expressed by certain state regulators about the notion that premium

rate modifications under the Plan will not require approval of the states in which the policies were issued. The concern is understandable given that there have not been many troubled companies for which the issue of rate increases in rehabilitation has arisen. Moreover, insurance rate regulation tends to be an area of intense public and political focus. In some states, Commissioners are constrained by statute in the magnitude of rate increases they can authorize for long-term care insurance policies. The Rehabilitator believes strongly that there is fundamental distinction between rate increases for companies in the market place and the extraordinary case of rate increases as part of a court supervised rehabilitation plan for a troubled company. While the matter is without an abundance of clear specific legal precedent, the Rehabilitator believes that the applicable legal authorities support the conclusion that it is properly within the purview of the Rehabilitator and the Commonwealth Court in an Article V rehabilitation proceeding. More importantly, the Plan would not be feasible, and would fail in a key goal, if rate modifications required approval from each of the states in which SHIP policies have been issued. First, that would prevent the plan from accomplishing its key goal of placing policyholders on "a level playing field" by having them pay substantially the same premium for the same coverage, thereby reducing or eliminating the much-criticized historical subsidies. Second, the need to obtain such approvals would insert a lengthy delay in the time-line that would be costly, if not fatal, to the Plan.

L. REINSURANCE

SHIP has assumed a number of LTC policies through co-insurance or reinsurance.

1. Transamerica

On October 11, 1994 JC Penney Insurance Company and JC Penney Life Insurance Company (collectively "JCP") entered into a Reinsurance and Purchase Agreement and Administrative Services Agreement with American Travelers Life Insurance Company ("American Travellers"). The Reinsurance and Purchase Agreement was structured on an Indemnity Reinsurance basis and a trust account was later established pursuant to a Trust Agreement executed on December 31, 2002. American Travellers was purchased by Conseco in 1996 and subsequently changed its name to Conseco Senior Health Insurance Company and then to Senior Health Insurance Company of Pennsylvania ("SHIP"). JCP changed its name to Stonebridge Life Insurance Company in 2002 and, as a result of corporate transactions, is now Transamerica Life Insurance Company.

2. Primerica

On December 20, 1995 Primerica Life Insurance Company ("Primerica") and Transport Life Insurance Company ("Transport Life") entered into a Reinsurance and Administration Agreement whereby Transport Life, on an indemnity basis, accepted 100% of the policy liabilities of Primerica's individual and group accident and health insurance policies. Transport Life merged with Conseco Senior Health Insurance Company in November 1997 and, with the separation from

Conseco, Senior Health Insurance Company of Pennsylvania ("SHIP") became the successor under the Reinsurance and Administration Agreement. Amendment #2 to the Reinsurance and Administration Agreement, dated November 11, 2008, limits the scope of SHIP's reinsurance and administration to long term care policies only.

3. **American Health and Life**

Pursuant to a Reinsurance Agreement dated November 1, 1996, Transport Life entered into a Reinsurance Agreement whereby Transport Life agreed to administer and reinsure, on a coinsurance basis, 100% of the liability of American Health and Life Insurance Company's long term care policies. As a result of certain corporate transactions, and later the separation of SHIP from Conseco, SHIP became the successor to Transport Life's interests under the Reinsurance Agreement and continues to administer the policies.

4. **Washington National Insurance Company**

On June 30, 1998, American Travellers entered into a Coinsurance Agreement with Conseco Life whereby American Travellers ceded 100% of its net liability for certain Connecticut resident state policies to SHIP, including servicing and administration of these policies. On April 1, 2013, CNO assumed, through novation, all of the policies with the exception of certain Connecticut policies which opted out of the assumption. Washington National Insurance Company reinsured those Connecticut policies that opted out.

5. **Conseco Life Insurance Company**

Under an Assignment Agreement effective October 1, 2008 with Conseco Life Insurance Company ("CLIC"), all the assets and liabilities pertaining to SHIP's non-long term care business were assigned to, and assumed by, CLIC, which, together with DXC Technology, administers all of the business. SHIP remains contingently liable for the assigned business in the event CLIC fails to perform its obligations under the Assignment Agreement. In recognition of this liability, CLIC is required to and does maintain assets in a trust account of which SHIP is beneficiary. That account appears to be adequately funded. The business they manage consists of

1. 7,106 Traditional Life,
2. 213 Universal Life,
3. 80 Deferred Annuity,
4. 223 Medicare Supplement,
5. 40,273 Specified Disease,
6. 756 Accident Only,
7. 667 Hospital Indemnity,
8. 521 Long term disability, and
9. 43 Other.

6. **Teacher's Protective Mutual Life Insurance Company**

Teacher's Protective Mutual Life Insurance Company ("Teachers'") and Senior Health Insurance Company of Pennsylvania ("SHIP") entered into an Indemnity and Assumption Reinsurance and Administrative Services Agreement on December 28, 2015 pursuant to which Teachers ceded to SHIP, on an indemnity reinsurance basis, 100% of liabilities and obligations paid or payable by Teacher's. These policies have been novated by SHIP so that they are treated as if they had been issued by SHIP in the first place.

All of these assumed LTCI policies have historically been treated administratively in material respects as if they had been issued directly by SHIP. That treatment will continue under the Plan unless the Court orders otherwise or a different agreement is reached with the cedents of those policies.

M. COMMISSIONS

The payment of commissions owed to Agents under agreements made prior to the inception of rehabilitation proceedings will be suspended under the Plan until policyholders have been made whole, that is, all their contractual claims have been paid in full and adequate provision made for reasonably anticipated future claims. Further, the Plan will suspend the accrual of commissions as of the Initial Plan Effective Date. Agents and brokers may assert claims for commissions earned prior to the Initial Plan Effective Date but, under the Plan, those claims will be subordinated to amounts owed to policyholders under SHIP insurance policies.

The Rehabilitator notes that Agents are not currently providing services at the request of and in support of the Rehabilitator. Since entering rehabilitation, SHIP has evaluated the ongoing role of Agents. It is the belief of the Rehabilitator that most policyholders do not have a close relationship with their Agents, often have not spoken with their Agents since their policies were purchased, and do not contact their Agents for questions about their policies or benefits. Most policyholders contact SHIP directly for policy information or questions, or a financial advisor or trusted professional (lawyer, banker, trustee or family member).

N. OPT OUT

The Company's LTC policies do not provide for any cash or surrender value and policyholders are not entitled to any cash payment upon cancellation either in the ordinary course of business or in liquidation. In short, upon liquidation, policyholders would not receive cash payments.

While the Plan does not propose a separately-identified cash opt-out option, certain features of the Plan satisfy an opt-out requirement. First, many policyholders will not be required by the Plan to make any changes in their policies. Second, every policyholder will have an option in every

scenario to select a Non-forfeiture Option under which no more premium will be due and he or she will receive at least the coverage that can be provided at the current benefit level by the aggregate of all premiums paid by the policyholder to date less claims paid under the policy to date. In fact, elements of the Plan make the NFO option materially more valuable than this baseline. See section II.I, page 22. Finally, every policyholder will have at least one option under which he or she would receive at least as much in benefits as would be provided by his or her Guaranty Association coverage.

O. STATE DEPOSITS

SHIP has been required to place deposits with various states as a condition of its licensing in those states. These state deposits total approximately $19.3 million. The Rehabilitator believes that once the Plan is approved (whether or not modified), she should pursue recovery of those deposits so that the funds can be used to support the Plan.

P. TAX MATTERS

The Plan is not intended to create net adverse tax consequences for policyholders or SHIP, and the Rehabilitator does not believe that it will do so if it is implemented as proposed. However, the tax effects of the Plan depend in part on events, circumstances and the conduct of other parties that are not within the control of, nor can be predicted by, the Rehabilitator.

While a number of federal income tax issues may arise under the Plan, two areas are of particular concern. First, will any modification of LTC policies under the Plan create adverse tax consequences for policyholders? Second, will the inability to fund fully policy obligations or provisions of the Plan create adverse tax consequences for SHIP?

1. Policy Modifications.

It does not appear that the Plan is likely to create adverse tax consequences for policyholders. However, if further analysis indicates that Policy Modifications or other provisions of the Plan, may raise such issues, it is likely that the Rehabilitator will seek from the Internal Revenue Service of the Department of the Treasury (the "IRS") a favorable private letter ruling ("PLR") to the effect that Policy Modifications under the Plan would not produce taxable deemed exchanges or other adverse tax consequences for policyholders.

2. Tax Issues for SHIP

It is possible that reductions in insurance reserves resulting from Policy Modifications or other elements of the Plan would be deemed taxable reserve releases creating taxable income. However, the Plan contemplates the restructuring of SHIP's policies, bifurcating the liabilities arising under them as between their IFRPV and their UBL, which will minimize this tax exposure.

The Plan contemplates discharge of SHIP's UBL to the extent that SHIP cannot pay them.

SHIP is part of consolidated group for federal income tax compliance purposes, which also includes its affiliates, the Trust and Fuzion. The group files a consolidated tax return. SHIP and its affiliates currently possess substantial Deferred Tax Assets ("DTAs") such as net operating loss carry-forwards. These DTAs may serve to offset taxable income generated by operation of the Plan. It is possible that implementation of the Plan may give rise to tax liability, however, because of certain limitations on the use of such carry-forwards in the Internal Revenue Code. The ability of SHIP to realize the benefit of these DTAs may also depend in part on decisions made by other members of the consolidated group. While Fuzion is SHIP's wholly owned subsidiary, and under its control, the Trust is governed independently. Current tax law may affect the degree to which other parties may make decisions adverse to SHIP's interest and rehabilitation. Moreover, the discharge of indebtedness under the Plan may also result in reducing or eliminating SHIP's ability to take advantage of these DTAs.

As indicated above, to the extent that the Plan results in the reduction of policy obligations through the modification of policies to make them properly priced or Self-sustaining (thereby removing their UBL), it is possible that such reduction will be subject to federal income tax. It is possible that not all of such income may be excludable under an insolvency exception for discharge of indebtedness income, or be offset against net operating loss carry-forwards and other DTAs. It is also possible, as noted, that implementation of the Plan may give rise to tax liability. The Plan is designed, and the Rehabilitator intends to implement it, in a manner that will minimize or eliminate such potential adverse tax consequences. However, there can be no assurances that these measures will be effective.

Nothing in the Plan Document is intended to provide, nor shall be interpreted as providing tax or legal advice. Policyholders and other persons affected by the Plan should consult their own tax or legal and other advisors regarding the possible tax and other effects of the Plan. The Rehabilitator may seek guidance (such as a private letter ruling) from the U.S. Secretary of the Treasury regarding certain potential tax aspects or consequences of the Plan.

Q. PRINCIPLES AND FAIRNESS OF THE PLAN

The Plan is designed to comply with applicable statutory provisions. In addition, by reference to Pennsylvania statutes and judicial opinions governing other insurance rehabilitation and insolvency proceedings in this and other states, the Rehabilitator has adopted the following core principles that should guide implementation of the Plan:

1. To the extent reasonably possible under the circumstances, the Plan should correct the conditions which constituted the grounds for the order to rehabilitate the Company;

2. The paramount goal of the Plan should be protection of policyholders;

3. The Plan should be fair and equitable;

4. The Plan should put policyholders and creditors as a group in a position not materially inferior to what liquidation of SHIP as of the Effective Date would produce; and

5. The Plan should include metrics to gauge progress.

The Rehabilitator believes that the Plan reasonably embodies these principles and that it is fair and equitable to policyholders, creditors and affected parties. It addresses historically discriminatory premium rates through asset allocations in determining Self-sustaining Policies and through the premium rate increase structure governing Policy Modifications. Within the means available, as regards policyholders the Plan is designed to reduce the Funding Gap which principally led to the inception of the rehabilitation proceeding. It does so through premium rate increases and benefit reductions to reduce or eliminate on a policy-by-policy basis the shortfall between assets and liabilities. The principal goal of the Plan is to protect the interests of policyholders by maximizing preservation of their insurance coverage. It treats similarly situated policyholders in the same way and devotes SHIP's assets to the fulfillment of its purposes in a non-discriminatory and non-arbitrary manner.

R. RISK FACTORS

There are substantial risks and uncertainties associated with the Plan and its implementation. Those described herein are not the only ones that could materially impact SHIP, the Plan, its implementation, and its impact on policyholders, creditors and the public.

1. The actuarial assumptions and projections used to develop the Plan, including investment income, default rates, lapse rates, expenses and claims may be materially different from actual results. Therefore, the benefits and claims that SHIP will be able to pay may be materially higher or lower than the amounts assumed in the Plan.

2. Although the Plan does not contemplate that SHIP will, as a result of the Plan, implement future premium rate increases not described in the Plan, there can be no assurances that such rate increases will not be sought by Guaranty Associations if SHIP is placed in liquidation.

3. Objections may be lodged against the Plan or its implementation which may not be able to be overcome without material changes in the Plan.

4. The Rehabilitator believes that the provisions of the Plan can be implemented with approval of the Commonwealth Court and without the need that insurance regulators in every state approve the Plan, including premium rate increases implemented under the Plan. However,

regulators in other states may conclude that their approval is required. The Rehabilitator cannot provide any assurance that approval from other regulators will not ultimately be deemed necessary. Neither can the Rehabilitator provide assurances that if such other state approvals are necessary they can be obtained consistent with the timing and substance of the Plan.

5. Governmental authorities may change the laws and regulations that apply to SHIP, its business and state insurance receiverships in ways that impact policyholders, SHIP, the Plan, or its implementation negatively.

6. Adverse developments in the broader economy may affect adversely the performance of SHIP's invested assets, the costs of its operations or the development of its liabilities. As a result, financial assumptions made in the Plan may differ materially from actual events.

7. Certain changes in the general health of SHIP's insured population (such as developments prolonging the period that such persons remain on claim, the severity of such claims, or the frequency with which policyholders go on claim) may affect materially the development of SHIP's insurance liabilities. As a result, loss assumptions made in the Plan may differ materially from actual events.

8. The emergence of the Coronavirus disease known as "COVID-19" has created unprecedented and wide-ranging disruptions in virtually every facet of American society. Its economic implications, and the changes that will result in American healthcare and insurance are only now beginning to surface and will take a prolonged time to develop completely and be fully understood. The Rehabilitator cannot predict what effect COVID-19 will have on the Plan and its implementation. The Special Deputy Rehabilitator and rehabilitation team are making efforts to incorporate in the Plan expanded timelines and elements of flexibility that will facilitate responding to these recent and continuing developments.

9. The Plan depends on implementation of a complex restructure of SHIP's insurance business for which there is no close precedent and which depends in part on legal provisions that may be difficult to implement. Failure to implement these provisions may have a material adverse effect on the success of the Plan.

10. The success of the Plan will depend in part on policyholder elections which are difficult to predict. The actual results of those elections may have a material adverse effect on the Plan.

S. DISCLAIMERS AND SOURCES OF INFORMATION

The discussion of the Rehabilitation Plan in this document describes how it is proposed to be implemented if approved by the Court as proposed by the Rehabilitator. If the Plan is

modified by the Court or pursuant to subsequent amendments proposed by the Rehabilitator, its implementation may differ materially from the description herein.

The Plan includes information concerning SHIP's history and current and projected financial condition. This information was prepared based on information available to SHIP and the Rehabilitator, including information provided by SHIP to the Rehabilitator or available in historical public filings, and on actuarial projections that inherently include a degree of uncertainty. The Rehabilitator has yet to conclude an investigation of all the reasons that led to the Company's distressed financial condition. Pursuant to her statutory ability to do so, the Rehabilitator has delegated broad responsibility to the SDR and in the Plan references to Rehabilitator should be interpreted as including the SDR unless specified otherwise. The Rehabilitator and SHIP do not make any warranty, express or implied, as to the accuracy or completeness of the information contained in the Plan. In particular, events and forces beyond the control of the Rehabilitator and SHIP may alter the assumptions upon which the disclosures in the Plan are based. The Plan Document includes certain projections, but they cannot forecast and reflect fully any events that may occur subsequent to the date hereof. Such events may have a material impact on the information contained in the Plan Document and any recovery or benefits that may be received by policyholders and other creditors of the Company. The Rehabilitator may or may not update the Plan (including the financial information and underlying assumptions) or may only update it in part or only after the passing of substantial amounts of time. Therefore, the financial information and projections set forth in this Plan document may become outdated with the passage of time.

THE REHABILITATOR AND SHIP ARE NOT OFFERING LEGAL, BUSINESS, FINANCIAL, TAX OR OTHER ADVICE TO ANY PERSON AND THE PLAN SHOULD NOT BE CONSIDERED TO CONTAIN ANY ADVICE OR INSTRUCTION CONCERNING SUCH MATTERS. THE READER SHOULD CONSULT WITH HIS OR HER LEGAL, BUSINESS, FINANCIAL, TAX AND OTHER ADVISORS AS TO ANY MATTERS CONCERNING THE PLAN.

The Plan document is not required to be prepared in accordance with federal or state securities laws. None of the Securities and Exchange Commission ("SEC"), any state securities commission, or any similar governmental body has approved the Plan Document or has opined on the accuracy or adequacy of the statements contained therein. None of the financial information in the Plan Document was prepared to comply with published guidelines of the SEC, the American Institute of Certified Public Accountants, U.S. Generally Accepted Accounting Principles or prescribed statutory accounting principles, except as specifically described therein.

The Plan Document may not be relied upon for any purpose (including to trade, buy or sell claims or securities) other than to obtain information about the details of the Plan and the related proceeding. Nothing contained herein is intended as or constitutes an admission of any fact or any party's liability with regard to any claim or litigation, including, but not limited to, any proceeding involving the Rehabilitator, SHIP, or any other party, or any proceeding with respect to the legal

effect of the transactions contemplated by the Plan. Nothing contained in the Plan Document constitutes an admission, or can be deemed evidence, of the tax or other legal effects of the Plan on SHIP or on holders of claims against, or equity interests in, SHIP or its affiliates. Statements as to the rationale underlying the treatment of claims and other matters under the Plan are not intended to, and will not, waive, compromise or limit any of the Rehabilitator's or SHIP's rights or causes of action.

The Plan document contains statements that are, or may be deemed to be, "forward-looking statements" within the meaning of the Private Securities Litigation Reform Act of 1995. Any such forward-looking statements are based upon a variety of estimates and assumptions that, though considered reasonable by the Rehabilitator, may not be realized, and are inherently subject to significant business, economic and other uncertainties and contingencies. Some assumptions inevitably will not materialize and events and circumstances occurring subsequent to the date on which the statements were prepared may be significantly different from those assumed, or may be unanticipated, and thus may affect financial or other results in a material and possibly adverse manner. The statements, therefore, should not be relied upon as a guaranty or other assurance of the actual results that will occur.

To ensure compliance with Internal Revenue Service Circular 230, holders of claims and other interests are hereby notified that: (a) any discussion of United States federal tax issues contained or referred to in the Plan Document is not intended or written to be used, and cannot be used, by holders of claims and other interests for the purpose of avoiding penalties that may be imposed on them under the Internal Revenue Code; (b) such discussion is provided solely in connection with the transactions or matters addressed herein; and (c) holders of claims and other interests should seek advice based on their particular circumstances from an independent tax advisor.

All summaries of the Plan contained herein or in other materials prepared by the Rehabilitator or others, including other filings with the Court, are qualified in their entirety by reference to the Plan as set forth in its entirety herein. Summaries of the Plan herein are not complete and are subject to, and qualified in their entirety by, reference to the full text of the Plan.

VII. GLOSSARY

The following are terms used in, or helpful in understanding, the Plan.

1) **"Accumulated Premium"** means, for a policy or group of policies, the total Gross Premiums paid, and premium waived under Waiver of Premium provisions, from inception until the valuation date.

2) **"Accumulated Premium Method"** means allocation of assets in proportion to the Accumulated Premium of the relevant policies as is more fully explained in Section II.E.4.e, page 17.

3) **"Active Allocable Assets"** is a notional determination applicable to policies not on claim and consisting of the Company's Allocable Assets less the amount required to fund fully the Disabled Life Reserve.

4) **"Active Asset Premium Ratio"** means the ratio of Active Allocable Assets to the aggregate of Accumulated Premiums for all Active Lives.

5) **"Active Block"** means the LTC insurance policies issued or assumed by the Company that remain in force and are not on claim.

6) **"Active Life Reserve"** or **"Statutory Active Life Reserve"** means the excess of the present value of future benefits over the present value of future Net Premiums. Net Premiums do not include provisions for any expenses and are typically set at policy issue. The assumptions used in statutory active life reserve calculations are locked-in and several of the assumptions are prescribed by law.

7) **"Active Policies"** or **"Active Policyholders"** referred to also as Policies Not On claim and Policyholders Not On claim, means respectively policies or policyholders that have not been terminated due to non-payment of premiums, cancellation, or exhaustion of benefits and also are not listed in the Company's records as having been approved for benefit payments and are not in the process of being approved for benefit payments as of the Determination Date.

8) **"Activities of Daily Living"** or **"ADL"** means eating, bathing, dressing, ambulating, transferring, toileting and continence.

9) **"Adult Day Care"** means a program for six or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly, or other disabled adults who can benefit from care in a group setting outside the home. It is generally administered as part of home health care benefits.

10) **"Adult Day Care Center"** means a facility which provides Adult Day Care programs and services and which is operated pursuant to the provisions of applicable state law relating to licensing and quality of care requirements.

11) **"Agent"** means any insurance agent, broker or producer that solicited, sold or placed insurance business issued or assumed by the Company or any of its predecessors.

12) **"Allocable Assets"** is a notional determination consisting of the total value of the Company's liquid invested assets, after making provision for costs and expenses of administration, contingencies, and accrued but unpaid claim payments.

13) **"Allocated Assets"** means, for a LTC policy or group of policies, the portion of the Allocable Assets notionally allocated to that policy or group of policies in accordance with the terms of, and solely for the purposes described in, the Plan. All asset allocations are notional and do not give any policyholder a right to any Allocated Assets or any particular sum of money.

14) **"Approval Order"** means an Order from the Commonwealth Court approving the Plan.

15) **"Article V"** means Article V of the Pennsylvania Insurance Department Act of 1921, P.L. 780, as amended, 40 P.S. § 221.1, et. seq.

16) **"Basic Policy Endorsements"** means certain endorsements that together constitute the policyholder Option Two under the Plan. They consist of specific Policy Modifications described fully in Section III.A.2.d, page 36, intended to provide reasonable benefits and premiums that will be immune from changes in Phase Two of the Plan. Policyholders making this election will not face additional modifications under the Plan except from paying full premium rather than Differential Premium if a Premium Waiver becomes inactive.

17) **"Benefit Triggers"** means the conditions that must be satisfied in order to be eligible for benefits under an LTC insurance policy.

18) **"Claim Reserve"** means the Disabled Life Reserve plus the reserve for pending and incurred but not reported claim payments as further defined herein.

19) **"Claim Waiver of Premium"** means a provision in a LTC insurance policy under which a policyholder who receives benefits under his or her policy for a specified period of time (such as 90 days) is no longer required to pay premiums for coverage after that time period as long as the policyholder remains eligible for benefits and/or receives a specified level of care.

20) **"Commonwealth Court"** or **"Court"** means the Commonwealth Court of Pennsylvania , which is the rehabilitation court for SHIP and has exclusive jurisdiction over SHIP's rehabilitation.

21) **"Company"** means SHIP.

22) **"Cost of Insurance"** means the amount of premium expected to fund future policyholder benefits. It does not include amounts for future operating expenses and profits.

23) **"Court"** means for purposes of the Plan, and unless otherwise specified, the Commonwealth Court of Pennsylvania.

24) **"Covered Benefits"** means the amount of policy benefits provided by SHIP's insurance policies that, if SHIP were placed in liquidation, would be within the limits, conditions and scope of coverage of the responsible Guaranty Association taking into account the residence and other attributes of the policyholders as determined by the responsible Guaranty Association in accordance with applicable law.

25) **"Current Premium"** means the premium paid by or waived for a LTCI policy before the applicable Effective Date under the Plan. This is also the target premium for the Downgrade Process. See Section III.A.1.c, page 30.

26) **"Daily Benefit Amount"** or **"DBA"**, also called Maximum Daily Benefit (MDB), means a maximum daily dollar amount available on a covered day of care as specified in the policy.

27) **"Default Option"** means the Plan Option selected automatically for a policyholder who fails to make a valid election by the required date.

28) **"Determination Date"** means a date, which may vary among policyholders, after the Policyholder Election Date and before the Initial Plan Effective Date or Supplemental Plan Effective Date (whichever is applicable) to be selected by the Rehabilitator pursuant to the Plan as of which all the determinations and calculations required to construct the options available to each policyholder will be made by the Rehabilitator.

29) **"Differential Premium"** means the applicable premium (If Knew, Phase One, or Self-sustaining) less the Current Premium and is payable under the Plan in lieu of the applicable premium by policyholders on waiver. Under the terms of the Plan, differential premiums cannot be less than zero.

30) **"Disabled Allocable Assets"** is a notional allocation consisting of the portion of the Company's assets allocable to policyholders on claim for purposes of determining whether they are Self-sustaining, and if not, their Shortfall Amounts. The method of determining the amount of such assets is described in Section II.E.4.d, page 16.

31) **"Disabled Life"** means a policyholder who is receiving, or has been approved to receive, policy benefits or a policy under which benefits are being provided, or have been approved, by the Company and is also referred to as a policyholder on claim.

32) **"Disabled Life Reserve"** or **"DLR"** means the present value of expected future benefits calculated for each policyholder listed in the Company's records as a policyholder on claim.

33) **"Downgrade Process"** means the process for reducing the benefits of a policy pursuant to Option One so that the policyholder may retain the Current Premium but reduce the benefits

provided by that policy to those that premium can fund on an If Knew basis in Phase One and a Self-sustaining Basis in Phase Two. It is described in detail at Section III.A.1.c, page 30.

34) **"Dual Waiver of Premium"** or **"Dual Waiver"** (DWOP), sometimes called Spousal Waiver of Premium, means a provision in a LTC insurance policy under which the premium of a spouse is also waived when the policyholder's premium is waived upon going on claim.

35) **"Effective Date"** means the date as of which the provisions of the Plan, including modification of LTC policies and Policyholder Elections, will become effective following the approval of the Plan. For most policyholders the Effective Date will be the Initial Plan Effective Date. For policyholders who undergo specified changes in status during the Policyholder Transition Period as described in Section II.K.3.c, page 26 the Effective Date will be the Supplemental Plan Effective Date.

36) **"Elimination Period"** or **"EP"** means the time period during which a policyholder's circumstances qualify for Long-term Care insurance benefits but for which no such benefits are yet payable by the Company. The Elimination Period is similar to a deductible or waiting period. The length of the elimination period varies by policy. The majority of the Company's policies include elimination periods of zero days, 30 days, 60 days, 90 days, and 110 days, although the Company has some policies with elimination periods up to 365 days.

37) **"Expected Losses"** means the average future benefit payments and increases in reserves calculated for a given policy using original issue assumptions as adjusted from time to time by the Company, including its demographic characteristics, policy characteristics, assumed claim incidence rates, assumed claim termination rates, and assumed claim intensity.

38) **"Final Approval Date"** means the date upon which the Approval Order becomes final and non-appealable or upon which an appellate Order affirming the Approval Order has itself become final and no longer appealable.

39) **"Fully Covered"** means that the maximum liability projected for a particular policy (its MPV) is no greater than the limits of Guaranty Association coverage that would apply to that policy if SHIP were placed in liquidation. A Fully Covered policy has no Uncovered Benefits.

40) **"Funding Gap"** means the gap between: (a) the sum of: (1) the amount of SHIP's assets, (2) projected future premiums, and (3) projected earnings on investments, and (b) the sum of: (1) SHIP's future policy benefits, (2) related expense payment obligations, and (3) other expenses.

41) **"Fuzion"** means Fuzion Analytics, Inc., a subsidiary of SHIP that, among other things,

provides management and administrative services to SHIP.

42) **"Gross Premium"** means the periodic payments that are required to keep the policy in force. The rates used to establish the Gross Premium are typically filed with, and subject to approval of, insurance regulators. Gross Premium includes provisions for expenses and profit margins.

43) **"Gross Premium Reserve"** or **"GPR"** means the present value as of the valuation date of expected benefits unpaid, expected expenses unpaid, and unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect and including provision for moderately adverse developments. Expected expenses include commissions and premium taxes (if applicable). GPR is the reserve amount that results from performing a GPV. For a Self-sustaining Policy GPR is no more than the assets allocated to that policy under the Plan for calculation purposes only.

44) **"Gross Premium Valuation"** or **"GPV"** is the determination of the present value of expected future benefits and related expenses less the present value of expected future premiums at current and anticipated rates where "expected" consists of best estimate assumptions including a provision for moderately adverse deviation. The gross premium valuation process is used in determining the GPR.

45) **"Guaranty Association"** means the life, health and accident insurance Guaranty Association or equivalent entity in a particular state responsible for providing benefits to the policyholders of an insolvent long-term care insurer.

46) **"HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, which among other things establishes data privacy and security safeguards for patient health information and which also provides that premiums paid for "Tax Qualified policies" as defined in the Act, may be deductible from federal income tax.

47) **"IBNR"** or **"Incurred But Not Reported"** reserve means a reserve for claims or rights to benefits that have occurred but which are not yet known to the Company.

48) **"If Knew Differential Premium"** means the If Knew Premium less the Current Premium. It is the Differential Premium when the applicable premium is the If Knew Premium. Under the terms of the Plan differential premiums cannot be less than zero.

49) **"If Knew Premium"** means the premium that if charged from inception would have produced the greater of the initial target loss ratio or the minimum loss ratio applicable to the policy form. For the sake of simplicity, this will be assumed to be 60%. It is sometimes described as the premium the insurer would have charged from inception had it known then what it knows now.

50) **"Impaired Policy"** means an LTCI policy: (1) for which the Current Premium is less than the If Knew Premium, and/or (2) that is Non-self-sustaining.

51) **"Inflation Protection"** means riders purchased by policyholders or policy features that provide for defined increases in benefits at regular intervals in order to protect against the effects of inflation on the cost of care.

52) **"Initial Funded Restructured Policy Value"** or **"IFRPV"** means a policy value equal to the portion of the liabilities arising under the policy that SHIP can reasonably be expected to meet based on future premiums and Allocated Assets. For a policy that is not an Impaired Policy, the IFRPV will be equal to the full amount of those liabilities.

53) **"Initial Plan Effective Date"** is the Effective Date for all policyholders other than those to whom the Supplemental Plan Effective Date applies. It will not be the same specific day for all policyholders. For each policyholder, the Initial Plan Effective Date will be the policy's ***Monthiversary Date*** occurring during the ***Initial Plan Effective Month***. See definitions, pages 95 and 97. The Initial Plan Effective Month will be the same for all policyholders for whom the Effective Date is the Initial Plan Effective Date, that is, those who have not undergone certain specified changes in status during the Policyholder Transition Period as described in Section II.K.3.c, page 26.

54) **"Initial Plan Effective Month"** means the calendar month immediately following the Plan Preparation Period. The Initial Plan Effective Month will be the same for all policyholders for whom the Effective Date is the Initial Plan Effective Date, that is, those who have not undergone certain specified changes in status during the Policyholder Transition Period as described in Section II.K.3.c, page 26.

55) **"Instrumental Activities of Daily Living"** or **"IADL"** means such activities as meal preparation, shopping and travel, light housekeeping, laundry, telephoning, money handling, taking medications, and bill paying.

56) **"Insurance Regulatory Authority"** means with respect to any state or the District of Columbia, the jurisdiction's applicable insurance department or equivalent regulatory agency or authority.

57) **"Lifetime Waiver of Premium" or "LWP"** means a provision in a LTC insurance policy under which the premium payments are permanently suspended upon the death of a covered spouse after a qualifying period (typically five, seven, or ten years).

58) **"Limited Benefit Period"** means any Maximum Benefit Period that is subject to a stated limit by the terms of the policy. It refers to a policy that is not a lifetime or unlimited benefit

policy.

59) **"Liquidation Benefits"** means the benefits a policyholder would reasonably be expected to receive if SHIP were liquidated under the provisions of Article V, taking into account the Company's history, the orders of the Court, the risks and uncertainties of the liquidation process, and the effect of Guaranty Association coverage.

60) **"Long-term Care"** or **"LTC"** insurance means defined benefit accident and health insurance policies covering long-term care services, including confinement to nursing facilities and assisted living facilities, as well as home health care and adult day care.

61) **"LTCI"** means long-term care insurance.

62) **"Maximum Benefit Amount"** means the dollar maximum in benefits available under a LTC policy.

63) **"Maximum Benefit Period"** or **"MBP"** means the maximum time (typically stated as number of days, either lapsed time or days of provided service) during which benefits will be available under a LTC policy. Benefits are usually defined in the contract to be a maximum amount payable per day or per month, for a maximum number of years. However, in some policies if the claimant uses less than the maximum amount permissible in a given period, the unused excess typically serves to lengthen the Maximum Benefit Period under what is known as the "pool of money'' clause. Benefits commence after satisfaction of an Elimination Period (EP) and continue until the recovery or death of the claimant or until the pool of money has been exhausted. In these cases the Maximum Benefit Period is sometimes expressed as a dollar amount, the Maximum Benefit Amount. Under other policies (sometimes called "days of care" policies) reducing the daily benefit amount utilized does not extend the benefit period. For these policies the Maximum Benefit Period is expressed as the number of days, months or years during which coverage remains available under the policies. In either case, modifications by the policyholder under the Plan may have the effect of reducing the Maximum Benefit Period.

64) **"Maximum Daily Benefit"** or **"MDB"** also called Daily Benefit Amount (DBA), means a maximum daily dollar amount available on a covered day of care as specified in the policy.

65) **"Maximum Guaranty Association Benefits"** means the maximum amount of benefits to which a particular policyholder would be entitled from the applicable Guaranty Association (typically determined by state of residence at the time of liquidation) if the Company were to be liquidated.

66) **"Maximum Policy Value"** or **"MPV"** means the product of a policy's Maximum Benefit Period times its Maximum Daily Benefit.

67) **"Monthiversary Date"** means the day of the month upon which premium is due under a particular policy or would be due except for a Premium Waiver provision.

68) **"NAIC"** means the National Association of Insurance Commissioners.

69) **"Net Accumulated Premium"** means the total gross premiums paid under a policy from inception until the valuation date, less the Expected Losses for that policy.

70) **"Net Premium"** means the part of the Gross Premium that is intended to cover the cost of future claims, as opposed to future operating expenses and profit margin. The Net Premium is typically set at issue.

71) **"Non-core Policy Benefits"** means certain benefits provided by some SHIP LTC policies other than nursing home, facility, home health (which often includes hospice) or adult day care. They are enumerated in section II.G, page 21.

72) **"Non-forfeiture Option"** or **"NFO"** traditionally means an option to exchange an existing LTC policy for a reduced paid up contract on which no future premiums need be paid by the policyholder but under which benefits are limited to premiums previously paid less benefits previously received. NFO benefits are enhanced substantially under the Plan.

73) **"Non-Self-Sustaining Policy"** means a LTC policy the Projected Benefit Amount (PBA) of which exceeds its Projected Credit Amount (PCA). It is a policy for which Current Premium rates are inadequate given assets available to be allocated to it and its projected liability for benefits and expenses.

74) **"Non-Tax-Qualified"** or **"NTQ"** benefit triggers means LTC insurance policy provisions under which the conditions that must be satisfied to be eligible for benefits do not conform to the legal standards for Tax Qualified policies. Such provisions were formerly called "traditional" Long-term Care Insurance. They often include a benefit "trigger" called a "medical necessity" trigger under which the insurer is obligated to pay if the policyholder's own doctor, or that doctor in conjunction with someone from the insurance company, determines that the policyholder needs covered care for any medical reason. The United States Department of the Treasury has not fully clarified the tax status of premiums paid for and benefits received under a NTQ Long-term Care Insurance policy as precisely as the status of benefits received under a tax qualified policy. Therefore, the federal taxation of benefits under a NTQ policy is not certain. **The Rehabilitator makes no representation and does not offer any opinion regarding tax matters.**

75) **"Partnership-Qualified"** (PQ), means LTC policies that are intended to satisfy the requirements under the Deficit Reduction Act of 2006 entitling the policyholder to a dollar

of asset disregard or spend-down credit with respect to Medicaid eligibility for every dollar of benefit received under the LTC policy.

76) **"On claim"** refers to a policyholder who is receiving, or has been approved to receive, policy benefits or a policy under which benefits are being provided by the Company.

77) **"Paid-Up Policy"** means an in-force policy that is paid in full and no longer requires premium payments under its terms.

78) **"Phase One Differential Premium"** means the Phase One Premium less the Current Premium. It is the Differential Premium when the applicable premium is the Phase One Premium. Under the terms of the Plan, the Phase One Differential Premium cannot be less than zero.

79) **"Phase One Premium"** means the premium calculated for a specified policy (or group of policies) on the If Knew basis, but not less than the Current Premium.

80) **"Phase Two Policyholder Election Package"** means the Policyholder Election Package sent to certain policyholders to inform them of options available in Phase Two of the Plan and to enable them to elect from among those options.

81) **"PID"** means the Pennsylvania Insurance Department.

82) **"Plan"** means this Rehabilitation Plan.

83) **"Plan Document"** means this document describing the Plan.

84) **"Plan Limits"** means the minimum and maximum modifications permitted by the Plan for Option One in Phase One a policy's Maximum Benefit Period (MBP) and Maximum Daily Benefit (MDB). A policy's MBP cannot be reduced by the Plan below the lower of (a) the current MBP or (b) four years, and cannot be increased by the Plan above the greater of (a) the current MBP or (b) six years. A policy's MDB cannot be reduced by the Plan below the lower of (a) the current MDB or (b) $300, and cannot be increased by the Plan above the greater of (a) the current MDB or (b) $600. As a practical matter, the minimum MPV under the Plan is $438,000 except for policies the current MPV of which is below that or the applicable GA limits for which are above that. The maximum MPV is $1,314,000 except for policies the current MPV of which, or the applicable GA limits for which, are above that.

85) **"Plan Operation Fund"** means an allocation of the Company's assets reserved for funding policyholder liabilities as part of the rehabilitation in an amount determined by the Rehabilitator in consultation with her advisors.

86) **"Plan Option"** means any of the options available to policyholders under the Plan, which are described on page 12.

87) **"Plan Premium"** means the premium that a policyholder must pay under the terms of the Plan. Depending on the policyholder's circumstances, it could be the Phase One Premium, If Knew Premium, Self-Sustaining Premium, Phase One Differential Premium, If Knew Differential Premium, or Self-sustaining Differential Premium.

88) **"Plan Preparation Period"** means the time between the Final Approval Date and the Effective Date of the Plan, during which preparatory steps necessary to implement the Plan will be completed. It includes the period during which policyholders will make elections under the Plan.

89) **"Policies Not On claim"** or **"Policyholders Not On claim"**, also called Active Policies or Policyholders, means policies or policyholders that have not been terminated due to non-payment of premiums, cancellation, or exhaustion of benefits and also are not listed in the Company's records as having been approved for benefit payments or in the process of being approved for benefit payments as of the Determination Date.

90) **"Policy Modifications"** means Premium Rate Increases or Benefit reductions selected by a policyholder, or made applicable, in accordance with the terms of the Plan.

91) **"Policyholder Election"** means the election by a policyholder to modify the premiums or benefits of a policy under the Plan.

92) **"Policyholder Election Date"** means the date by which the Rehabilitator must receive properly completed Policyholder Election Forms in order to give them effect.

93) **"Policyholder Election Form"** means the form on which a policyholder specifies whether, and if so how, he or she elects to modify his or her LTC policy in accordance with the terms of of the Plan.

94) **"Policyholder Election Package"** means the materials, including the Policyholder Election Form, to be sent to policyholders by the Rehabilitator so that they may make the elections available under the Plan.

95) **"Policyholders"** means holders of insurance policies and certificate holders under group insurance policies.

96) **"Policyholder Transition Period"** means the period between the Policyholder Election Date and the Initial Plan Effective Date during which policyholders may experience changes

in circumstances (such as going on claim) as the result of which they may have to make new elections under the Plan.

97) **"Possible Active Benefit Reductions"** means the list of possible benefit reductions applicable to premium paying active policyholders who select a Downgrade option as described fully beginning on page 32.

98) **"Possible On Claim Benefit Reductions"** means the list of possible benefit reductions applicable to policyholders on claim who select a Downgrade option as described fully beginning on page 41.

99) **"Premium Waiver"** means a policy provision that allows a policyholder to discontinue paying premiums and maintain the policy in force during a period of covered care or under circumstances specified in the policy.

100) **"Projected Benefit Amount"** or **"PBA"** means the present value as of the valuation date of unpaid expected benefits and unpaid expected policy expenses. For purposes of this determination "expected" consists of best estimate assumptions including a provision for moderately adverse deviation.

101) **" Projected Credit Amount"** or **"PCA"** means, for a LTC insurance policy, the sum of (a) the present value as of the valuation date of expected premiums, adjusted for future premium increases reasonably expected to be put into effect and (b) the assets allocated to that policy using the Accumulated Premium Method. For purposes of this determination "expected" consists of best estimate assumptions including a provision for moderately adverse deviation.

102) **"Reduced Paid-up Policy"** or **"RPU"** means a policy offering reduced long-term care benefits but for which no more premium has to be paid and which will not lapse before the death of the policyholder. The Non-forfeiture Option offered under the Plan is a RPU.

103) **"Rehabilitation Plan"** means this Plan for the rehabilitation of SHIP's Long-term Care insurance business.

104) **"Rehabilitator"** means Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, and her successors in office, in the capacity of Statutory Rehabilitator of the Company. Pursuant to her statutory authority to do so, the Rehabilitator has delegated broad responsibility to the Special Deputy Rehabilitator and in the Plan documents references to the Rehabilitator should be interpreted as including the SDR unless specified otherwise.

105) **"Restoration of Benefits"** means a LTC insurance policy feature under which the benefit period for a policyholder who has received benefits will be restored to the original Maximum

Benefit Period after receiving some or all claim benefits if the policyholder does not need or receive care during a specified period of time (such as 180 days).

106) **"Restructured Policy"** means a policy that has been restructured as described in Section VI.H, page 77, to reduce the liabilities arising under the policy to its IFRPV.

107) **"Return of Premium"** means a LTC insurance policy feature which provides for the return of a percentage of premium paid by the policyholder (such as 80%) if the policyholder does not make a claim (or has a limited expected amount of benefits paid) during a given period of time in which the policy was in force (such as ten years).

108) **"Self-sustaining"** means a policy for which its Projected Credit Amount (PCA) equals or exceeds its Projected Benefit Amount (PBA). It is a policy for which Current Premium rates are adequate given assets available to be allocated to it and its projected liability for benefits and claims expenses.

109) **"Self-sustaining Differential Premium"** means the Self-sustaining Premium less the Current Premium. It is the Differential Premium when the applicable premium is the Self-sustaining Premium. Under the terms of the Plan, differential premiums cannot be less than zero.

110) **"Self-sustaining Premium"** means the premium calculated by determining the amount of premium required to eliminate a policy's Shortfall Amount.

111) **"Senior Health Care Oversight Trust"** means the Pennsylvania business trust governed by an independent Board of Trustees comprised of former insurance regulators and an independent actuary, who also served as members of the board of directors of SHIP, created in 2008 to be the sole owner of SHIP.

112) **"SHIP"** means the Senior Health Insurance Company of Pennsylvania, the subject of this Rehabilitation Plan.

113) **"Shortfall Amount"** for a LTC policy means the difference between its Projected Benefit Amount and its Projected Credit Amount where the difference is more than zero. The Shortfall Amount can also be expressed as a policy's GPR less its Allocated Assets. If the difference is zero or less there is no shortfall and the policy is Self-sustaining.

114) **"Shortfall Percentage"** means for an LTC policy a fraction (expressed as a percentage) the numerator of which is the policy's Shortfall Amount and the denominator of which is the policy's Projected Benefit Amount. For a Self-sustaining Policy the Shortfall Percentage will be zero or less.

115) **"Special Deputy Rehabilitator"** or **"SDR"** means Patrick H. Cantilo or his successors, appointed by the Rehabilitator to serve as the Special Deputy Rehabilitator for SHIP.

116) **"Standard Rate Increases"** means those premium rate increases sought or obtained by the Company for groups of policies in the ordinary course of its business and unrelated to the Plan.

117) **"Statutory Reserve"** means the insurance reserve required by Pennsylvania insurance laws to be included in an insurer's financial statement on account of its insurance business in force.

118) **"Supplemental Plan Effective Date"** is the Effective Date for policyholders who undergo certain changes in status during the Policyholder Transition Period as described in Section II.K.3.c, page 26. It will occur on the policy's Monthiversary Date during the month specified by the Rehabilitator following the Policyholder Transition Period.

119) **"Tax Qualified"** or **"TQ"** benefit triggers means the conditions that must be satisfied to be eligible for benefits under a LTC insurance policy that is designed to conform to certain standards in federal law and may offer certain federal tax advantages. TQ policies were created as a result of HIPAA, which included provisions for favorable tax treatment of qualified Long Term Care Insurance contracts. To comply with those standards, TQ policies are required to cover services for a chronically ill individual, and do not have a "medical necessity" benefit trigger. A TQ benefit trigger requires that a person 1) be expected to require care for at least 90 days, and be unable to perform 2 or more Activities of Daily Living (eating, dressing, bathing, transferring, toileting, and continence) without substantial assistance (hands on or standby); or 2) for at least 90 days, need substantial assistance due to a severe cognitive impairment. In either case a licensed healthcare professional must certify a plan of care. Premiums paid for a TQ policy may be deductible from taxable income, and benefits from a TQ policy may not be subject to federal income tax. **The Rehabilitator makes no representation and does not offer any opinion regarding tax matters.**

120) **"Total Allocable Assets"** means the Company's invested assets less reserves for costs of administration, contingencies, and certain debts of higher priority.

121) **"TQ Triggers"** means the requirements that must be met under a Tax Qualified LTC policy in order to receive benefits.

122) **"Trust"** means the Senior Health Care Oversight Trust, as defined above.

123) **"Uncovered Benefits"** means the portion of the LTC policy benefits to which policyholders are contractually entitled on the Effective Date that exceed Guaranty Association statutory

limits or otherwise are not covered by Guaranty Associations as determined by the responsible Guaranty Association in accordance with applicable law.

124) **"Waiver of Premium"** see Claim Waiver of Premium, Dual Waiver of Premium, and Lifetime Waiver of Premium.

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1 SHP 2020

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

ORDER APPROVING THE PLAN OF REHABILITATION FOR SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

AND NOW, this ____ day of _____, 2020 upon consideration of the Application of Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as statutory Rehabilitator of Senior Health Insurance Company of Pennsylvania ("SHIP") for approval of the Plan of Rehabilitation for SHIP, and any objections filed thereto, and after hearing, it is hereby ORDERED as follows:

1. This Court has original jurisdiction over proceedings to rehabilitate SHIP and over SHIP's insurance business pursuant to Article V of the Insurance Department Act of 1921, 40 P.S. §§ 221.1-221.63. Under 40 P.S. § 221.16(d), this Court has the power to approve or disapprove a plan of rehabilitation or modify such plan and approve it as modified.

2. SHIP was placed into rehabilitation by Order of this Court dated January 29, 2020.

3. The Rehabilitator filed a Plan of Rehabilitation for SHIP (the "Plan") on April 22, 2020.

4. By Order dated _____, 2020 (the "Notice Order"), this Court directed the Rehabilitator to provide notice of the filing of the Plan in the form approved thereby (the "Plan Notice") to the persons and by the means set forth in the Notice Order.

5. The Notice Order required, among other things, that objections to the Plan to be filed no later than _____, 2020 and fixed _____, 2020 as the date for the commencement of a hearing on the Plan.

6. At the hearing on the Plan, all persons having interests affected by the Plan and who complied with the Notice Order were afforded an opportunity to be heard regarding support for or objections to the Plan.

7. The Court therefore finds that it has jurisdiction over the persons and entities identified in the Notice Order or who otherwise intervened, submitted comments, or participated in the hearing on the Plan.

8. Having heard the Rehabilitator's evidence in support of the Plan, having heard argument on the Plan, and having considered the support for and objections

to the Plan, this Court hereby approves the terms, conditions, and provisions of the Plan and the attachments thereto and finds the Plan to be fair and equitable and free of any abuse of the Rehabilitator's discretion. The Rehabilitator is authorized to implement the Plan and carry out any transactions contemplated by the Plan without further order of this Court.

9. All objections to the Plan are overruled.

10. All other orders, injunctions, and stays issued by this Court in this matter shall continue in full force and effect except as modified hereby.

BY THE COURT:

_____
MARY HANNAH LEAVITT
President Judge

Received 4/22/2020 8:37:52 PM Commonwealth Court of Pennsylvania

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1 SHP 2020

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

CERTIFICATE OF SERVICE

I, Michael J. Broadbent, hereby certify that a Notice of Filing of the foregoing Application is being served on all parties listed on the Master Service List, if any, by electronic mail or facsimile, or by First Class Mail where no electronic mail address or facsimile number was available, and that an electronic copy of the foregoing Application has been posted on SHIP's website at https://www.shipltc.com/court-documents.

/s/ Michael J. Broadbent
Michael J. Broadbent

Dated: April 22, 2020

EXHIBIT 4

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

RE: Application for Approval of the Plan of Rehabilitation for Senior Health Insurance Company of Pennsylvania

BEFORE: HONORABLE MARY HANNAH LEAVITT, Judge

OPINION NOT REPORTED FILED: August 24, 2021

MEMORANDUM OPINION AND ORDER

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I. Introduction

Before the Court is the application of Jessica K. Altman, Pennsylvania Insurance Commissioner, which she filed in her capacity as Statutory Rehabilitator of Senior Health Insurance Company of Pennsylvania (SHIP). By this application, the Rehabilitator seeks approval of her Second Amended Plan of Rehabilitation (Second Amended Plan or Plan) for SHIP pursuant to Section 516(d) of Article V of The Insurance Department Act of 1921 (Article V), Act of May 17, 1921, P.L. 789, *added by* the Act of December 14, 1977, P.L. 280, 40 P.S. §221.16(d). The Rehabilitator has the statutory responsibility to develop a plan to correct the conditions that caused SHIP's hazardous financial condition. Giving deference to the Rehabilitator's discretion in formulating this Plan, this Court must decide whether to approve the Plan, approve the Plan with modifications, or disapprove the Plan.

At present, SHIP has approximately $1.4 billion in assets and $2.6 billion in liabilities, producing a deficit of approximately $1.2 billion (also referred to as the Funding Gap). The Second Amended Plan's ultimate goal is to eliminate the Funding Gap by increasing premium revenue and modifying the existing terms of most of the approximately 39,000 policies in force. The Plan is structured to maximize policyholder choice in several ways. Depending on his circumstances and preferences, a policyholder may choose to continue his policy with all benefits and terms unchanged by paying the actuarially justified annual premium for that policy. Alternatively, the policyholder may choose to reduce some policy coverages as more suitable to the policyholder's current circumstances in order to avoid or temper a premium increase. A policyholder who is 95, for example, may decide to reduce the

maximum coverage period from 10 to 5 years in lieu of paying the premium required for a policy with a 10-year period of coverage.

The Second Amended Plan also seeks to correct SHIP's discriminatory premium rate structure. At present, SHIP policyholders pay substantially different premiums for the same coverages. The difference in premiums is attributed to the decisions of different state regulators on SHIP's proposed rate increases. The state where the policy is issued retains authority for all rate increases, even after the policyholder moves to another state. Policyholders whose state of issue has approved the requested rate increase pay more for the same coverages than policyholders whose state of issue has disapproved the requested rate increase. As a result, the former group of policyholders pays more than its fair share of the costs of providing the coverages and the latter group pays less than its fair share. The Second Amended Plan seeks to eliminate these inequities.

The Court conducted a hearing on the Second Amended Plan from May 17, 2021, through May 21, 2021. The parties submitted post-hearing briefs on June 21, 2021, and June 28, 2021. On July 21, 2021, the Rehabilitator and Intervening Agents and Brokers filed an application for the Court's approval of a settlement agreement, which will amend Part VI.N of the Plan. The Rehabilitator's application for approval of the Second Amended Plan is ready for disposition, with the exception of Part VI.N, on which a decision will be deferred for 30 days to allow a hearing on the Rehabilitator's settlement agreement with the Intervening Agents and Brokers.

II. Findings of Fact

A. Business and History of SHIP

SHIP is a Pennsylvania life and health insurance company. Its origins date to 1887, when its corporate predecessor, the Home Beneficial Society,

commenced business. By the 1980s, the company was known as American Travelers Insurance Company and was primarily writing long-term care insurance. In 1996, the company was acquired by, and merged into, CIHC, Inc., a wholly-owned subsidiary of 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 waiver[3] or have previously taken a non-forfeiture option, which allows the policyholder to discontinue paying premiums in exchange for a period of coverage equal to the premiums previously paid to the company less any benefits previously received. Approximately 13% of SHIP's long-term care policyholders are on claim, and the Rehabilitator expects that number to rise to 32% of all policyholders by 2050. Ex. RP-56 at 21. The Rehabilitator also expects the volume of SHIP's claims to continue outpacing its premium collections. Specifically, in the absence of the Rehabilitator's plan, SHIP will pay another $3 billion in claims but collect only $230 million in premiums. *Id*. at 20.

B. SHIP's Financial Condition

SHIP has approximately $1.4 billion in assets and $2.6 billion in liabilities, *i.e.,* a Funding Gap of $1.2 billion. Ex. RP-31 at 1-2. The major causes

[3] Approximately 99% of SHIP's long-term care policies provide that a policyholder who receives benefits under his policy for a specified period of time (such as 90 days) is no longer required to pay premiums for coverage after that time period as long as the policyholder remains eligible for benefits or receives a specified level of care. "Once the policyholder's eligibility for benefits ends, the policyholder is required to resume paying premiums." Ex. RP-55 at 86 (Second Amended Plan).

of SHIP's insolvency were the use of erroneous actuarial assumptions to develop initial premium rates, poor investment returns, high operating costs, and the inability to obtain the approval of actuarially justified rate increases from state insurance regulators. Two significant adverse events exacerbated SHIP's financial situation. In 2018, following the appointment of a Special Deputy Rehabilitator and a revision of SHIP's key actuarial assumptions, SHIP recorded a $374 million premium deficiency reserve; a $44 million increase in claim reserves; and a $176 million investment loss from the so-called Beechwood investment program. These accounting entries increased SHIP's 2018 deficit by $500 million. *See* Ex. RP-56 at 23. In 2019, revised actuarial assumptions required an increase in reserves, thereby adding another $400 million to SHIP's deficit. *Id*. SHIP's annual premium revenue as of December 31, 2020, is $58 million. *Id*. at 14.

C. Rehabilitation Plan

Given SHIP's negative capital and surplus, the Insurance Department applied to this Court for an order placing SHIP in rehabilitation, with the consent of the Senior Health Care Oversight Trust and SHIP's directors. On January 29, 2020, the Court granted the application and appointed the Pennsylvania Insurance Commissioner to serve as Rehabilitator of SHIP; to take steps to address SHIP's financial challenges; and to protect its policyholders and other creditors.

The Rehabilitator engaged a Special Deputy Rehabilitator, Patrick Cantilo, and actuarial consultants, including Oliver Wyman, to study SHIP's financial condition and to manage the company while they developed corrective measures. On April 22, 2020, the Rehabilitator filed a plan for the rehabilitation of SHIP. The Court issued a case management order which, *inter alia*, solicited formal

and informal comments from any interested person. Several intervened to offer comments on the rehabilitation plan and participate in any proceedings, including:[4]

1) The Maine Superintendent of Insurance, the Massachusetts Commissioner of Insurance, and the Washington Insurance Commissioner (Intervening Regulators);

2) The National Organization of Life and Health Guaranty Associations (NOLHGA);

3) ACSIA Long Term Care, Inc.; Global Commission Funding LLC; LifeCare Health Insurance Plans, Inc.; Senior Commission Funding LLC; Senior Health Care Insurance Services, Ltd., LLP; and United Insurance Group Agency, Inc. (Intervening Agents and Brokers);

4) Anthem, Inc.; Health Care Service Corporation; Horizon Health Care Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey; and UnitedHealthcare Insurance Company (Intervening Health Insurers); and

5) James Lapinski, a policyholder and agent, and Georgianna Parisi, a policyholder.

After reviewing the formal and informal comments, the Rehabilitator filed an amended rehabilitation plan on October 21, 2020. Following a second comment period and a pre-hearing conference, the Rehabilitator filed the Second Amended Plan on May 3, 2021.

The Second Amended Plan is designed to be implemented in three phases. Phase One, beginning immediately upon Court approval, is the principal phase and seeks to reduce substantially or eliminate the Funding Gap. This phase identifies the SHIP policies that require modification because their current premium

[4] The original intervening persons also included Transamerica Life Insurance Company and Primerica Life Insurance Company, both of which issued policies reinsured and administered by SHIP. These parties are no longer actively participating in the proceeding.

falls below the "If Knew Premium" for the benefits provided by the policies. Ex. RP-55 at 10. The If Knew Premium rate is the rate that, if charged from inception, would have produced an underwriting loss ratio of 60% for each policy form. *Id*. at 27. If Knew Premium rates are intended to price policies adequately on a lifetime basis, but not to recoup losses due to inadequate pricing in the past. Further, the policyholder's age and current medical condition are not taken into account when setting the If Knew Premium rate. The If Knew Premium is an accepted methodology for setting premiums for long-term care insurance policies.

Policyholders whose current premium (including the premium they would be paying but for a premium waiver) falls below the If Knew Premium for the policy's benefits will be required to elect one of four options:

> Option 1: continue paying the current premium or maintain the premium waiver if one is in effect, but if the current or waived premium is less than the If Knew Premium, have the policy benefits reduced in accordance with Plan provisions so that the premium for the reduced benefits (including waived premium) is equal on an If Knew Premium basis to the current premium. The benefit reductions will be selected automatically by the Plan.
>
> Option 2: select certain policy endorsements that provide essential benefits (sometimes greater than the benefits provided by Option 1) for an actuarially justified premium. The maximum benefit period is capped at four years, the maximum daily benefit is capped at $300 and inflation protection is capped at 1.5%.
>
> Option 2A: an enhanced alternative with a five-year benefit period and 2% inflation rider. Options 2 and 2A will not be subject to further rate increases or benefit reductions in Phase Two of the Plan. Options 2 and 2A are designed to provide reasonable coverage at reasonable premium rates.
>
> Option 3: Non-forfeiture Option (NFO) through which the policyholder will receive a Reduced Paid-up (RPU) policy providing limited benefits but for which no future premiums will

> be charged. Under the Plan, this option will include more generous benefits than the typical industry non-forfeiture option or reduced paid-up policy, most notably in that it will offer as much as a 30-month benefit period unless the current policy has a shorter benefit period. Moreover, policyholders who select this option will never have to pay additional premiums and this policy will never lapse.
>
> Option 4: retain the current policy benefits and pay the corresponding If Knew Premium (unless equal to or lower than the policyholder's current premium). For many policyholders this may require a substantial increase in premium.

See Ex. RP-55 at 11-12. Policyholders who presently pay a premium at or above the If Knew Premium may elect Option 2 or Option 3 if preferable, given their present circumstances. Otherwise, these policyholders will not have their policies modified in any respect.

Before making an election, each policyholder will receive information detailing the premiums and benefits associated with each option. Special elections will apply to policyholders who are not currently paying premium due to a premium waiver provision in their or their spouses' policies. Most of these policyholders have a current premium (what they would be paying but for the waiver) that is lower than the If Knew Premium. These policyholders will be required to pay a differential premium, which represents the difference between (1) the premium they would be paying but for the premium waiver in effect (the current premium), and (2) the If Knew Premium appropriate for their policy coverages. Ex. RP-55 at 12. Should the premium waiver terminate, these policyholders will then be required to pay the full applicable If Knew Premium. Similar options will be offered to policyholders on claim.

For every policyholder there will be a default option that applies automatically if no election is made. For the policyholder whose current premium falls at or above the If Knew Premium, the default option leaves the policy unchanged. For the policyholder whose current premium falls below the If Knew Premium, the default option will be identified in the election materials. For policyholders on premium waiver, the default option will be Option 1 (the benefit downgrade). Where the nonforfeiture option would provide these policyholders better benefits than the downgrade, Option 3 will be the default option. For policyholders paying premium, Option 2 (basic policy endorsements) will be the default option.

In Phase Two of the Second Amended Plan, the results of Phase One will be evaluated to determine whether additional policy modifications may be necessary for certain policies that are still underpriced. It is expected that modifications in Phase Two will largely be based on achieving a self-sustaining premium for every policy. The goal of Phase Two will be to eliminate any Funding Gap not eliminated in Phase One. In Phase Three, the Rehabilitator will complete the run-off of SHIP's long-term care insurance business remaining in force.

The Second Amended Plan corrects the condition that caused SHIP's insolvency: the underpricing of policies. The Plan will address the Funding Gap by increasing premiums or modifying policy coverages. The Rehabilitator has concluded that a modification of coverages will do more to reduce the Funding Gap than premium increases. Further, many policyholders are paying for more coverage than they are likely to use.

The Rehabilitator designed the Plan around the core principle of policyholder choice. All policyholders will have at least one option for preserving

their current coverage (by paying an increased premium) and at least one option for preserving their current premium (by reducing policy benefits). The Plan's premium rate structure takes rate increase history and product differences into account, and it will develop premium rate increases based solely on the characteristics of each policy and not on the policyholder's state of residence or the state where the policy was issued.

The payment of commissions owed to agents under agreements made prior to the inception of rehabilitation proceedings will be suspended under the Second Amended Plan until policyholders' claims have been paid in full and adequate provision made for reasonably anticipated future claims. Accrual of commissions will also be suspended as of the effective date of the Plan, *i.e.,* the date the policyholder elections become effective. Claims for commissions owed to agents and brokers will be subordinated to policyholder claims. The Plan's treatment of agent and broker commissions reflects the Rehabilitator's belief that most policyholders do not maintain a close relationship with their agent after purchasing their policy. They typically contact SHIP or another trusted professional when they have questions about their policy.

D. Hearing on Second Amended Plan

At the hearing on the Second Amended Plan, the Rehabilitator offered testimony from the following witnesses: Special Deputy Rehabilitator Patrick Cantilo, who was admitted as an expert in insurer insolvency matters, specifically as to long-term care insurers; Marc Lambright, an actuarial consultant to the Rehabilitator, who testified as a fact witness; and Vincent Bodnar, an actuarial consultant to the Rehabilitator, who was admitted as an actuarial expert and as an expert on long-term care insurance, including product development and sales

practices, the rate setting and approval process for insurers, and the liquidation of financially troubled insurers.

i. Rehabilitator's Evidence

a. Patrick Cantilo

Special Deputy Rehabilitator Patrick Cantilo provided the history of the business of SHIP, summarized above, and his involvement in the rehabilitation since 2018.

He first discussed the effects of the COVID-19 pandemic on SHIP's business and financial condition. Cantilo testified that since the beginning of the pandemic in 2020, SHIP has experienced a moderate increase in mortality, *i.e.*, more of its insureds died than would normally be expected, which generated a moderate increase in policy lapses. There was a small increase in morbidity, *i.e.*, the expected incidence of disease. The pandemic adversely affected SHIP's expected yield on invested assets. Cantilo opined that the aggregate effects of the pandemic had a relatively moderate impact on SHIP's financial condition and are not material to the Second Amended Plan.

Cantilo focused his testimony on the approximately 39,000 long-term care policies of SHIP. Approximately 53% of SHIP's current policyholders are paying premium, generating $58 million in revenue as of year-end 2020. The remaining 47% of policyholders are on claim, have previously selected a non-forfeiture option or are on premium waiver. *See* Ex. RP-56 at 14. Many policyholders have been paying less premium than is necessary to fund their coverages, and this premium deficiency has existed for years. SHIP policies that create the greatest liability have a 5% compounded inflation rider; unlimited lifetime benefits; and are non-tax qualified, meaning that they have lower benefit triggers

and shorter elimination periods. The effect of the inflation rider has been to increase the maximum daily benefit up to $650, without regard to actual inflation levels or the actual cost of the policyholder's care. Cantilo testified that the inflation rider is a "big contributor" to SHIP's overall deficit. Notes of Testimony (N.T.), 5/17/2021, at 34.

Cantilo testified that the majority of policyholders pay an annual premium of less than $2,500 per year. N.T., 5/17/2021, at 37-38. *See* Ex. RP-56 at 14. The group is 71% female, and the majority are in their 80s and 90s. Approximately 70% of the policies in force provide comprehensive coverage for both home health care and facility care in either an assisted living facility or nursing home. Inflation protection is a feature of 47% of these policies. The majority of policies, 54%, provide between one and four years of benefits; and 27% provide lifetime benefits. Ex. RP-56 at 17.

Cantilo opined that SHIP's claims, when compared to premiums, do not present "a good picture." N.T., 5/17/2021, at 41. The number of policies in force has declined since SHIP began operating in 2009, and at present, the cost of claims outpace the premium revenue. Of the total premium revenue that SHIP is expected to collect prior to the expiration of the policies in force, approximately $7.4 billion, it has already collected $7.1 billion. Stated otherwise, SHIP expects to collect only about $300 million in additional premium. On the other hand, SHIP's expected claims during that same period total approximately $11 billion; it has paid only $7.7 billion so far. In short, SHIP can expect to pay another $3 billion in claims but to collect only $300 million in premium, unless its business is restructured in a rehabilitation.

Cantilo testified that SHIP is not atypical in the industry. Long-term care insurers collect more premium than needed in the early years of writing policies. They invest the excess, put it aside, and then tap into those invested assets to pay claims. When a company stops writing new business, as SHIP did 18 years ago, the premium curve begins to flatten and the claim curve begins to rise. Cantilo testified that the assets set aside for the purpose of paying claims did not earn the expected income that was needed to meet liabilities.

Cantilo discussed the reasons for SHIP's insolvency, beginning with the erroneous actuarial assumptions made when the policies were first issued. SHIP underestimated the number of people who would become ill and qualify for benefits. At the same time, SHIP overestimated how quickly people would recover and stop needing care, referred to in the industry as morbidity improvement. SHIP overstated mortality by assuming more people would die before submitting claims than actually did. Relatedly, SHIP overestimated the number of policies that would lapse by reason of death or non-payment of premium. Cantilo estimated that through 2040, when most of the block of business will have terminated, the aggregate effect of the erroneous actuarial assumptions approximately equals the total deficit of $1.2 billion. *See* Ex. RP-56 at 29.

Another factor in SHIP's insolvency is its investment history. SHIP experienced lower market yields than it anticipated while it was selling and pricing its long-term care policies. To counter the effects of economic conditions, in 2009, SHIP invested in two programs, the Beechwood program and Roebling Re. Instead, these programs produced investment losses between $150 million and $300 million (as reported in 2018).

Cantilo testified that a significant cause of SHIP's insolvency is its discriminatory premium rate structure. As SHIP management realized its premium rates were inadequate, it began seeking premium rate increases from state regulators across the country from 2009 to 2021. SHIP received wildly different rate approvals. *See* Ex. RP-56 at 45. Cantilo testified that from 2009 to 2019, SHIP lost $312 million in cumulative premium due to rejected rate increase filings, or $371 million using an assumed 3.5% interest rate of return on investments. N.T., 5/17/2021, at 63-64; Ex. RP-56 at 50-51. The different responses of state regulators to SHIP's requested rate increases have created a discriminatory rate structure, which has been the focus of criticism in the regulatory community. Policyholders whose state of issue has approved rate increases are effectively subsidizing policyholders whose state of issue has not approved rate increases. Similarly situated policyholders are paying vastly different premiums for the same coverage. Cantilo opined that this has created an unfortunate side effect: states inclined to approve actuarially justified rate requests become hesitant to do so because of the failure of other states to act in kind.

The Rehabilitator's team had to decide whether to pursue a rehabilitation or liquidation of SHIP. Cantilo testified that the team chose rehabilitation because SHIP is financially able to provide a reasonable package of coverages to the remaining 39,000 policyholders. The Rehabilitator also considered that, in a liquidation, guaranty association coverage will be triggered, resulting in taxpayers contributing hundreds of millions of dollars to pay claims of policyholders who have not paid an appropriate premium. Rather than shifting the burden of the inadequate premium to taxpayers, the team concluded that the better course was to right-size the existing policies to an actuarially justified premium. Acknowledging that no rehabilitation plan will magically restore SHIP to solvency, Cantilo testified

the Second Amended Plan will, at a minimum, substantially reduce the Funding Gap and correct SHIP's inequitable premium rate structure. He explained that the Plan must be implemented quickly because of the advanced age of the policyholders.

In preparing the Second Amended Plan, the Rehabilitator relied on the combined expertise of Cantilo; Vincent Bodnar and other actuarial analysts at Oliver Wyman; Robert Robinson, who was appointed Chief Rehabilitation Officer of SHIP and who served as Chief Rehabilitation Officer and Chief Liquidation Officer for Penn Treaty;[5] Pennsylvania Insurance Department legal counsel and staff; and SHIP technical staff. The Rehabilitator also sought and considered the input of state insurance regulators, staff of the National Association of Insurance Commissioners, policyholders and other formal and informal commenters. The Rehabilitator's team prepared extensive analyses of SHIP's finances, its policyholders, the long-term care insurance market, and other matters relevant to SHIP's condition and prospects for rehabilitation. Key data and information have been made available to interested persons through a data site, which included actuarial files relating to assumptions and analyses, a seriatim actuarial file for every policy at issue, and tailored reports related to the Second Amended Plan.

Cantilo explained how the Second Amended Plan will operate. He described it as "completely scaleable," meaning that the elements of the Plan can respond to changes in the amount of the Funding Gap as SHIP moves through Phase

[5] Penn Treaty Network America Insurance Company, a Pennsylvania insurer, and its subsidiary, American Network Insurance Company (collectively, Penn Treaty), provided long-term care insurance to over 126,000 policyholders in all 50 states and the District of Columbia. Penn Treaty became insolvent for many of the same reasons that SHIP is insolvent, *i.e.*, benefit-rich policies were underpriced at inception and the company's active live reserves became understated. Penn Treaty was placed into rehabilitation by the Pennsylvania Insurance Commissioner on January 6, 2009. Rehabilitation ultimately proved unsuccessful, and on March 1, 2017, this Court ordered the liquidation of Penn Treaty.

One and into Phase Two and Phase Three. N.T., 5/17/2021, at 97. In Phase One, the policyholder's options are based on the If Knew Premium, and in Phase Two the options will be developed to establish a self-sustaining premium structure.[6] Cantilo testified that it was important to give each policyholder at least two options: (i) retain his current coverages by paying the actuarially justified premium (Option 4) or (ii) retain his current premium by adjusting coverages to match that premium (Option 1). Between those two options there is a non-forfeiture option (Option 3) that is more generous than a non-forfeiture option in liquidation and basic policy options (Options 2 and 2A), which provide a reasonable package of long-term care coverage at an affordable price.

Cantilo testified that the If Knew Premium was selected as the target premium in Phase One because it is generally accepted by regulators across the country; it was the methodology used by guaranty associations to increase premium rates for policyholders in the Penn Treaty liquidation; it is an easy rate methodology to explain to policyholders; and it achieves the goal of putting policyholders on a level playing field when it is calculated on a seriatim basis.

Cantilo explained in detail each Phase One option in the Second Amended Plan. Option 1 is the downgrade option. It allows the policyholder to keep his current premium but reduces benefits until the premium is adequate, on an If Knew basis. The policyholder will not choose which benefits to downgrade, which was discovered to be too complicated in the Penn Treaty liquidation. The methodology for reducing benefits under Option 1 will proceed in the following sequence: elimination of benefit restoration provisions; elimination of benefit

[6] The scope of Phase Two can only be determined after the completion of Phase One and an assessment of the remaining Funding Gap. Cantilo anticipates that the Rehabilitator will return to the Court at that point in the rehabilitation process.

extension provisions; adoption of tax-qualified benefit triggers; discontinuation of return of premium provisions; removal of inflation protection and locking of maximum daily benefit at current levels; conversion from indemnity to reimbursement of actual expenses up to the maximum daily benefit amount; reduction in the maximum daily benefit; extension of any elimination period to 90 days and applying it to each period of care; reduction in the policy's maximum benefit period; elimination of all premium waiver provisions; and conversion of the policy to a pool of money with a reduction of the maximum benefit period to the amount required to match the current premium. Ex. RP-55 at 45-46; Ex. RP-56 at 69. If the first revision is sufficient to match the policy's coverages to the existing premium, no further coverage modifications will be made.

Under Option 2, the policyholder selects basic policy coverages and a corresponding If Knew Premium. After extensive policyholder outreach, the Rehabilitator selected the key components of long-term care that most policyholders desire if they cannot afford the most expensive package of coverages. These include a maximum benefit period equal to the lesser of the current benefit period or four years; a maximum daily benefit equal to the lesser of 80% of the current daily benefit or $300 for nursing facility care;[7] and an annual inflation adjustment capped at 1.5%. Option 2A, which is an enhanced version of Option 2, provides a maximum benefit period of five years and an annual inflation adjustment of 2% for a higher premium. Policyholders who elect Option 2 or 2A will not be expected to participate in Phase Two of the Second Amended Plan.

Option 3 is the non-forfeiture option, which offers the policyholder a maximum benefit period of 2.5 years and a maximum daily benefit equal to the lesser

[7] The maximum daily benefit for facility care other than nursing home care is $225. The maximum daily benefit for home health care is $150.

of 80% of the current daily benefit or $300 for nursing facility care.[8] Cantilo contrasted Option 3 with the standard non-forfeiture option in the industry, which offers the policyholder the equivalent of accumulated premium less claims. Typically, this results in only several months of coverage, particularly where the policy is rich in benefits. By contrast, Option 3 provides a reasonable alternative to a "luxurious" policy. Policyholders who election Option 3 will not be required to participate in Phase Two of the Plan.

Option 4 allows the policyholder to keep his current coverages by paying the If Knew Premium. Cantilo testified that this option is the least favored by the Rehabilitator because if the majority of policyholders choose this option the Funding Gap will only be reduced by half. N.T., 5/17/2021, at 191. This is because the If Knew Premium does not cover the prior years of premium inadequacy.

Cantilo explained that the options will vary depending on whether the policyholder is on claim or paying premium. A policyholder on premium waiver may choose to pay a differential premium, *i.e.*, the difference between the waived premium and the If Knew premium. The policyholder may choose not to pay the differential premium, but the benefits of his policy will be reduced in a commensurate amount. Cantilo testified that the rationale behind the differential premium is to apportion the burden of rehabilitation among all policyholders, not just the subset still paying premium. It would be unfair for the 13% of policyholders on premium waiver to be immunized from a premium adjustment at the expense of the other 87%.

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

[8] The maximum daily benefit for facility care other than nursing home care is $225. The maximum daily benefit for home health care is $150.

sections. The first section describes the policyholder's current policy, including the monthly premium, available benefits, maximum policy value and the applicable statutory guaranty association limit were SHIP to be liquidated. The second section provides information on each option and how it changes the key provisions of his policy, *e.g.*, duration of benefit period and maximum daily benefit amount. The amount of the maximum policy value not covered by the applicable guaranty association is also provided. The third section contains two key pieces of information: the policyholder's estimated annual premium should a liquidation be ordered and the policyholder's estimated self-sustaining premium in Phase Two of the rehabilitation. Cantilo explained that these two numbers will enable policyholders to better choose among the options, especially since Options 1 and 4 will subject them to Phase Two.

To create user-friendly policyholder election materials, the Rehabilitator has engaged consultants who specialize in preparing Medicare supplement materials. The election forms will use graphics and be intuitively easy to follow. The Rehabilitator also plans to post a video tutorial online to guide the policyholder through the election forms. Cantilo testified that the Rehabilitator's goal is 100% policyholder participation. If a policyholder whose current premium is below the If Knew Premium does not make an election by the deadline, there are default options. For policyholders on premium waiver, the default option is Option 1, the downgrade option, unless Option 3 will provide better coverage, in which case it will be the default. For policyholders paying premium, the default option is Option 2, the basic policy endorsements.

The Rehabilitator conducted considerable outreach about the rehabilitation of SHIP beginning in the early stages of the rehabilitation. The

Rehabilitator participated in regular meetings of the National Association of Insurance Commissioners and organized numerous meetings and conference calls with state regulators. The goal was to design a rehabilitation plan to address all concerns, particularly those expressed about state-of-issue responsibility for premium rate review. The Rehabilitator set up a secure data site for interested persons that contains all of the exhibits to this proceeding, including the seriatim actuarial files for every policy. Individual reports were generated for each state explaining how resident policyholders of that state would fare under the plan.

To date, the Rehabilitator has received comments from approximately 100 policyholders. Cantilo testified that this was far fewer than the number of comments in Penn Treaty. As expected, most policyholder concerns related to reduction of benefits and rate increases. Cantilo was surprised how many policyholders were supportive of a rehabilitation and the plans submitted by the Rehabilitator.

The principal concerns raised by state insurance regulators related to the following areas: (1) treatment of reinsurance assumed; (2) setting of premium rates by the Rehabilitator and this Court rather than by state-of-issue regulators; (3) desirability of liquidation instead of rehabilitation; and (4) feasibility of the Second Amended Plan. Cantilo discussed each of these areas in turn.

On the first concern, Cantilo explained that SHIP's assumed reinsurance involved approximately 2,000 long-term care policies originally issued by American Health and Life, Primerica and TransAmerica, or the predecessors of those companies. SHIP's predecessors entered into agreements to reinsure 100% of these policies and administer claims. In the case of TransAmerica, on December 29, 2020, this Court approved an agreement by which TransAmerica recaptured its

policies from SHIP. Cantilo opined that the recapture was consistent with industry norms.

With regard to premium rates, Cantilo acknowledged the objections of the Intervening Regulators. They contend that the state where the policyholder resided when the policy was issued is solely responsible for the regulation of the policy's premium rate. Cantilo opined that this makes sense for solvent insurers, but when an insurer enters rehabilitation, the domiciliary state has sole responsibility for the insolvent insurer and the restructuring of its business. This responsibility includes the adjustment of premiums and policy coverages where necessary to correct the insurer's financial condition.

Cantilo testified that the Intervening Regulators' legal assertion that they have the right to review and approve premium rates for policies issued by SHIP in their states creates "some ironic consequences." N.T., 5/17/2021, at 157. For example, 34 policies issued in Maine, 84 policies issued in Massachusetts and 89 policies issued in Washington are held by policyholders who now reside in other states. Thus, the Intervening Regulators assert the right to set the rates for 207 policyholders who live outside of their states. Ex. RP-56 at 97. Further, 21 policyholders who reside in Maine, 83 policyholders who reside in Massachusetts and 87 policyholders who reside in Washington had their policies issued in other states. Under the Intervening Regulators' legal assertion, other state regulators would set the rates for 191 policyholders residing in the states represented by Intervening Regulators. *Id*. at 98. In short, their inflexible view of rate regulation results in approximately 400 policyholders residing in Maine, Massachusetts and Washington having their rates set by states in which they do not reside. The better approach, in Cantilo's view, is for the domiciliary regulator of an insurer in

rehabilitation to manage rate and contract modifications as part of a comprehensive rehabilitation plan.

Nevertheless, the Second Amended Plan contains an Issue State Rate Approval Option. As Cantilo explained, every state will be given the option of opting out of the rate approval section of the Second Amended Plan. If a state opts out, the Rehabilitator will file an application to increase premium rates for policies issued in that state to the If Knew Premium level. No rate increase will be sought for policies on premium waiver or which are already at or above the If Knew Premium. The Rehabilitator will file the application on a seriatim basis to eliminate subsidies and restore a level playing field. The regulator for the opt-out state will then render a decision on the application; if it is only partially approved, the Rehabilitator will downgrade the benefits for the affected policies.[9] Cantilo testified that this is essential to eliminate the subsidies that exist between policyholders across states by virtue of uneven rate increase approvals over the years. Each opt-out state policyholder will still have four options, which are not exactly the same as those offered in the Second Amended Plan. They are: (1) pay the approved premium and have benefits reduced to match; (2) accept a downgrade of benefits to match the current premium; (3) accept an issue-state non-forfeiture option; or (4) keep the current benefits and pay the If Knew Premium. Cantilo pointed out that the non-forfeiture option available to opt-out policyholders will not be as generous as the enhanced non-forfeiture option in Option 3 of the Second Amended Plan. There will also be no "basic policy benefits" option, *i.e.,* Option 2 in the Plan.

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

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

Intervening Regulators focus on the present value of future benefits less the present value of future premiums, also referred to as the "Carpenter value," to support their view that policyholders would fare better in a liquidation. N.T., 5/17/2021, at 175.[10] Cantilo criticized this measure because it does not give an accurate picture of a policyholder's situation. He offered the example of an actual 92-year-old SHIP policyholder currently paying $2,761 for a policy with unlimited benefits. Ex. RP-56 at 102. Using the Intervening Regulators' preferred methodology, the "Carpenter value" of that policy is $33,890, which is higher than the "Carpenter value" produced under any of the four Plan options. However, to receive this value of $33,890, the policyholder would have to pay $11,520 in annual premium. By contrast, this policyholder could choose Option 3, a paid-up policy with a slightly lower "Carpenter value" of $33,550. With a paid-up policy, however, this policyholder would receive 2.5 years of coverage and never pay another premium. Cantilo offered other examples where Option 3 would be the best option for a policyholder, given the annual premium the policyholder would be required to pay to the guaranty association in a liquidation. *See, e.g.*, Ex. RP-56 at 103. Cantilo opined that these are not exceptions; "[t]here are many cases where the raw projection of future benefits less future premium doesn't really tell you what the real value of the policy is." N.T., 5/17/2021, at 177.

Cantilo discussed several different ways to compare the value of the Plan options to what would be available in a liquidation. Using the Intervening Regulators' standard of present value of future benefits less present value of future premiums, 85% of policyholders will have at least one option as favorable in

[10] "Carpenter value" refers to the United States Supreme Court's decision in *Neblett v. Carpenter*, 305 U.S. 297 (1938), which is often cited for the proposition that, in order for a rehabilitation plan to be constitutional, policyholders must fare as well in rehabilitation as they would in a liquidation.

liquidation and 15% will not. Ex. RP-56 at 105. Using the present value of future benefits divided by annual premiums, those numbers are 79% and 21%. *Id*. at 106. Using the maximum policy value divided by annual premium, those numbers are 89% and 11%. *Id*. at 107. Using the maximum policy value less present value of future premiums, those numbers are 96% and 4%. *Id*. at 108. Finally, using the Rehabilitator's preferred standard of maximum policy value, also referred to as the "benefit account value" or "lifetime maximum benefit" in some policies, *id*. at 104, 100% of policyholders will have at least one option in the Plan that offers the same or a better value than in a liquidation. *Id*. at 109.

Cantilo acknowledged that these are actuarial techniques that rely on the exercise of professional judgment. He opined that the maximum policy value is what policyholders use when they purchase an insurance policy, *i.e.,* the maximum daily benefit and the maximum benefit period.

Cantilo offered additional reasons to explain why rehabilitation is preferable to liquidation. First and foremost is the value of policyholder choice. Second, the Second Amended Plan contains features that would not be available to policyholders in liquidation, such as an option to retain their current policy level of coverage, which may exceed the applicable guaranty association cap, by paying the If Knew Premium. Third, there is the enhanced non-forfeiture option that provides reasonable coverage for no additional premium. In a liquidation, the non-forfeiture option would be locked into the policy's present coverages and terms, which may result in a very short period of coverage. Fourth, the Plan reduces or eliminates the subsidies in the current rate structure, which cannot be done in a liquidation.

Finally, Cantilo testified about the likelihood of success of the Second Amended Plan. He opined that the Plan is designed to eliminate the Funding Gap

over three phases. This is not likely to happen in Phase One, but Phase One will materially reduce the Funding Gap.

Cantilo offered an exhibit illustrating the amount of the Funding Gap reduction under 11 hypothetical policyholder election scenarios. In general, the more that policyholders elect to pay the If Knew Premium for their current benefits (Option 4), the worse the outcome for the Funding Gap. For example, in Scenario 1, where 7% elect Option 1, 8% elect Option 2 or 2A, 4% elect Option 3 and 81% elect Option 4, the Funding Gap is reduced by $525 million. Ex. RP-56 at 113. At the other extreme, in Scenario 11, where a very small number of policyholders elect Option 4 and the rest split evenly among Options 1, 2, 2A and 3, the Funding Gap is completely eliminated. *Id*. This underscores how the policyholders will be the masters of the fate of SHIP. No matter how much of the Funding Gap is eliminated in Phase One, SHIP will be in better shape if it eventually has to be liquidated because the discriminatory subsidies in the premium rate structure will be eliminated and the policies will be right-sized.

On examination by the Intervening Health Insurers, Cantilo testified that the SHIP policies contain provisions that allow SHIP to modify the premium rate. Some policies provide that rate increases will require the approval of state regulators, while others specify that rate increases may be sought only where an increase is warranted given the claims experience of the cohort of policyholders covered by the same policy form. Cantilo stated that these provisions are standard in long-term care insurance policies. The Rehabilitator designed the If Knew Premium methodology in the Second Amended Plan to be consistent with the standards for setting long-term care insurance premium rates, which are substantially the same in every state.

b. Marc Lambright

Marc Lambright, an accident and health insurance actuary with Oliver Wyman, testified for the Rehabilitator. Lambright testified that the Pennsylvania Insurance Department engaged Oliver Wyman in early 2017 to conduct a targeted examination of SHIP's reserves and the assumptions used by its actuarial firm, Milliman, to set the reserves. Following its examination, Oliver Wyman submitted a report making several observations: Milliman's cash flow testing assumptions were too optimistic; claim reserves for the past several years were inadequate; and the Beechwood investment program was riskier than assumed in the 2016 cash flow test report. Ex. RP-56 at 53. Oliver Wyman made several recommendations for the ongoing financial monitoring of SHIP. They included using more recent experience to develop morbidity, lapse and termination assumptions. *Id*. Milliman largely rejected Oliver Wyman's recommendations.

In 2018, after SHIP was placed under the supervision of the Insurance Department, Cantilo asked SHIP to devise a corrective action plan.[11] Cantilo also asked Oliver Wyman to continue analyzing SHIP's financial condition. Lambright testified that much of 2018 was spent pressing SHIP to substantiate some of its actuarial assumptions. Lambright testified that the Beechwood investment losses ($176 million) and the premium deficiency reserve booked in 2018 ($347 million) had a significant impact on SHIP's financial picture. N.T., 5/18/2021, at 374. In 2019, Lambright assisted Vincent Bodnar as he built the corrective action plan that would become the rehabilitation plan.

[11] Section 510(a) of Article V authorizes the Insurance Commissioner to "make and serve upon the insurer and any other persons involved, such orders … as are reasonably necessary to correct, eliminate or remedy" the insurer's condition that required the supervision. 40 P.S. §221.10(a).

c. Vincent Bodnar

Vincent Bodnar, an actuary at Oliver Wyman with a specialty in long-term care insurance, testified as an expert witness. Bodnar performed actuarial work for the Rehabilitator and was involved in developing the Second Amended Plan, including the Phase One options to be offered to the policyholders.

Bodnar described the seriatim model as the core of the Second Amended Plan. A seriatim model, which produces actuarial projections for each policy individually, has become the industry standard in the past five years. The input to the seriatim model consists of individual policyholder characteristics such as age, gender, issue age, benefit features of the policy, and the premium charged. Applied to the input file are actuarial assumptions, including morbidity and mortality rates, lapse rates, and exhaustion rates, which Oliver Wyman has developed using SHIP's historical experience. The seriatim model projects future premiums and future claims for each policy on a month-by-month basis. N.T., 5/18/2021, at 397.

Bodnar explained that the If Knew Premium methodology employed in Phase One determines the premium an insurer would charge had it known when the policy was issued what it knows today, *i.e.*, that it would experience lower returns on investments, lower mortality rates, lower lapse rates, and higher claim incidence rates. The If Knew Premium assumes a 60% lifetime loss ratio from inception of a policy, *i.e.,* the use of 60% of expected premium to pay benefits to policyholders. The other 40% of expected premium is used to pay salaries, administrative overhead, premium taxes, federal taxes and profit for the insurer. The goal of the lifetime loss ratio is to establish a premium level that is reasonable in relation to the benefits paid. The 60% lifetime loss ratio is the benchmark required for a premium rate increase in most states. The If Knew Premium methodology employed in Phase One will be

actuarially justified and will not recoup past underpricing losses, although several states allow such recoupment. In the Penn Treaty liquidation, guaranty associations sought premium rate increases from the states based on an If Knew Premium methodology similar to the one employed in Phase One.

Because the Second Amended Plan intends to set premium rates on a seriatim basis, each policyholder will receive an individual premium increase calculated on the benefit features of his policy and the policyholder's characteristics. The model does not consider individual claim experience but, rather, "all the various variants that make up a given assumption" for a risk class. N.T., 5/18/2021, at 412. By contrast, in a traditional rate application process, insurers request state approval of an aggregate premium rate increase, although their models might be developed on a seriatim basis.

Bodnar testified that it is common for an insurer to receive mixed responses to a premium rate increase request from state regulators because each state has its own approach to reviewing rates. Additionally, the rate review process typically takes between 90 days and 2 years. Protracted rate reviews with drastically different outcomes has resulted in some SHIP policyholders paying a premium rate that subsidizes the inadequate premium rates of other SHIP policyholders. The Second Amended Plan seeks to eliminate this inequitable discrimination in premium payments.

Based on his experience with insurance product development and consumer choices, Bodnar testified that, generally, policyholders look at maximum policy value, *i.e.,* the maximum daily benefits, elimination period, and premium rate in choosing an insurance policy. Bodnar considered all these factors in developing the options in the Second Amended Plan. Option 1 allows policyholders to retain

their current premium rates with reduced benefits. Options 2 and 2A provide policyholders with basic policy coverages at corresponding If Knew Premium rates. The basic policy retains the key components of long-term care and reduces or eliminates some features, such as a 4.5% inflation rider, that are not so important to policyholders. The maximum daily benefit, although reduced, would continue to provide meaningful coverage to most policyholders. The policyholders who elect Option 2 or 2A would not be subject to a rate increase in Phase Two, which is an appealing feature. In the Penn Treaty liquidation, policyholders were offered a benefit reduction option similar, but not identical to, Options 1 and 2 or 2A, but Bodnar did not recall how that affected their premium level. N.T., 5/19/2021, at 517, 520. By contrast, the Second Amended Plan proposes to offer policyholders three options by which to reduce their coverages and save premiums.

Option 3 of the Second Amended Plan offers a non-forfeiture option, which allows policyholders to receive up to 2.5 years of coverage and stop paying any additional premium. This is more generous than the standard non-forfeiture option, which caps coverage to the amount of premiums the policyholder has paid from inception. Policyholders in the Penn Treaty liquidation who chose the standard non-forfeiture option received continued coverage for a shorter period of time, sometimes only months. *Id*. at 435.

Option 4 of the Second Amended Plan allows policyholders to keep their current policy benefits and pay the If Knew Premium rate to retain those benefits. The guaranty associations in the Penn Treaty liquidation did not offer an equivalent option to policyholders whose coverages exceeded the statutory limits. Instead, they offered a rate increase option that retained the policy's coverages up to the statutory maximum amount allowed for each resident.

Bodnar explained how the different Phase One options relate to Phase Two of the Plan. Policyholders who elect Options 1 and 4 and have a policy providing coverage in excess of the guaranty association limits will be subject to a rate increase in Phase Two. Phase Two seeks to deploy a self-sustaining premium rate methodology, which will keep the lifetime loss ratio at 60% and thus be actuarially justified. Phase Two is not absolutely necessary under the Second Amended Plan because Phase One could close the Funding Gap, or the assumptions deployed in Phase One could play out differently than projected. Bodnar opined that any meaningful reduction in the Funding Gap during the rehabilitation would be a success.

Bodnar opined that a rehabilitation as proposed in the Second Amended Plan, as opposed to an immediate liquidation, presents policyholders with better options; sets the premium rates to equitable levels; and reduces SHIP's Funding Gap. There is no formulaic method to determine whether policyholders are better off in a rehabilitation or in a liquidation; the so-called "Carpenter test" is not an actuarial test. Policyholders who choose Option 4 will have a policy with a net present value greater than or equal to what they would have in liquidation because it will not be capped at the level set forth in the applicable guaranty association statute. However, Option 4 has the least effect on reducing the Funding Gap. N.T., 5/19/2021, at 512-513.

Bodnar opined that policyholders are likely to consider the maximum policy value/premiums analysis or the maximum policy value analysis in making determinations. The present value analysis, or "Carpenter test," is appropriate for evaluating the impact of the Phase One options on SHIP's liabilities. However, he explained that policyholders do not use a present value analysis when they choose

their long-term care insurance coverage. Nor would they rely solely on the present value analysis to select one of the options offered under the Second Amended Plan.

Upon approval of the Second Amended Plan, Bodnar and the actuarial team at Oliver Wyman will prepare an actuarial memorandum in support of the If Knew Premium rates, similar to what would be submitted to state regulators in a rate increase filing. In developing the Second Amended Plan, Oliver Wyman has prepared an actuarial report describing the If Knew Premium rating methodology and an assumption report, Ex. RP-16 and Ex. RP-17, and has gathered all the information needed for the actuarial memorandum. N.T., 5/19/2021, at 460.

ii. Intervening Regulators' Evidence

a. Frank Edwards

Frank Edwards, the vice president and chief life health actuary of INS Consultants, testified as a fact witness on behalf of the Intervening Regulators. Edwards testified that under the Second Amended Plan, policyholders bear the responsibility for the $1.2 billion Funding Gap through benefit reductions and premium increases. By contrast, in liquidation, policyholders would bear a burden of approximately $397 million, and the guaranty associations would bear a burden of approximately $837 million. This represents the difference between the net amount the guaranty associations would pay to policyholders and the distributions they would receive from the SHIP estate. Because a rehabilitation does not trigger the guaranty associations, these funds will not be available to benefit policyholders under the Second Amended Plan.

Edwards observed that among the four options in the Second Amended Plan for Phase One, Option 4 provides a net present value for approximately 83% of policyholders that is greater than they would receive in a liquidation. The other

options provide policyholders with a net present value that is lower than they would receive in liquidation.

Oliver Wyman presented 10 scenarios to illustrate the potential results of the Second Amended Plan for SHIP's liabilities, each leaving a deficit that ranged from $699 million to $186 million. Ex. RP-16 at 11. Only Scenario 11, later added, eliminates the Funding Gap. Based on the information provided by Oliver Wyman, Edwards calculated a "Best Interest" scenario, which assumed that each policyholder will choose the option that provides the greatest net present value, or "Carpenter value." Ex. SIR 5-4. Option 4 would give 67.13% of the policyholders the greatest net present value, which would reduce SHIP's Funding Gap by $184 million. *Id*.

Edwards addressed a comparison of rehabilitation to liquidation under Phase Two. Edwards calculated the effects of hypothetical Phase Two premium increases on policyholders who selected Option 4 in Phase One. Assuming a premium increase of 50% in Phase Two, the percentage of policyholders receiving a net present value greater than in a liquidation under Option 4 drops to 33.89%. The percentage of policyholders in a rehabilitation, in the aggregate, that would receive a net present value greater than liquidation is 54.57%. Assuming a premium increase of 100% in Phase Two, the percentage of policyholders for whom Option 4 provides a net present value greater than in a liquidation drops to 22.92%. The percentage of all policyholders in a rehabilitation, in the aggregate, that would receive a net present value greater than in a liquidation is 47.21%. Even so, these hypothetical premium increases of 50% and 100% would leave remaining a Funding Gap of approximately $858 million and $676 million, respectively. Ex. SIR 5-5.

Edwards observed that the information presented by Oliver Wyman indicated that the net present value of Option 2 for policies with benefits in excess

of guaranty association limits is typically less than the net present value of the guaranty association limits. Ex. SIR 5-6.

Edwards did not evaluate Oliver Wyman's work. He compared the Second Amended Plan to liquidation using hypotheticals in which policyholders made elections based solely on maximizing the present value of future policy benefits minus the present value of future premiums, or the "Carpenter value."

iii. Intervenor NOLHGA's Evidence

a. Peter Gallanis

Peter Gallanis, the president of NOLHGA, testified as a fact witness. NOLHGA intervened in this proceeding to offer its suggestions on the Second Amended Plan; provide background information on the guaranty association system; and identify and request certain information material to its guaranty association members.

NOLHGA's members are life and health guaranty associations, one for each state and the District of Columbia, which are nonprofit entities created by state statutes to protect policyholders when a life or health insurance company is liquidated. In multi-state insurance insolvencies, the guaranty associations collaborate and coordinate through NOLHGA to fulfill their statutory obligations. NOLHGA has been involved in approximately 100 multi-state insurance receiverships, nine of which involved long-term care insurance. If SHIP goes into liquidation, most NOLHGA member guaranty associations would be activated to provide coverage to SHIP policyholders, subject to the statutory limit on coverage in the member's state, which is generally $300,000 per resident.

Gallanis testified that the Second Amended Plan should emphasize that the options that policyholders select in Phase One will be permanent. The Second

Amended Plan's discussion of SHIP's unfunded liability needs clarification, or it should be eliminated. The subject need not be addressed until a liquidation may occur.

He testified that the Rehabilitator's sample Illustrative Policyholder Guidance Pages on guaranty association coverage and premium rates in liquidation could be misleading. In response, NOLHGA prepared a sample Summary of Policyholder Protection by Guaranty Associations in Liquidations that it believes should be sent to policyholders during Phase One. Ex. N-1. Gallanis believes NOLHGA should review all policyholder communications that refer to liquidation or guaranty associations and be allowed to comment on these communications before they are sent to policyholders.

Gallanis testified that NOLHGA wants more information on SHIP's reinsurance agreements with Transamerica, American Health and Life Insurance Company, and Primerica Life Insurance Company. NOLGHA also seeks more information on SHIP's in-force policies that are not long-term care policies.

Gallanis explained that members of a guaranty association are licensed life and health insurers. If SHIP is placed under an order of liquidation, the guaranty associations will provide resident policyholders with coverage up to the lesser of the maximum benefit level provided in the policy or the statutory limit for guaranty association coverage, which is $300,000 per resident in most states.[12] The guaranty associations may continue coverage under the policy; work with the receiver to transfer the business to a financially solvent insurer; or issue alternative policies. The guaranty associations may seek premium rate increases or offer policyholders

[12] The guaranty association limits range between $100,000 in Puerto Rico, $300,000 in 42 states and the District of Columbia, $500,000 in 6 states, $615,525 in California, and no limit in New Jersey.

modified benefits based on current premium rates, as was recently done in the Penn Treaty liquidation. The guaranty associations generally do not charge premiums to policyholders who have been on premium waiver. The options offered by the guaranty associations in the Penn Treaty liquidation are illustrative of what could be offered in a potential SHIP liquidation.

In a liquidation, the guaranty associations will assess their member insurers, using the methodology set forth in their governing statutes to determine each member insurer's assessment. The member insurers pay the assessments from their general accounts. In some states, the member insurers can offset a portion of the assessment against state premium taxes that the insurers would otherwise owe. Member insurers can also impose surcharges on their policyholders to fund assessments. The guaranty associations are not funded by state revenues.

Gallanis explained that NOLHGA does not endorse or oppose the Second Amended Plan. NOLHGA intends to monitor the rehabilitation if this Court approves the Second Amended Plan, so that the guaranty associations will be prepared if SHIP ultimately is liquidated.

b. Matthew Morton

Matthew Morton, an actuary with the Long Term Care Group and an advisor to NOLHGA, testified as a fact witness about guaranty association coverage and premium rate increases in liquidation. Morton assisted NOLHGA in several long-term care insurer insolvencies, including the Penn Treaty liquidation.

In a liquidation, a policyholder receives a continuation of coverage from a guaranty association. The policy's benefits are paid in full until the policyholder exhausts the maximum benefit amount or maximum coverage period set forth in the policy, or until the payments reach the statutory coverage limit. Many

long-term care policyholders are not affected by the statutory coverage limit because: (1) the policy's maximum benefit amount is less than the statutory coverage limit; (2) the policyholder never goes on claim; or (3) the policyholder does not stay on claim long enough to reach the statutory coverage limit.

In the Penn Treaty liquidation, the guaranty associations implemented a nationwide rate increase program, which resulted in 34 states approving 100% of the requested rate increases; 11 states approving between 80% and 100% of the requested rate increases; and 3 states approving less than 60% of the requested rate increases. No state denied a rate increase request. The majority, 44 states, approved the initial rate increase filing within 15 months. The guaranty associations spent 6 to 12 months preparing and filing the rate increase applications.

The guaranty associations' methodology for calculating premium rate increases in the Penn Treaty liquidation was similar to the If Knew Premium methodology proposed in the Second Amended Plan, with two exceptions. First, the Second Amended Plan proposes to calculate rate increases seriatim, or individually, while Penn Treaty's rate increase applications were developed on a cohort basis, by which policyholders were grouped together by policy form. The cohort basis is the industry standard for an insurer that is a going concern. Second, the Second Amended Plan proposes to calculate rate increases based on the total maximum value of the policy. In Penn Treaty's liquidation, the premium rates were calculated based on benefits being capped at the guaranty association statutory limits.

Morton testified that the premium rate increase methodology used by the guaranty associations in the Penn Treaty liquidation "largely" addressed the inequities in premium rates and the cross-state rate subsidization issue. N.T., 5/20/2021, at 806. When asked on cross-examination to expound on his

understanding of "largely," Morton acknowledged that using a cohort method to adjust premium rates results in some policyholders paying more than the If Knew Premium. *Id*. at 817-18. If a seriatim method is used, all policyholders will pay the If Knew Premium and no more.

In the Penn Treaty liquidation, the default option for policyholders who failed to make elections was to accept the rate increase. Policyholders were offered policy modifications, including lowering daily benefits or the inflation rider; a reduced paid-up policy; or a cash-out option in exchange for termination of the policy. Only one state approved the cash-out option. Approximately 76% of the Penn Treaty policyholders accepted the rate increase, among which "a little bit less than a half" took the option by default; 13% of the policyholders reduced their benefits; 8% of the policyholders elected to cash out; and 3% of the policyholders elected a reduced paid-up policy. *Id*. at 812. The guaranty associations treated Penn Treaty policyholders on premium waiver the same before and after the liquidation by continuing the waiver.

iv. Intervening Agents and Brokers' Evidence

a. Daniel Schmedlen

Daniel Schmedlen, Chief Executive Officer of LTC Global, testified on behalf of the Intervening Agents and Brokers. These agents and brokers are all employed by LTC Global and are paid commissions by SHIP. The commission is set forth in the agency agreement and based on a percentage of premium. The policyholder pays a premium to the insurer, which deducts a certain percentage of the premium and remits it to the agent as a commission. The agent is not obligated to contact the insured after issuance of the policy, although the agent might accept the initial premium payment on behalf of the insurer.

A sample agent agreement was introduced into evidence by the Rehabilitator. It provided that the agent and successors "shall have the vested right to receive all commissions payable under this [a]greement." Ex. RP-10 at 3. Schmedlen understood this language as creating the agent's vested property interest in that part of any premium collected by SHIP that it owed to the agent as a commission. LTC Global expects that its agents will continue to receive commissions during SHIP's rehabilitation, as they did during Penn Treaty's rehabilitation.

The insurer determines the amount of commission payable to the agents. Once a policy is issued and delivered, the agent is paid a commission in accordance with the commission schedule set forth in the agency agreement. The first-year commission is higher than the renewal commission, and the amount of renewal commission changes with time. The commission schedule in the sample agent agreement showed that the first-year commission ranged from 45% to 70% of the first-year premium, depending on the age of the policyholder. After 10 years, the commission is typically reduced to a percentage of premium in the "middle single digits." N.T., 5/20/2021, at 850. If the insurer has to refund any portion of the premium to the insured, the agent returns his commission to the insurer in proportion to the refunded premium. Where there is no premium paid, there is no commission owed to the agent.

v. Intervening Health Insurers' Evidence

Intervening Health Insurers introduced into evidence six sample insurance policies issued by SHIP's predecessors and assumed by SHIP. The policies provided that SHIP may increase premium rates over time without

specifying the methodology to be used in calculating the rate increases. The policies are silent on agent and broker commissions.

vi. Intervening Policyholders' Evidence

a. James Lapinski

Intervenor James Lapinski, a policyholder of SHIP as well as a broker, testified on his own behalf. He expressed concern about the Second Amended Plan's discussion of the impact of the COVID-19 pandemic on the long-term care insurance industry. He requested that the Rehabilitator update the discussion with more recent data. Lapinski presented a three-page excerpt from the Society of Actuaries report, dated September 30, 2020, which indicated that COVID-19 has had an impact on emerging long-term care insurance experience through higher mortality and lower claim incidence. An excerpt of a newsletter produced by Fairfax County, Virginia, suggested that more than 80% of COVID-19 deaths have been adults over 65 years old. Further, 34% of COVID-19 deaths in the United States have been seniors living in long-term care facilities, which accounts for less than 1% of the U.S. population. Lapinski opined that a combination of a decline in claim utilization and increase in lapse or cancellation of policies suggests that SHIP has experienced a major decrease in claims experience due to the pandemic.

Lapinski presented a balance sheet of SHIP showing that the value of SHIP's bond holdings as of December 31, 2020, declined by approximately $500 million from the previous year. SHIP's reported cash on hand and short-term investment income also declined from the previous year by approximately $500,000. This does not correlate with the decrease in the value of the bonds. Lapinski questioned the changes in reserves shown in the balance sheet. Specifically, he requested the Rehabilitator to explain the decline in SHIP's capital and surplus from

approximately $12 million in 2017 to a deficit of $916 million in 2019, as well as the decline in the number of policies in force from 151,000 in 2009 to approximately 39,000 as of the filing of the Second Amended Plan. Observing that the Second Amended Plan contains excerpts from SHIP's unfiled 2019 statutory financial statement and the internal 2020 financial information (*see* Appendix B of the Second Amended Plan), Lapinski requested that SHIP file its 2019 and 2020 statutory financial statements before this Court rules on the Second Amended Plan.

Lapinski and his wife pay annual premiums totaling $9,000 for their three policies. Over the past 25 years, they have paid over $200,000 in premiums. He estimated that skilled nursing facilities cost $500 per day, which they cannot afford without insurance coverage. Lapinski raised concerns with the timing of the rehabilitation and stated his desire for SHIP to avoid the lengthy process that Penn Treaty had gone through prior to liquidation.

b. Rose Marie Knight

Rose Marie Knight, a policyholder, also testified. She agreed with Lapinski's testimony. She has been a policyholder for 22 years and currently pays an annual premium of $1,200. She questioned why SHIP has not raised her premium for the last four or five years. Knight's policy has a lifetime benefit period. She will have to pay a higher premium to retain this maximum coverage period under the Second Amended Plan. Knight expressed concern about her ability to pay a higher premium and becoming a burden on her children. N.T., 5/21/2021, at 935. She noted that the government has recently incurred great debts, which will cause inflation that "is starting to hit." *Id*. at 933-34.

Both Lapinski and Knight expressed concern and confusion as to the Second Amended Plan's proposed policy restructuring, which they interpreted as removing benefits or cancelling guaranty association coverage.

III. Standard of Review

Section 516(b) of Article V authorizes the Rehabilitator to "take such action as [she] deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate the insurer. … [She] shall have full power … to deal with the property and business of the insurer." 40 P.S. §221.16(b). The legislatively stated purpose of Article V, to which the Court must give effect, is "the protection of the interests of insureds, creditors, and the public generally...." and the "equitable apportionment of any unavoidable loss" through, *inter alia*, "improved methods for rehabilitating insurers...." *Grode v. Mutual Fire, Marine and Inland Insurance Co.*, 572 A.2d 798, 803 (Pa. Cmwlth. 1990) (*Mutual Fire I*) (single-judge opinion) (quoting Section 501 of Article V, 40 P.S. §221.1).

The Pennsylvania Supreme Court has explained this Court's role in a rehabilitation as follows:

> In overseeing the course of rehabilitation to check any abuse of discretion by the Commissioner, the Commonwealth Court is authorized to "approve or disapprove the plan [of rehabilitation] proposed, or may modify it and approve it as modified. If it is approved, the rehabilitator shall carry out the plan." 40 P.S. § 221.16(d). Therefore, in order for the Plan to warrant the Commonwealth Court's imprimatur it must be found to be free from any abuse of the Rehabilitator's discretion.

Foster v. Mutual Fire, Marine and Inland Insurance Co., 614 A.2d 1086, 1091 (Pa. 1992) ("*Mutual Fire II*"). Further, "it is not the function of the courts to reassess the

determinations of fact and public policy made by the Rehabilitator." *Id*. Our Supreme Court has explained:

> 'It has been established as an elementary principle of law that courts will not review the actions of governmental bodies or administrative tribunals involving acts of discretion *in the absence of bad faith, fraud, capricious action or abuse of power* .... That the court might have a different opinion or judgment in regard to the action of the agency is not a sufficient ground for interference; *judicial* discretion may not be substituted for *administrative* discretion.'

Id. at 1092 (quoting *Norfolk and Western Railway Co. v. Pennsylvania Public Utility Commission*, 413 A.2d 1037, 1047 (Pa. 1980) (emphasis in original)).

With the above principles in mind, the Court considers whether the Rehabilitator abused her discretion in formulating the Second Amended Plan. The Court is also mindful that "the Rehabilitator is constrained by constitutional mandate[s]." *Mutual Fire I*, 572 A.2d at 804.

IV. Legal Analysis

A. The Second Amended Plan Serves a Rehabilitative Purpose and is within the Discretion of the Rehabilitator

1. Goals of the Plan

There is no fixed goal that every rehabilitation plan must satisfy to obtain this Court's approval. Specifically, the Pennsylvania Supreme Court has stated that a

> rehabilitation, in order to be legitimate, does not have to restore the company to its exact original condition. So long as the rehabilitation properly conserves and equitably administers "the assets of the involved corporation in the interest of investors, the public and others, (with) the main purpose being the public good" the plan of rehabilitation is appropriate.

Mutual Fire II, 614 A.2d at 1094 (quoting 2A COUCH ON INSURANCE 2d §22.10).

The unrefuted testimony of the Rehabilitator's witnesses established two overarching goals of the Second Amended Plan: (i) to reduce or eliminate the Funding Gap and (ii) to eliminate SHIP's inequitable and discriminatory premium rate structure, which is marked by cross-policyholder subsidies. The Plan will meet these goals by setting premium rates for all policyholders pursuant to an actuarially sound methodology, the If Knew Premium rate, which is widely accepted by regulators across the country, and by offering policyholders meaningful options. Instead of being forced to accept rate increases commensurate with their current coverages, policyholders will have the option to reduce coverages, thereby reducing their premiums.

In pursuing these goals, the Second Amended Plan addresses one of the major causes of SHIP's financial distress: policy underpricing. The Plan will address underpricing by (i) resetting premiums, on a prospective basis, to what they would have been without the erroneous actuarial assumptions and (ii) doing so on a seriatim basis, thereby ensuring that the premiums going forward are consistent across the entire pool of policyholders so that similarly situated policyholders will not be paying different premiums. The Plan will give policyholders meaningful choices for coverage in lieu of rate increases, without placing the cost of SHIP's historical policy underpricing upon the public through the guaranty association system. These goals serve the public good. *See Mutual Fire II*, 614 A.2d at 1094, n.4 (determining that the state's interest in "regulat[ing] the fiscal affairs of its insurers for the welfare of the public" is a legitimate and significant public purpose).

2. No Contrary Evidence

The Intervening Regulators, who object to the Second Amended Plan in its totality, did not introduce an expert witness to dispute any of the Rehabilitator's

actuarial projections, including the impact of the various options on policyholders and the Funding Gap, or the Plan's proposed premium rate methodologies. The Intervening Regulators' actuary, Frank Edwards, testified as a fact witness, and he acknowledged that he was not asked to evaluate the Rehabilitator's work.

Edwards' testimony consisted of "mathematical exercises," N.T., 5/19/2021, at 564, that compared the Plan to a liquidation. He assumed that policyholders are "better off" with the "maximum present value" of their policies. *Id*. at 568. Known as the "Carpenter value," maximum present value is future benefits minus future premiums, adjusted to their present value. Edwards acknowledged that he could not opine on policyholder preferences. Cantilo and Bodnar, both qualified experts, testified persuasively that policyholders do not make choices based on the maximum present value of their policies. Rather, policyholders will rely on other metrics, most notably the maximum policy value, such as maximum daily benefit and maximum benefit period, to make choices. Using those metrics provides a better outcome for policyholders than they would experience in liquidation.

B. The Goals of the Plan Could Not Be Achieved in Liquidation

The Rehabilitator's evidence demonstrated that immediate liquidation of SHIP would be improvident for several reasons. First, a liquidation of SHIP will not address the Funding Gap. Second, a liquidation will not address the existing inequitable premium rate structure and cross-policyholder subsidies. Instead, it will perpetuate those problems. Third, a liquidation of SHIP will unnecessarily delay any resolution of SHIP's financial condition. Fourth, the options available to policyholders under the Second Amended Plan are better than what would be offered by guaranty associations in a liquidation.

1. Liquidation Will Not Address the Funding Gap

As noted, the Funding Gap is largely attributable to significant historical underpricing of SHIP's policies. In a liquidation, the entire cost of this shortfall will be shifted to the guaranty association system and, ultimately, to the public. As NOLHGA's Peter Gallanis acknowledged, the guaranty associations will fund the cost of the underpricing by assessing their member companies, which, in turn, fund the assessments from their policyholder generated funds. These insurers will then recoup some portion of the loss through premium tax offsets or by raising rates they charge to their own policyholders. The Rehabilitator concluded that shifting the burden to taxpayers and policyholders of other life and health insurers will not serve the "public good." *Mutual Fire II*, 614 A.2d at 1094. That determination is within her discretion and is entitled to deference. *Id*. at 1091 ("[T]he involvement of the judicial process is limited to the safeguarding of the plan from any potential abuse of the Rehabilitator's discretion.").

2. Liquidation Will Perpetuate the Inequitable Premium Rate Structure

In a liquidation of SHIP, assuming the guaranty associations would seek rate increases as they did in the Penn Treaty liquidation, similarly situated policyholders will continue to pay different rates. NOLHGA's actuary, Matthew Morton, acknowledged that this is attributable to the guaranty associations' practice of seeking rate increases for cohorts of policyholders. Using a cohort method results in some policyholders paying more than the If Knew Premium in liquidation. The Second Amended Plan will adjust premium rates on a seriatim basis, which eliminates the possibility of any policyholder paying more than the If Knew Premium.

Further, the guaranty associations must request rate increases from the state of issue, not the state where the policyholder resides. The experience from the Penn Treaty liquidation showed that states do not act uniformly. For example, Florida (one of Penn Treaty's largest states by premium) granted only 50% of the guaranty associations requested, and actuarially justified, rate increases for policies written in that state. Florida similarly has refused to grant SHIP's requested rate increases, and there is no reason to believe the result would be any different in a liquidation. *See* Ex. RP-53 (showing that since 2009, SHIP has requested approximately $62.6 million in premium rate increases from the Florida Insurance Department, but only $7.6 million has been approved).

The Intervening Regulators' States of Maine, Massachusetts and Washington are illustrative of the problem. Since 2009, only Massachusetts has approved a significant percentage of the rate increases sought by SHIP. *See* Ex. RP-53 (showing a 90% approval ratio in Massachusetts but an 11% approval ratio in Maine and a 63% approval ratio in Washington). The Rehabilitator's evidence demonstrated that a liquidation will not alleviate SHIP's premium rate inequities and cross-policyholder subsidization issues.

3. Liquidation Involves Inherent Delays

At a minimum, a liquidation would cause a material delay in addressing the policy underpricing which lies at the root of SHIP's insolvency. NOLHGA's actuary testified that in the Penn Treaty liquidation it took six months to a year to prepare and file the rate applications on behalf of the guaranty associations. It took an additional 15 months to receive decisions from most of the state insurance regulators, with the final state's approval taking more than 4 years. Bodnar testified that the rate approval process can take anywhere from 90 days to 2 years or more.

Thus, at best, in a liquidation of SHIP it would take nearly two years to prepare, file and receive approvals on rate increase requests, and there would be no certainty that the rates would be approved at the requested actuarially justified level.

By contrast, the Second Amended Plan can be implemented quickly, thereby addressing the causes of SHIP's financial distress, preserving assets, and reserving flexibility for Phase Two and beyond. Cantilo testified that it would take approximately six months to prepare and transmit election packages to policyholders and gather any Issue State Opt-out elections. Upon implementation of the Plan, the Rehabilitator will know within approximately eight months how much of the Funding Gap will be eliminated. The outcome of Phase One will determine whether Phase Two will be necessary and, if so, its scope. While the Self-Sustaining Premium methodology proposed for Phase Two is actuarially justified according to Bodnar's undisputed expert testimony, the Rehabilitator may consider alternatives as necessary depending on the outcome of Phase One. The Rehabilitator will also provide reports to the Court at the appropriate times with her recommendations regarding Phase Two. A liquidation does not offer this kind of flexibility. *See Mutual Fire I*, 572 A.2d at 803 ("[T]he benefits of rehabilitation – its flexibility and avoidance of inherent delays – are preferable to the static and cumbersome procedures of statutory liquidation.").

4. Policyholders Will Have Fewer Choices in Liquidation

In a liquidation of SHIP, policyholders will not be offered the choices provided under the Second Amended Plan. NOLHGA's witnesses acknowledged that the benefit modification offers made by the guaranty associations in the Penn Treaty liquidation, which were the first of their kind in a long-term care insurance liquidation, do not match the options offered under the Plan. Specifically, there was

no equivalent to the basic policy coverages provided in Option 2/2a. There was no enhanced non-forfeiture option similar to Option 3. There was no option similar to Option 4 that could provide coverage above the applicable guaranty association cap. The Plan provides greater flexibility for policyholders than they would have in liquidation by offering meaningful policy modification alternatives that will also alleviate the Funding Gap and inequitable rate structure.

C. The Plan Meets the Legal Standards for Confirmation

1. The Plan's Rate Approval Mechanism and Issue-State Rate Approval Alternative are Permissible Under Pennsylvania Law and the United States Constitution

The Intervening Regulators object to the Second Amended Plan for the stated reason that the Plan proposes to have premium rates set by the Rehabilitator and this Court rather than by state-of-issue regulators. Intervening Regulators' Memorandum of Law, 6/14/2021, at 41. The Intervening Regulators assert that the Rehabilitator's statutory powers under Article V to "direct and manage" the "property and business of the insurer," Section 516(b) of Article V, 40 P.S. §221.16(b), does not include authority to change "SHIP's policies and rates without required regulatory approvals." Intervening Regulators' Memorandum of Law at 44. They also assert that the Plan's deviation from the ordinary state-by-state rate review process violates the Full Faith and Credit Clause of the United States Constitution[13] and is inconsistent with the principle of comity. The Plan's Issue

[13] It states:

> Full Faith and Credit shall be given in each State to the public Acts, Records, and judicial Proceedings of every other State. And the Congress may by general Laws prescribe the Manner in which such Acts, Records and Proceedings shall be proved, and the Effect thereof.

State Rate Approval Option does not cure these infirmities because it is coercive and offers, at most, a "nominal deference" to the state of issue's authority to regulate the premium rates for policies issued in that state. Intervening Regulators' Memorandum of Law at 50, 52.

We begin with a review of Section 516 of Article V, which sets forth the powers and duties of the Rehabilitator. It states, in pertinent part, as follows:

> (b) *The rehabilitator may take such action as he deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate the insurer.* He shall have all the powers of the directors, officers and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator. He shall have full power to direct and manage, to hire and discharge employes subject to any contract rights they may have, and to deal with the property and business of the insurer.
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> * * *
>
> (d) The rehabilitator may prepare a plan for the reorganization, consolidation, conversion, reinsurance, merger or other transformation of the insurer. Upon application of the rehabilitator for approval of the plan, and after such notice and hearing as the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. If it is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens upon the equities of policyholders of the company, provided that all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for such period and to such an extent as may be necessary.

U.S. CONST. art. IV, §1. A statute is a "public Act" within the meaning of the Full Faith and Credit Clause. *Franchise Tax Board of California v. Hyatt*, 136 S.Ct. 1277, 1281 (2016) (*Hyatt II*) (citing *Carroll v. Lanza*, 349 U.S. 411, 412 (1955)).

40 P.S. §221.16(b)(d) (emphasis added).

The Rehabilitator may "take such action as [she] deems necessary or expedient to correct the condition" that caused the need for rehabilitation, 40 P.S. §221.16(b), and in doing so, she may prepare a rehabilitation plan to "*impair the contractual rights of some policyholders* in order to minimize the potential harm to all of the affected parties." *Consedine v. Penn Treaty Network American Insurance Co.*, 63 A.3d 368, 452 (Pa. Cmwlth. 2012) (*Penn Treaty*) (citing *Mutual Fire II*, 614 A.2d at 1094) (emphasis added). This authority includes a reduction of coverage to match the policyholder's existing premium. It has long been understood that the legislature has vested the Rehabilitator with broad discretion in proposing a rehabilitation plan. *Mutual Fire I*, 572 A.2d at 804, *affirmed*, *Mutual Fire II*, 614 A.2d at 1086 (observing that the insurance commissioner, as statutory rehabilitator of an insurer, is given broader discretion to structure a rehabilitation plan than is given to a statutory liquidator).

In the *Mutual Fire* rehabilitation, the plan amended the policyholders' contractual right to full payment on covered claims by reducing all claim payments by an equal percentage. Here, the Rehabilitator could have done something similar by reducing the coverage of each policy to match the premium being paid. This would equitably address the Funding Gap. However, this would not give policyholders a choice. Further, policyholders whose premium is very inadequate might find themselves with a policy with very limited coverage.

Mutual Fire was a different receivership. There, the policies lapsed during the rehabilitation, and the sole object of the rehabilitation was to pay outstanding claims to the fullest extent possible. By contrast, here, the SHIP policies

are still in force and will remain in force until SHIP emerges from rehabilitation. In this respect, SHIP's rehabilitation is more complex.

A core cause of SHIP's insolvency is policy underpricing, and the Rehabilitator proposes to "correct the condition" through a combination of benefit modifications and premium rate increases. Section 516(b) of Article V, 40 P.S. §221.16(b). Policyholders will be able to decide which of the four options offered under the Second Amended Plan best fits their individual circumstances. The Plan follows the principles of *Mutual Fire I* and *II* and extends them to a different context, as appropriate for a long-term care insurer. The Plan falls within the Rehabilitator's "broad powers … to effectuate equitably the intent of the Rehabilitation statutes." *Mutual Fire II*, 614 A.2d at 1094. The Plan's mechanism for setting actuarially justified rates also falls within the Rehabilitator's broad powers, and they will be reviewed by the Court as part of the rehabilitation proceeding.

Arguably, the only contract "right" given up by the SHIP policyholder is the expectation that the state where the policy was issued will approve the premium rate for each of the four options in Phase One. No policyholder commented on this "right" to state-by-state rate regulation. Policyholder Rose Marie Knight expressed concern about the fact that her premium had not been increased for years. N.T., 5/21/2021, at 933.

The Intervening Regulators assert that the Plan's rate approval provisions "override the insurance laws of other [s]tates" and, thus, violate the Full Faith and Credit Clause of the United States Constitution. Intervening Regulators' Memorandum of Law at 38. Alternatively, the Intervening Regulators contend that this Court should refrain from approving the Plan under the principle of comity because the Plan's "displacement of the rate setting authority of the individual

[s]tates" is a "blatant intrusion" on the sovereignty of other states. Intervening Regulators' Memorandum of Law at 49. The Court finds no merit to these arguments.

Article V empowers this Court to rehabilitate the business of "a domestic insurer or an alien insurer domiciled in this Commonwealth." Section 515(a) of Article V, 40 P.S. §221.15(a). As a general rule, the insolvent insurer's state of domicile "has an overriding interest in assuring that the rehabilitation, if possible, is effectuated." *Matter of Mutual Benefit Life Insurance Co.*, 609 A.2d 768, 777 (N.J. Super. 1992). The court's "decree approving the rehabilitation plan for an insolvent insurer domiciled in its state has a *res judicata* effect upon out-of-state policyholders so as to preclude a subsequent attack upon the plan in another state." 1 COUCH ON INSURANCE 3d §5:31.

Maine, Massachusetts, and Washington have adopted, in substantial part, the Uniform Insurers Liquidation Act (UILA),[14] which was approved by the National Conference of Commissioners on Uniform State Laws in 1939. The UILA addressed the difficulties that arise in the receivership of an insolvent insurer with assets and liabilities located in several states; the UILA provides a "uniform system for the orderly and equitable administration of the assets and liabilities of defunct multistate insurers." *Altman v. Kyler*, 221 A.3d 687, 692 n.6 (Pa. Cmwlth. 2019) (quotations omitted). Pennsylvania, on the other hand, adopted the Insurer's Supervision, Rehabilitation and Liquidation Model Act (Model Act) approved by the National Association of Insurance Commissioners. *See Koken v. Reliance*

[14] *See* 24-A Me. Stat. Ann. §4363; *In re Liquidation of American Mutual Liberty Insurance Company*, 747 N.E.2d 1215, 1225 n.13 (Mass. 2001); and *American Star Insurance Co. v. Grice*, 865 P.2d 507, 509 (Wash. 1994).

Insurance Co., 893 A.2d 70, 76 (Pa. 2006). Following the Model Act, Article V addresses "the problems of interstate rehabilitation and liquidation by facilitating cooperation between states in the liquidation process, and by extending the scope of personal jurisdiction over debtors of the insurer outside this Commonwealth." Section 501(c) of Article V, 40 P.S. §221.1(c).

Given Maine, Massachusetts, and Washington's adoption of the UILA and Pennsylvania's adoption of the similar Model Act, a single, cohesive, uniform handling of SHIP's rehabilitation through a single state is consistent with the underlying policies sought to be served by those laws. Notably, the laws of Maine, Massachusetts and Washington also designate the domiciliary insurance commissioner as the receiver of an insurer undergoing liquidation or rehabilitation.[15] The Intervening Regulators have presented no reason to set aside Pennsylvania's primacy in SHIP's receivership.

Nor does the Full Faith and Credit Clause require this Court to apply the insurance rate regulatory laws of Maine, Massachusetts, and Washington with respect to the establishment of the If Knew Premium rate in the Second Amended Plan. The purpose of the full faith and credit command

> was to alter the status of the several states as independent foreign sovereignties, each free to ignore obligations created under the laws or by the judicial proceedings of the others, and to make them integral parts of a single nation throughout which a remedy upon a just obligation might be demanded as of right, irrespective of the state of its origin.

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

Baker by Thomas v. General Motors Corporation, 522 U.S. 222, 232 (1998) (citation omitted). Congress' Full Faith and Credit Act[16] requires that "all courts ... treat a state court judgment with the same respect that it would receive in the courts of the rendering state." *Standard Chartered Bank v. Ahmad Hamad Al Gosaibi and Brothers Co.*, 99 A.3d 936, 941 (Pa. Super. 2014) (citing *Matsushita Electric Industrial Co. v. Epstein*, 516 U.S. 367, 373 (1996)).

The relevant precedent differentiates between the credit owed to *laws* and the credit owed to *judgments* under the Full Faith and Credit Clause. *Baker*, 522 U.S. at 232. The Full Faith and Credit Clause "does not compel a state to substitute the statutes of other states for its own statutes dealing with a subject matter [] which it is competent to legislate." *Id*. (citation omitted). Instead, "it is frequently the case under the Full Faith and Credit Clause that a court can lawfully apply either the law of one State or the contrary law of another." *Franchise Tax Board of California v. Hyatt*, 538 U.S. 488, 496 (2003) (*Hyatt I*). By contrast, "[a] final judgment in one State, if rendered by a court with adjudicatory authority over the subject matter and persons governed by the judgment, qualifies for recognition throughout the land." *Baker*, 522 U.S. at 233. A court may be guided by the forum state's public policy in determining the law applicable to a controversy,

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[16] It provides:

> Such Acts, records and judicial proceedings or copies thereof, so authenticated, shall have the same full faith and credit in every court within the United States and its Territories and Possessions as they have by law or usage in the courts of such State, Territory or Possession from which they are taken.

28 U.S.C. §1738.

Likewise, the Pennsylvania legislature has enacted the Uniform Enforcement of Foreign Judgments Act, which defines "foreign judgment" as "any judgment, decree, or order of a court of the United States or of any other court requiring the payment of money which is entitled to full faith and credit in this Commonwealth." 42 Pa. C.S. §4306.

but there is no "public policy exception" to the full faith and credit due a court's judgment. *Id*. at 233.

At issue here is whether the Second Amended Plan, if approved by this Court, would give full faith and credit to the insurance laws of Maine, Massachusetts, and Washington. The Court concludes that it would.

In *Carroll v. Lanza*, 349 U.S. 411 (1955), the United States Supreme Court considered a negligence action brought by a Missouri worker against a general contractor in Arkansas, where he sustained injuries. Both Missouri and Arkansas had enacted a workers' compensation law that provided the exclusive remedy of the employee for a work-related injury. The Arkansas law, however, also allowed the injured employee to pursue common-law tort claims against a third party. The Supreme Court held that the Full Faith and Credit Clause did not make Missouri's statute a bar to enforcement of Arkansas' law. Arkansas had sufficient grounds to apply its own law because of its interest in protecting persons injured within its borders and, thus, "opened its courts to negligence suits against prime contractors, refusing to make relief by way of workmen's compensation the exclusive remedy." *Id*. at 412-13. In sum, Missouri law (compared with Arkansas Law) embodied "a conflicting and opposed policy," and Arkansas law did not embody "any policy of hostility to the public Acts of Missouri." *Id.* at 413.

Likewise, in *Hyatt I*, 538 U.S. 488, a former California resident who had moved to Nevada brought tort actions in Nevada state court against the California franchise tax board, alleging negligent misrepresentation, invasion of privacy, fraud, and other torts in connection with the board's assessments and penalties for taxes he allegedly owed. The Nevada Supreme Court applied Nevada law, which gave state agencies immunity for negligence but not for intentional torts.

Accordingly, the Nevada Supreme Court ordered the trial court to dismiss the negligence claim for lack of jurisdiction but allowed the intentional tort claims to proceed to trial. The tax board appealed.

The United States Supreme Court upheld the Nevada Supreme Court's decision. The Court emphasized that the Full Faith and Credit Clause does not require one state to apply another state's law that violates its "own legitimate public policy." *Id.* at 497 (internal quotations omitted). Nevada's choice of law in that case did not "exhibi[t] a policy of hostility to the public Acts of a sister State." *Id.* at 499 (citing *Carroll*, 349 U.S. at 413). Further, Nevada had "sensitively applied principles of comity with a healthy regard for California's sovereign status" by "relying on the contours of Nevada's own sovereign immunity from suit as a benchmark for its analysis." *Id*. at 499.

Following remand, a jury found in the taxpayer's favor and awarded him almost $500 million in damages and fees. The tax board again appealed to the Nevada Supreme Court, arguing that the Full Faith and Credit Clause required Nevada to limit damages to $50,000, the maximum that Nevada law would permit in a similar suit against its own agencies. The Nevada Supreme Court affirmed $1 million of the award. Instead of applying the Nevada statute applicable to suits against Nevada's own agencies, the Nevada Supreme Court applied a special rule for one case. On further appeal, the United States Supreme Court held that this decision of the Nevada Supreme Court violated the Full Faith and Credit Clause because it lacked the "healthy regard for California's sovereign status" and "reflect[ed] a constitutionally impermissible policy of hostility to the public Acts of a sister State." *Franchise Tax Board of California v. Hyatt*, 136 S.Ct. 1277, 1282-83 (2016) (*Hyatt II)* (citation omitted).

In the case *sub judice*, the evidence demonstrated that the Rehabilitator will use the If Knew Premium methodology in the implementation of the Plan. This methodology will assume a 60% lifetime loss ratio, which is the benchmark for a premium rate increase in Pennsylvania and most other states. The If Knew Premium methodology is used by insurance regulators nationwide to set long-term care insurance premium rates. The self-sustaining premium to be implemented in Phase Two of the Plan will likewise use a 60% lifetime loss ratio. *See* 31 Pa. Code §89a.117 ("Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least 60%[.]").

A review of the insurance statutes of Maine, Massachusetts, and Washington shows that these sister states share Pennsylvania's interest in ensuring that long-term care insurance premium rates are not excessive, unfairly discriminatory, or unreasonable in relation to the benefits provided under the policy.[17] This commonly-shared interest will be advanced, rather than impaired, by the Second Amended Plan, which seeks to correct SHIP's discriminatory premium rate structure; sets the premium rates to appropriate levels; and employs the If Knew

[17] The Maine Insurance Code requires that the state insurance regulator determine that the rate filings on health insurance policies comply with "the requirements that rates not be excessive, inadequate or unfairly discriminatory." 24-A Me. Stat. Ann. §2736. The insurance statute in Massachusetts provides that the insurance commissioner may "disapprove such form of policy if the benefits provided therein are unreasonable in relation to the premium charged, or if it contains any provision which is unjust, unfair, inequitable, misleading or deceptive, or which encourages misrepresentation as to such policy[.]" Mass. Gen. Laws Ann. Ch. 175 §108(8)(A). Likewise, the insurance statute in Washington provides that long-term care insurance rate increases are not permitted "if the benefits provided therein are unreasonable in relation to the premium charged." Wash. Rev. Code §48.18.110. These standards are similar to the Pennsylvania standard for adjusting long-term care insurance premium rates. *See* Section 353 of The Insurance Company Law of 1921, Act of May 17, 1921, P.L. 682, *as amended*, *added by* the Act of June 23, 1931, P.L. 904, 40 P.S. §477a.

Premium methodology to establish a premium level that is reasonable in relation to the benefits paid.

Alternatively, under an Issue-State Rate Approval Option, a state may opt out of the rate approval section in the Plan. If a state opts out, the Rehabilitator will file an application to increase rates for policies issued in that state to the If Knew Premium level. The regulator for the opt-out state will render a decision on the Rehabilitator's rate increase application; if it is only partially approved, the Rehabilitator will downgrade the benefits under the affected policies accordingly. Cantilo testified that policyholders in an opt-out state will still have four options, although they are not exactly the same as those offered in the Second Amended Plan. This does not render the Issue-State Rate Approval Option "coercive" or "nominal," as the Intervening Regulators assert; rather, it provides the issue state with a meaningful way to control the mix of benefit reductions and premium rate increases. It prevents the opt-out state from interfering with Pennsylvania's ability to rehabilitate SHIP. In sum, the Second Amended Plan gives a "healthy regard" for the insurance laws of other states by "relying on the contours of [Pennsylvania insurance law] as a benchmark for its analysis." *Hyatt I*, 538 U.S. at 499.

The Second Amended Plan does not follow the ordinary rate review process for a solvent insurer, but it preserves the substantive rights of SHIP's policyholders to have their premium reviewed by a qualified actuary and an insurance regulator to ensure that the rate is actuarially justified and reasonable in relation to the benefits. The Plan changes the forum for the premium determinations to the state responsible for the rehabilitation of SHIP, *i.e.*, Pennsylvania. The conflict between Pennsylvania law and the laws of Maine, Massachusetts, and Washington, if any, is one of procedure, to which this Court owes no deference. *See*

Wilson v. Transport. Ins. Co., 889 A.2d 563, 571 (Pa. Super. 2005) (citation omitted) (the "choice of law" analysis applies only to conflicts of substantive law, which "creates the rights and duties of the parties to a judicial proceeding").

The insistence of the Intervening Regulators that the Rehabilitator submit rate increase applications to 46 states, the District of Columbia, and the U.S. Virgin Islands renders a rehabilitation of SHIP an impossibility. Pennsylvania has a compelling interest in enforcing Article V, which protects "the interests of insureds, creditors, and the public generally" through

> *(i) early detection of any potentially dangerous condition in an insurer, and prompt application of appropriate corrective measures; (ii) improved methods for rehabilitating insurers, involving the cooperation and management expertise of the insurance industry;* (iii) enhanced efficiency and economy of liquidation, through clarification and specification of the law, to minimize legal uncertainty and litigation; *(iv) equitable apportionment of any unavoidable loss;* (v) lessening the problems of interstate rehabilitation and liquidation by facilitating cooperation between states in the liquidation process, and by extending the scope of personal jurisdiction over debtors of the insurer outside this Commonwealth; and (vi) regulation of the insurance business by the impact of the law relating to delinquency procedures and substantive rules on the entire insurance business.

Section 501(c) of Article V, 40 P.S. §221.1(c) (emphasis added).[18] Furthermore, as this Court observed in *Mutual Fire I*,

> the benefits of rehabilitation—its flexibility and avoidance of inherent delays—are preferable to the static and cumbersome procedures of statutory liquidation. The statute's purpose is, in the end, that to which we must give effect. That legislatively

[18] Section 501(b) of Article V states that its provisions "shall be liberally construed to effect the purpose stated in subsection (c)." 40 P.S. §221.1(b).

> stated purpose is "the protection of the interests of insureds, creditors, and the public generally...." and the "equitable apportionment of any unavoidable loss" through, *inter alia*, "improved methods for rehabilitating insurers...." Section 501 of the Act, 40 P.S. §221.1. No interest is served by adding to the delay which has already occurred in this case. On the contrary, the goals of Article V of the Act are better served by a rehabilitation which effectively ensures more distribution in a shorter period of time than would occur in liquidation.

572 A.2d at 803.

Here, the evidence established that the ordinary rate filing process often involves 6 to 12 months of preparation and years of review in some states. "No interest is served by adding to the delay which has already occurred in this case." *Mutual Fire I*, 572 A.2d at 803. Further, a state-by-state rate filing process would not address the inconsistent rate approvals from state insurance regulators, which leave SHIP with less revenue than needed and similarly situated policyholders paying vastly different premiums for the same coverage. Cantilo credibly testified that the Plan's premium rate methodologies and approval mechanisms are necessary to address the inequities in SHIP's current rate structure. The use of the If Knew Premium across all policies will put all policyholders on a level playing field because it is calculated on a seriatim basis.

In sum, under Article V, the Rehabilitator has the authority to propose, and this Court has the authority to approve, the Second Amended Plan's provisions regarding the establishment of premium rates for the four policyholder options in Phase One. The Full Faith and Credit Clause does not require the Rehabilitator to submit these premium rates to 46 states, the District of Columbia, and the U.S. Virgin Islands for their review and approval. This would fracture Pennsylvania's "own legitimate public policy" in the rehabilitation of SHIP, a Pennsylvania-

domiciled insurer. *Hyatt I*, 538 U.S. at 497. In no way does this aspect of the Second Amended Plan reflect "a policy of hostility to the public Acts of a sister State." *Id.* at 499. To the contrary, the interests of Maine, Massachusetts, and Washington in ensuring that long-term care insurance premium rates are not excessive, unfairly discriminatory, or unreasonable to the benefits provided will be advanced, rather than impaired, by the Plan.

Finally, the Court rejects the Intervening Regulators' arguments on comity. Application of comity is "a matter of judicial discretion," and Pennsylvania courts exercise comity "when application of another state's law contradicts no public policy of Pennsylvania and instead furthers a Pennsylvania policy." *Chestnut v. Pediatric Homecare of America, Inc.*, 617 A.2d 347, 350 (Pa. Super. 1992). The Plan has "sensitively applied principles of comity with a healthy regard" for the insurance laws of other states by "relying on the contours of [Pennsylvania insurance law] as a benchmark for its analysis." *Hyatt I*, 538 U.S. at 499.

Once this Court renders a judgment on the Second Amended Plan, it is Maine, Massachusetts, and Washington that owe this Court's judgment full faith and credit. *See Underwriters National Assurance Co. v. North Carolina Life and Accident and Health Insurance Guaranty Association*, 455 U.S. 691 (1982). *See also* 1 COUCH ON INSURANCE 3d §5:31 (discussing state court's violation of Full Faith and Credit Clause by refusing to treat prior judgment of another state's insurance rehabilitation court as *res judicata*).

2. The Plan Satisfies all Constitutional Requirements

The Intervening State Insurance Regulators argue that the Second Amended Plan is unconstitutional because it does not satisfy the standard that "[c]reditors and policyholders must fare at least as well under a rehabilitation plan

as they would under a liquidation." *Koken v. Fidelity Mutual Life Insurance Co.*, 803 A.2d 807, 826 (Pa. Cmwlth. 2002) (citing *Neblett v. Carpenter*, 305 U.S. 297 (1938)). In applying the *Carpenter* standard, this Court is guided by the three-part test adopted in *Mutual Fire II*.[19] The "threshold inquiry" is whether the state action "has operated to substantially impair a contractual relationship" in violation of Article I, Section 10 of the United States Constitution and Article I, Section 17 of the Pennsylvania Constitution.[20] *Mutual Fire II*, 614 A.2d at 1094 n.4. An impairment of contractual rights is not a *per se* violation of law. *Id*. If a particular policyholder is found to be worse off under a rehabilitation plan, the impairment could be considered "substantial," but the Court still needs to determine whether (1) the rehabilitator has acted for a legitimate and significant public purpose and (2) the adjustment of contractual rights is reasonable and of a nature appropriate to that public purpose. *Id*. To that end, the Court must be mindful that Article V is intended to protect "the interests of insureds, creditors, and the public generally[.]" Section 501(c) of Article V, 40 P.S. §221.1(c).

i. The Plan Satisfies Pennsylvania's Interpretation of *Carpenter*

Under the so-called "*Carpenter* test," a rehabilitation plan should be confirmed if creditors will fare at least as well under the plan as they would in liquidation. *Mutual Fire II*, 614 A.2d at 1093-94. As our Supreme Court has

[19] Several of the objectors to the Mutual Fire rehabilitation plan argued that the plan impaired their contractual rights. In analyzing their argument, our Supreme Court expressly adopted the three-part test announced by the United States Supreme Court in *Energy Reserves Group, Inc. v. Kansas Power and Light Co.*, 459 U.S. 400, 411 (1983), for determining when a state law may impair a contractual right. *Mutual Fire II*, 614 A.2d at 1094 n.4. Thus, whether an alleged contractual impairment is caused by a receiver's workout plan or a statute, the analysis is the same.

[20] Article I, Section 10 of the United States Constitution states, in pertinent part: "No State shall … pass any … Law impairing the Obligation of Contracts[.]" U.S. CONST. art. 1, §10. Article I, Section 17 of the Pennsylvania Constitution states: "No … law impairing the obligation of contracts … shall be passed." PA. CONST. art. I, §17.

explained, this does not mean that every single policyholder must satisfy that test. *See id*. at 1102 ("individual interests might have to be sacrificed or compromised in order to preserve the ultimate goal of [the rehabilitation] process[.]"); *see also Penn Treaty*, 63 A.3d at 453 ("[*Carpenter*] did not establish the broad principle that a rehabilitation plan is *per se* invalid unless every policyholder will fare as well in rehabilitation as in liquidation."). Instead, the Court is guided by the three-part test established by *Mutual Fire II*. *Penn Treaty*, 63 A.3d at 453.

Under that test, if a particular policyholder is found to be worse off under a rehabilitation plan than in liquidation, and that impairment is "substantial," the Court should confirm the plan so long as the Rehabilitator has acted for a legitimate and significant public purpose and the contractual modification is reasonable and appropriate to that public purpose. *Id.* In this regard, "[t]he Court must consider the greater good, including the consequences to the larger class of policyholders and the taxpaying public." *Id.* (citing *Vickodil v. Insurance Department*, 559 A.2d 1010, 1013 (Pa. Cmwlth. 1989)).

The Second Amended Plan meets that test. Even assuming, *arguendo*, that the Plan substantially impairs policies, it serves a legitimate and significant public purpose, and the policy modifications are reasonable and appropriate to that purpose. At the hearing, Special Deputy Rehabilitator Cantilo aptly observed:

> And the question that we were debating [was], is it reasonable, if a policyholder has been paying a quarter for a dollar's worth of insurance for decades, to adopt, as the workout plan, a plan in which the taxpayers step up to pay their remaining 75 cents.
>
> And what we concluded is that we could right size the policy, and we could create a set of options for policyholders that would enable them to get fundamental [long term care] coverage but pay reasonable rates like the rest of the country for that coverage and not shift all that burden to the taxpayers.

N.T., 5/17/2021, at 78-79. In short, the Plan narrows the Funding Gap, promotes fairness and equity among policyholders, and appropriately balances the interests of the policyholders and the broader taxpaying public.

ii. The Intervening Regulators' Interpretation of *Carpenter* is Flawed

The Intervening Regulators urge a rigid application of *Carpenter*, *i.e.*, that all policyholders must fare as well in rehabilitation as they would in liquidation. To that end, the Intervening Regulators compared the net present value of the benefits policyholders will receive under the Second Amended Plan with the net present value of the benefits they can expect to receive in a liquidation. Notably, the Court in *Carpenter* was comparing the cash payment to policyholders under a rehabilitation plan with the cash payment they would receive in a liquidation, at a time when there was no guaranty association protection for policyholders. Here, the alternatives are not cash payments but continued insurance coverage. The value comparison of coverage to SHIP policyholders in a rehabilitation as compared to a liquidation cannot be reduced to dollar amounts.

The Intervening Regulators' metric is one not actually used by policyholders when making the decision to purchase long-term care insurance. As testimony from Cantilo and Bodnar established, consumers choose their policy benefits and limits according to their personal circumstances. For example, a policyholder may wish to protect his estate against dissipation by an extended stay in a nursing home. Each policyholder will have different goals and different financial situations that will affect the type and amount of coverage they purchase. Not a single witness testified that the liquidation value of a policy figures into this analysis. Cantilo and Bodnar opined that the comparison methodology policyholders use is the maximum policy value, not the *Carpenter* value. Cantilo

provided compelling examples of actual SHIP policyholders whose *Carpenter* value, using the Intervening Regulators' proposed net present value metric, would, in fact, produce a poor option for that policyholder. *See* Ex. RP-56 at 102-03. The Court credits Cantilo's statement that "[t]here are many cases where the raw projection of future benefits less future premiums [doesn't] really tell you what the real value of the policy is." N.T., 5/17/2021, at 177.

In any event, even under the Intervening Regulators' metric, 85% of SHIP policyholders will be offered one option with a value equal to or higher than the value of the policy they will have in liquidation. Several other metrics produced even higher percentages of policyholders who will fare at least as well under the Plan as in liquidation.

3. The Plan is Feasible to the Extent Required by Pennsylvania Law

The Intervening Regulators argue that the Second Amended Plan is not feasible because it is unlikely to eliminate the Funding Gap and restore SHIP to solvency. To begin, there is no statutory requirement in Pennsylvania that a rehabilitation plan must be "feasible" in order to be approved, nor has that standard been adopted in our decisional law. The only reference to feasibility anywhere in Pennsylvania law occurred in the Mutual Fire receivership during the implementation of an already approved rehabilitation plan. *Mutual Fire II*, 614 A.2d 1086. The Intervening Regulators have not cited any other case in which "feasibility" appears. Notably, in *Mutual Fire*, the rehabilitator raised "feasibility" to support a request to modify the Court-approved rehabilitation plan. *Id*. at 1090. The Intervening Regulators' attempt to read a non-existent pre-approval "feasibility" requirement into Article V has no support in *Mutual Fire II*.

The Intervening Regulators argue that a "feasible" rehabilitation plan must be "reasonably likely to succeed in restoring the company to solvency" in order to be approved. Intervening Regulators' Post-Hearing Memorandum at 5.

First, the Court notes that the meaning of "company solvency" is context specific. The peak of SHIP's activity in the insurance marketplace was in the late 1990s, when it had more than 300,000 policies in force. N.T., 5/17/2021, at 40; Ex. RP-56 at 18. By 2003, when SHIP discontinued writing new business and went into run-off, the number of policies in force was already in a steep decline. N.T., 5/17/2021, at 40; Ex. RP-56 at 18. The Second Amended Plan, if successful, will restore SHIP to what it was pre-receivership, *i.e.*, an insurer winding down its long-term care insurance business and able, as a going concern, to continue coverage and pay the claims of its existing policies. The Court rejects the Intervening Regulators' suggestion that a return to solvency by SHIP requires more than a return to its pre-receivership status. SHIP had long ceased being an active and growing presence in the insurance marketplace.

Second, the Pennsylvania Supreme Court has stated that "[s]o long as the rehabilitation properly conserves and equitably administers 'the assets of the involved [insurer] in the interest of investors, the public and others, (with) the main purpose being the public good' the plan … is appropriate." *Mutual Fire II*, 614 A.2d at 1094 (quoting 2A COUCH ON INSURANCE 2d §22.10). Simply, the Court rejected the notion that a rehabilitation plan must contemplate a resuscitation of the insolvent insurer's operations.

Under any outcome, the Second Amended Plan will materially reduce the Funding Gap and significantly improve SHIP's financial condition. The Intervening Regulators offered no substantive evidence to overcome the

Rehabilitator's evidence on this issue. The Intervening Regulators correctly point out that the ultimate goal of the Mutual Fire rehabilitation plan was to restore the company to solvency. The Second Amended Plan has, as its ultimate goal, SHIP's return to solvency. It "does not have to restore the company to its exact original condition." *Mutual Fire II*, 614 A.2d at 1094.

Further, as a matter of public policy the rehabilitation of an insurer, where possible, is the preferred course. *Penn Treaty*, 63 A.3d at 440 (recognizing liquidation as a remedy of last resort); *Koken v. Legion Insurance Co.*, 831 A.2d 1196, 1230 (Pa. Cmwlth. 2003) (same); and *Mutual Fire II*, 614 A.2d at 1094 (same). As this Court explained, "a liquidation, no matter how 'successful,' is certain to cause harm to the policyholders, creditors and taxpaying public[.]" *Penn Treaty*, 63 A.3d at 461.

In summary, Article V does not require the Second Amended Plan be "feasible" in order to be approved, and the Intervening Regulators' arguments to the contrary simply voice a disagreement with the Rehabilitator's exercise of discretion. The Plan will eliminate or reduce the Funding Gap, which is a legitimate purpose. The ultimate goal of the Second Amended Plan is to return SHIP to the level of solvency needed to run-off its long-term care insurance business.

4. The Plan is Fair and Equitable

As stated, SHIP's current premium rate structure is unfairly discriminatory because policyholders with substantially similar coverage are not paying the same premium, thereby burdening some policyholders with subsidizing the premium payments of other policyholders. This Court has recognized that eliminating these unfair "subsidies between policyholders in different states and

between different groups of policyholders" is itself a legitimate goal of rehabilitation. *Penn Treaty*, 63 A.3d at 443, 460.

The Intervening Regulators argue that unless the Plan maintains SHIP's current unequal treatment of policyholders on a state-by-state basis, then the Plan is unlawful. The Intervening Regulators' position fails for several reasons.

First, the Intervening Regulators lack standing to assert the claim that the Plan treats "policyholders in different States differently." Intervening Regulators' Post-Hearing Memorandum at 32. They expressly disavowed that they were appearing in a *parens patriae* or other representative capacity for policyholders in their states. N.T., 5/19/2021, at 541-47. Even so, the Intervening Regulators failed to present any evidence showing how policyholders in their respective states would be unfairly treated by the Plan's proposal to eliminate unfair subsidies between groups of policyholders.

Second, the Plan will end the existing unequal treatment of similarly situated policyholders. The Intervening Regulators strain to characterize some policyholders as receiving "more" by "suffering smaller benefit cuts" when compared to other policyholders receiving "less" by "suffering greater benefit cuts." Intervening Regulators' Post-Hearing Memorandum at 38. This is a function of the fact that many policyholders presently pay an inadequate premium. The Court rejects the Intervening Regulators' characterization of right sizing premium to policy coverage as itself an act of unequal treatment.

To eliminate the unfair subsidies between policyholders, the change in rates or coverages will have a greater impact on the more underpriced (and over-subsidized) policies that have benefited at the expense of other policyholders. The Plan will require similarly situated policyholders to pay the same premium coverage.

The Plan's elimination of unfair subsidies between policyholders aligns with this Court's precedent in the Penn Treaty receivership, which recognized that a rehabilitation plan may properly eliminate such subsidies. *Penn Treaty*, 63 A.3d at 443, 460.

Third, the Intervening Regulators improperly invoke Section 544(b) of Article V, 40 P.S. §221.44(b), which states that no subclasses may be created within the policyholder class in a liquidation. As a threshold matter, this is a rehabilitation, not a liquidation. More fundamentally, the Plan does not give "some policyholders greater consideration than others." Intervening Regulators' Post-Hearing Memorandum at 35. To the contrary, the Second Amended Plan treats similarly situated policyholders the same regardless of the state in which their policy was issued.

D. Other Concerns and Objections Raised at the Hearing are Overruled or Have Been Adequately Addressed

1. Intervening Regulators' Application for Reconsideration

At the close of the hearing on May 21, 2021, this Court granted the Rehabilitator's oral motion "for judgment in the nature of a directed verdict" against the Intervening Regulators regarding the Issue State Rate Approval Option in the Second Amended Plan. N.T., 5/21/2021, at 981. The Rehabilitator argued that the Intervening Regulators did not present any evidence that their interests would be harmed by the Issue State Rate Approval Option, and as such, their objection to the Issue State Rate Approval Option cannot serve as a basis for this Court to disapprove the Plan. *Id*. at 986-88.

On June 1, 2021, the Intervening Regulators filed an application for reconsideration for the stated reason that the Rehabilitator's motion was vague, was made without notice and lacked support in the applicable court rules. More

specifically, the Intervening Regulators contend that the term "[I]ssue [S]tate [R]ate [A]pproval [O]ption" is not "meaningful," as "it is impossible to tell" whether it was referring to the "opt-out" provision under the Second Amended Plan. Application for Reconsideration at 7. They also contend that a motion for a directed verdict can be filed only in a "jury case" or an "adversarial proceeding," which is not the case here. *Id*. at 8, 12. Even so, to grant a motion for a directed verdict requires this Court to consider "all of the evidence before it in the light most favorable to the [Intervening] Regulators." *Id.* at 14. They assert that the Rehabilitator's motion "[f]ails on the [r]ecord" because Cantilo and Bodnar testified that the Plan seeks to "supersede the existing state rate approval system," which would impact state regulators and policyholders. *Id*. at 14-15. The Intervening Regulators' arguments are not persuasive.

To begin, the Rehabilitator's motion for a directed verdict was not vague. In moving for a directed verdict, the Rehabilitator's counsel stated that "the [Intervening Regulators] have failed to put on any evidence which would or could support an interest they purport to represent with respect to the issue[] state rate approval option." N.T., 5/21/2021, at 981-82. Counsel went on to assert that "absent any testimony as to the ways in which a regulator is constrained or harmed by that option, the [Intervening Regulators] here have no argument to present which would show that [the option] does not sufficiently address the concerns that they have raised at some earlier stage in these proceedings." *Id*. at 986. The Intervening Regulators objected to the motion for the reason that granting a directed verdict would be improper under the circumstances as the case presents "significant open legal issues." *Id*. 989. The Rehabilitator's counsel responded:

> To be clear, we're only seeking the directed verdict on the [I]ssue [S]tate [R]ate [A]pproval [O]ption issue. I don't have here where

> it was raised in the memorandum. We're not seeking a directed verdict as to, generally, the questions of whether the [P]lan is fair and equitable or the exercise of the [R]ehabilitator's discretion generally. This is a narrow motion, Your Honor, on the [I]ssue [S]tate [R]ate [A]pproval [O]ption and the opt-out offer thereunder[.]

Id. at 991.

After hearing arguments from both parties, the Court granted the motion. It stated that "there is an opt-out option that preserves the right of the [] … state of issue to pursue a state rate approval powers and [Intervening Regulators'] witness did not address why the [P]lan was deficient … in that way." *Id*. at 994. In short, the motion was not vague.

This Court also rejects the Intervening Regulators' argument that the Rehabilitator's motion for a directed verdict lacked due notice. The Intervening Regulators do not cite, and this Court did not find, any legal authority which would have required such notice. The Rehabilitator did not need to disclose her litigation strategy at the hearing with the Intervening Regulators. In any event, the Intervening Regulators were given an opportunity to file with this Court an application for reconsideration, which they did on June 1, 2021.

Nor did the Intervening Regulators cite any legal authority to support their proposition that a directed verdict can only be entered in a jury trial. Notably, the Intervening Regulators' proposition is at odds with their earlier position that this Court should have ruled on the legal issues before holding an evidentiary hearing on the Second Amended Plan.

Pennsylvania Rule of Appellate Procedure 106 provides:

> Unless otherwise prescribed by these rules the practice and procedure in matters brought before an appellate court within its original jurisdiction shall be in accordance with the appropriate

> general rules applicable to practice and procedure in the courts of common pleas, so far as they may be applied.

PA. R.A.P. 106. However, the Intervening Regulators point to Pennsylvania Rule of Appellate Procedure 3783(b), which provides that "[t]he Pennsylvania Rules of Civil Procedure shall apply to adversarial proceedings."[21] PA. R.A.P. 3783(b). Because an action to rehabilitate an insurer pursuant to Article V is a "formal proceeding," not an "adversarial proceeding," PA. R.A.P. 3772(f), the Intervening Regulators argue that it is not subject to the Rules of Civil Procedure.

The Intervening Regulators overlook the precept that the Court has discretion to conduct a statutory proceeding as is expedient and appropriate to move the case to a conclusion in a methodical fashion. *See, e.g., In re Tax Sale Held September 10, 2003 by Tax Claim Bureau of County of Lackawanna*, 859 A.2d 15, 18 (Pa. Cmwlth. 2004) (recognizing that while a trial court is not required to use the Pennsylvania Rules of Civil Procedure in tax sale proceedings, it has discretion to use the Rules of Civil Procedure where appropriate).

Here, the Rehabilitator seeks approval of the Second Amended Plan in this Court's original jurisdiction.[22] Pennsylvania Rule of Civil Procedure 226(b)

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[21] Rule 3772(c) defines "adversarial proceeding" as

> [a]ny action (1) initiated by the rehabilitator or liquidator against persons other than the insurer, (2) asserting a right or interest afforded by Article V and for which neither Article V nor prior orders of the Court provide an avenue for redress, and (3) that the Court determines shall be governed by Pa. R.A.P. 3783 (adversarial proceedings) as an adversarial proceeding.

PA. R.A.P. 3772(c). Pennsylvania Rules of Appellate Procedure 3771 to 3784 (Summary and Formal Proceedings Against Insurers) apply to all actions in the Commonwealth Court arising under Article V. PA. R.A.P. 3771-3784.

[22] 42 Pa. C.S. §761(a)(3) (This Court has "original jurisdiction of all civil actions or proceedings … [a]rising under Article V of the act of May 17, 1921 (P.L. 789, No. 285), known as 'The Insurance Department Act of 1921.'").

provides that a trial court may, "[a]t the close of all the evidence … direct a verdict upon the oral or written motion of any party." PA. R.C.P. No. 226(b). This Court has affirmed the entry of a directed verdict following a single-judge bench trial. *See, e.g., Geschwindt v. Wagner*, 1 A.3d 970 (Pa. Cmwlth. 2010) (affirming directed verdict entered by trial court following bench trial). This Court has entered directed verdicts in matters brought within its original jurisdiction. *See, e.g., Pennsylvania Human Relations Commission v. School District of Philadelphia*, 651 A.2d 177 (Pa. Cmwlth. 1993) (granting a school district's motion for a directed verdict by treating it as a motion for a compulsory nonsuit[23] against the Pennsylvania Human Relations Commission on the ground that it had failed to demonstrate that mandatory desegregation measures were feasible).

> A directed verdict can be entered in one of two circumstances:
>
> > one, the movant is entitled to judgment as a matter of law and/or two, the evidence is such that no two reasonable minds could disagree that the outcome should have been rendered in favor of the movant. With the first, the court reviews the record and concludes that, even with all factual inferences decided adverse to the movant, the law nonetheless requires a verdict in his favor. Whereas with the second, the court reviews the evidentiary record and concludes that the evidence was such that a verdict for the movant was beyond peradventure.

Hall v. Episcopal Long Term Care, 54 A.3d 381, 395 (Pa. Super. 2012) (quoting *Campisi v. Acme Markets, Inc.*, 915 A.2d 117, 119 (Pa. Super. 2006)).

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[23] While the trial court may, "[*a*]*t the close of all the evidence* … direct a verdict upon the oral or written motion of any party," PA. R.C.P. No. 226 (emphasis added), "the court, on oral motion of the defendant, may enter a nonsuit on any and all causes of action if, *at the close of the plaintiff's case on liability*, the plaintiff has failed to establish a right to relief." PA. R.C.P. No. 230.1(a)(1) (emphasis added).

The issue raised in the Rehabilitator's motion for a directed verdict is a narrow one: whether the Issue State Rate Approval Option is unlawful as the Intervening Regulators alleged. This is a mixed question of law and fact. The Intervening Regulators assert that the Issue State Rate Approval Option is coercive and provides them with no meaningful review of the rate filings. In their application for reconsideration, the Intervening Regulators contend that the "opt-out" provision cannot be "separated from the larger concern over superseding [s]tate rate approval statutes[.]" Application for Reconsideration at 7.

The Intervening Regulators did not present any evidence to support their challenge to the opt-out provision of the Plan. Cantilo credibly testified that if a state chooses to exercise the Issue State Rate Approval Option, the Rehabilitator will file an application on a seriatim basis to increase rates for policies issued in that state. The Intervening Regulators assert that the requirement that opt-out states act within 60 days and review the rate filings on a seriatim basis is "inconsistent" with "state practices." Application for Reconsideration at 16. However, no evidence in the record supports this claim.

In sum, the Intervening Regulators did not show that the Issue State Rate Approval Option is unconstitutional or otherwise is harmful to their interests. Collectively, those interests involve approximately 2,000 of the 39,000 policyholders affected by the Plan. Ex. RP-22 at 2. This Court properly entered a directed verdict on the Intervening Regulators' objection to the Issue State Rate Approval Option. However, this Court disagrees with the Rehabilitator's proposition that the Intervening Regulators should be dismissed from the rehabilitation proceeding. The Rehabilitator's motion was a narrow one, as was this Court's order granting the motion.

For the foregoing reasons, this Court denies the Intervening Regulators' application for reconsideration.

2. Policy Restructuring

NOLHGA and Lapinski raised concerns about the policy restructuring provisions in the Second Amended Plan that impact SHIP's tax liability. The restructuring will address potential taxable income owed by SHIP for cancellation of indebtedness and will bifurcate policy liabilities into funded and unfunded portions. This policy restructuring will not affect coverage for policyholders either now or in the event of a liquidation. Cantilo testified that the restructuring does not affect policyholder choices and will not be performed on a seriatim basis. N.T., 5/17/2021, at 143.

As a result of the concerns raised at the hearing, the Rehabilitator will file a separate application with this Court to address the restructuring and tax issues. N.T., 5/21/2021, at 996. All parties will have an opportunity at that point to raise objections.

3. Policyholder Communications

NOLHGA raised concerns regarding policyholder communications, especially with respect to information related to guaranty associations and their coverage limit. However, NOLHGA's president and fact witness, Peter Gallanis, acknowledged that the Rehabilitator has not refused to engage with NOLHGA regarding its concerns with the Plan or consider NOLHGA's proposed changes. N.T., 5/20/2021, at 686. NOLHGA is free to propose modifications to the Plan and continue to communicate with the Rehabilitator, as NOLHGA has done to date. Gallanis acknowledged that the Rehabilitator is a "capable commissioner" who understands the "important aspects" of the guaranty association system. *Id.* at 680.

4. COVID-19 Pandemic

Policyholder James Lapinski raised concerns regarding the impact of COVID-19 on long-term care insurance experience through higher mortality and lower claim incidence. With regard to this issue, Cantilo credibly testified that SHIP has experienced a moderate increase in mortality since the beginning of the pandemic in 2020, which generated a moderate increase in lapses of policies. The pandemic also caused a small increase in morbidity and adversely affected SHIP's expected yield on invested assets. However, the actuarial report prepared by Oliver Wyman shows that the aggregate effects of the pandemic had a moderate impact on SHIP's financial condition and are not material to the implementation of the Second Amended Plan. N.T., 5/17/2021, at 26; N.T., 5/21/2021, at 944.

Lapinski requested that the Second Amended Plan's discussion on COVID-19 be updated with more recent data. Oliver Wyman's actuarial report noted the evolving nature of COVID-19's impact and stated that while certain assumptions "were developed based on claims data predating the effects of COVID-19[,] [the actuarial team] will consider the effects of COVID-19 when [they] update [their] actuarial assumptions in 2021." Ex. RP-16 at 28. As Bodnar testified, upon approval of the Plan, Oliver Wyman will prepare an actuarial memorandum in support of the If Knew Premium rates, similar to one that would ordinarily be submitted to state regulators in a rate increase filing. All parties will have an opportunity at that point to raise objections.

5. Funding Gap and SHIP's Balance Sheet

Lapinski questioned the size of SHIP's Funding Gap and the decline of SHIP's capital and surplus and value of its bond holdings as reflected in its balance sheet ending December 31, 2020. In that regard, Cantilo provided extensive

testimony on SHIP's hazardous financial condition, the causes of SHIP's insolvency, and the actions taken by the Pennsylvania Insurance Department prior to rehabilitation. The evidence that the Second Amended Plan will substantially reduce the Funding Gap and address SHIP's inequitable rate structure was extensive. As for the decline in the value of SHIP's bond holdings, Cantilo credibly explained that it was due to a decline in yield in the markets in which SHIP's bonds were invested, which added to SHIP's deficit from 2019 to 2020. N.T., 5/21/2021, at 950-51.

6. Timing

Finally, Lapinski raised concerns with the timing of the rehabilitation proceeding and stated his desire for SHIP to avoid the lengthy process that Penn Treaty went through prior to liquidation. This Court shares Mr. Lapinski's desire to address SHIP's financial condition swiftly, as does the Rehabilitator. Cantilo testified that the Plan can be implemented quickly: within eight months of approval, the Rehabilitator anticipates receiving policyholder elections, which will enable her to measure the precise impact of Phase One on SHIP's Funding Gap. N.T., 5/18/2021, at 339-40.

V. Conclusions of Law

1. The Rehabilitator is authorized to "take such action as he deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate the insurer." Section 516(b) of Article V, 40 P.S. §221.16(b). This includes preparing "a plan for the reorganization, consolidation, conversion, reinsurance, merger or other transformation of the insurer." Section 516(d) of Article V, 40 P.S. §221.16(d).

2. Upon application of the Rehabilitator for approval of a plan of rehabilitation, and after notice and a hearing thereon, "the court may either approve

or disapprove the plan proposed, or may modify it and approve it as modified. If it is approved, the rehabilitator shall carry out the plan." Section 516(d) of Article V, 40 P.S. §221.16(d).

3. "[I]t is not the function of the courts to reassess the determinations of fact and public policy made by the Rehabilitator[]" in formulating a plan of rehabilitation. *Mutual Fire II*, 614 A.2d at 1091. "Rather, the involvement of the judicial process is limited to the safeguarding of the plan from any potential abuse of the Rehabilitator's discretion." *Id*.

4. The Rehabilitator's evidence established that the Second Amended Plan will conserve and equitably administer the assets of SHIP in the interest of policyholders, creditors and the public, "with the main purpose being the public good." *Id*. at 1094. The Plan is designed to return SHIP to its pre-receivership status as a run-off company able to meet its obligations as they come due.

5. The Rehabilitator's evidence established that the Second Amended Plan will reduce or eliminate the Funding Gap and eliminate SHIP's inequitable and discriminatory premium rate structure by offering policyholders meaningful choices to modify their long-term care insurance policies.

6. The Rehabilitator's evidence established that policyholders will fare as well or better under the Second Amended Plan than they would in liquidation. The Plan will provide the benefits of rehabilitation, such as flexibility and the accelerated disposition of claims, which is preferable to the static procedures of liquidation.

7. The Rehabilitator is authorized under Article V to establish actuarially sound premium rates for SHIP policyholders, as needed to rehabilitate

SHIP, and without the additional approval of the state insurance department where the policy was initially issued.

8. The Rehabilitator did not abuse her discretion in formulating the Second Amended Plan.

VI. Conclusion

The Rehabilitator has made a compelling case in support of her Second Amended Plan of Rehabilitation. Indeed, her evidence was not contradicted on any material fact. The Intervening Regulators suggest that they would have exercised their discretion differently, but this is not a basis for the Court to disapprove the Plan.

The opposition of the Intervening Regulators is based upon their belief that the state-by-state regulation of premium rates must be the starting point of any plan to rehabilitate an insolvent insurer. The Court has several responses.

First, the standard for an appropriate premium rate is substantially the same in every state: the premium must be reasonable in relation to the coverage provided in the policy. The evidence presented at the hearing demonstrated that the premium rates used in the four options in Phase One of the Second Amended Plan will satisfy that standard. The Rehabilitator will be tasked with proving satisfaction of that standard in her actuarial memorandum. The Intervening Regulators presented no evidence that she cannot or will not be able to do so.

Second, the Issue State Rate Approval Option preserves the state-by-state procedure for those states that share the concerns of the Intervening Regulators. To the extent a state does not believe that the Rehabilitator, and this Court, should be solely responsible for the task of establishing the seriatim premiums used for the four policyholder options in Phase One, the state can assume responsibility to do so by opting out of this aspect of the Second Amended Plan.

Neither SHIP's policies nor state rate regulatory statutes insulate policyholders from paying a reasonable premium for their coverage. To the contrary, they require the opposite. The Second Amended Plan will advance, not undermine, a reasonable and non-discriminatory premium rate structure, which is the point of rate regulation.

Essentially, the Intervening Regulators exalt the process by which insurance premium rates are set over the rehabilitation of an insolvent insurer whose condition was caused by an inadequate and discriminatory premium structure. As was established by the Rehabilitator's evidence, a rehabilitation of SHIP cannot be accomplished by placing the correction of the company's premium rates into the hands of 46 states.

In all respects, the Second Amended Plan satisfies applicable constitutional requirements. Neither the Full Faith and Credit Clause nor principles of comity require this Court to apply the insurance rate regulatory laws of other states when considering a plan to rehabilitate SHIP, a Pennsylvania domiciled insurer in receivership. Nevertheless, the Seconded 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

O R D E R

AND NOW this 24th day of August, the Court hereby ORDERS as follows:

1. The Application for Approval of the Plan of Rehabilitation for Senior Health Insurance Company of Pennsylvania (SHIP) filed by Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as Statutory Rehabilitator of SHIP, is GRANTED. The Second Amended Plan of Rehabilitation, filed on May 3, 2021, is APPROVED, with the exception of Section VI.N of the Plan (relating to suspension of agent and broker commissions).

2. The Court defers resolution of the Joint Application for Approval of Settlement Agreement, filed by the Rehabilitator and Intervenors ACSIA Long Term Care, Inc., Global Commission Funding LLC, LifeCare Health Insurance Plans, Inc, Senior Commission Funding LLC, Senior Health Care Insurance Services, Ltd., LLP, and United Insurance Group Agency, Inc., pending a hearing to be scheduled by separate order. The Rehabilitator shall continue paying commissions until Phase One of the Second Amended Plan of Rehabilitation is implemented.

3. The Rehabilitator shall promptly submit an actuarial memorandum in support of the If Known Premium rates to be used in Phase One of the Second Amended Plan of Rehabilitation to the Pennsylvania Insurance Department for its review and approval.

4. The Rehabilitator, in her capacity as Insurance Commissioner, shall designate an appropriate deputy insurance commissioner to review the actuarial memorandum submitted to the Insurance Department. Thereafter, the Rehabilitator shall submit the approved actuarial memorandum to the Court.

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

Order Exit
08/25/2021

EXHIBIT 5

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1 SHP 2020

EXHIBIT A

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

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

SEPTEMBER 30, 2021

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

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

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HOW TO PROVIDE COMMENTS AND OBJECTIONS

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

Formal Comments were required to be made by September 15, 2020, in compliance with the June 12, 2020 Case Management Order of the Commonwealth Court of Pennsylvania, which is available at www.shipltc.com. No provision has been made by the Court for additional Formal Comments.

THIS PLAN DOCUMENT PROVIDES DETAILS ABOUT THE PLAN APPROVED BY THE COMMONWEALTH COURT OF PENNSYLVANIA ON AUGUST 25, 2021, FOR SHIP'S REHABILITATION (THE "PLAN"). IT DESCRIBES IN DETAIL THE OPTIONS FROM AMONG WHICH SHIP POLICYHOLDERS CAN CHOOSE UNDER THE PLAN. EACH LONG-TERM CARE ("LTC") POLICYHOLDER WILL RECEIVE PERSONALIZED INFORMATION BEFORE HE OR SHE IS ASKED TO CHOOSE AN OPTION UNDER THE PLAN. THIS INFORMATION WILL BE PROVIDED IN A SIMPLIFIED FORMAT.

This version dated September 30, 2021, corrects an omission on page 19 of the September 24 version regarding disposition of the agent's commissions issue left open in the Court's August 25, 2021, Memorandum Opinion approving the Plan.

IMPORTANT NOTICE

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

THE PLAN ENVISIONS THE IDENTIFICATION OF THOSE SHIP POLICIES OF LONG-TERM CARE INSURANCE THAT ARE ACTUARIALLY PROJECTED TO BE UNDERPRICED IN PHASE ONE AND NON-SELF-SUSTAINING IN PHASE TWO, AS DEFINED IN THE PLAN DOCUMENT. THIS PLAN DOCUMENT ALSO DESCRIBES THE METHODOLOGY BY WHICH POLICYHOLDERS WHO HAVE SUCH UNDERPRICED OR NON-SELF-SUSTAINING LONG-TERM CARE POLICIES MAY ELECT FROM AMONG SEVERAL OPTIONS TO MAKE SUCH POLICIES APPROPRIATELY PRICED OR SELF-SUSTAINING. SOME POLICYHOLDERS WILL BE FOUND TO HAVE POLICIES THAT ARE ADEQUATELY PRICED OR SELF-SUSTAINING. THESE POLICYHOLDERS WILL NOT BE REQUIRED TO MODIFY THEIR POLICIES BUT WILL HAVE THE OPTION TO DO SO IF THEY SO CHOOSE. FOR POLICYHOLDERS WHO ARE REQUIRED TO MAKE SUCH ELECTIONS BUT FAIL TO DO SO, THE PLAN INCLUDES AUTOMATIC DEFAULT OPTIONS.

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

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

THE PLAN IS DESIGNED TO REDUCE OR ELIMINATE THE SHORTFALL BETWEEN SHIP'S PROJECTED LIABILITIES AND THE ASSETS AND PREMIUMS PROJECTED TO BE AVAILABLE TO FUND SUCH LIABILITIES. THERE CAN BE NO ASSURANCE THAT THE PLAN WILL SUCCEED IN THIS GOAL. IF THE PLAN FAILS IN THIS RESPECT, IT IS POSSIBLE THAT SHIP WILL BE PLACED IN LIQUIDATION. IN THAT EVENT, THERE CAN BE NO ASSURANCE THAT SHIP WILL BE ABLE TO FULFILL THE CONTRACTUAL OBLIGATIONS ENTAILED IN LTC POLICIES MODIFIED UNDER THE PLAN TO THE EXTENT THAT SUCH OBLIGATIONS INCLUDE UNCOVERED BENEFITS AS DEFINED IN THE PLAN DOCUMENT.

THIS PLAN DOCUMENT STRIVES TO PROVIDE AN EXPLANATION OF THE SIGNIFICANT ELEMENTS OF THE APPROVED REHABILITATION PLAN. NONETHELESS, IT IS POSSIBLE THAT ISSUES WILL ARISE THAT HAVE NOT BEEN ENVISIONED IN THIS PLAN DOCUMENT, AND THAT CHANGES AND EVENTS OCCURRING AFTER THIS PLAN WAS APPROVED BY THE COURT WILL REQUIRE ADDITIONAL ADJUSTMENTS TO THE PLAN. THE REHABILITATOR ANTICIPATES OBTAINING FROM THE COURT AUTHORITY TO MAKE SUCH CHANGES, OR TAKE SUCH ADDITIONAL STEPS, IN IMPLEMENTING THE PLAN AS SHE CONCLUDES ARE NECESSARY TO GIVE EFFECT TO THE SPIRIT OF THE COURT'S ORDER APPROVING THE PLAN. THE FINAL PLAN AS IMPLEMENTED MAY THEREFORE VARY IN SOME MEASURE FROM THE DESCRIPTION IN THIS PLAN DOCUMENT.

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REHABILITATION PLAN DOCUMENT

I. BASIC INFORMATION ABOUT THE PLAN

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

The Rehabilitation Order required that the Rehabilitator file a preliminary plan of rehabilitation by April 22, 2020. The Rehabilitator complied with this requirement and has since received many comments, formal and informal, about that preliminary plan of rehabilitation. In addition, the Special Deputy Rehabilitator and the rehabilitation team have continued their analysis of the many issues raised by the plan. As a result, on October 21, 2020, the Rehabilitator filed the ***Amended Rehabilitation Plan,*** among other things, addressing many of the issues raised in those comments. Additional comments have been received following the filing of the Amended Rehabilitation Plan and work continued to improve the plan. The ***Second Amended Rehabilitation Plan*** was filed with the Court on May 3, 2021, in contemplation of the hearing held by the Court beginning on May 17, 2021. Following the conclusion of that hearing and the submission of briefs, the Court approved the Proposed Rehabilitation Plan in a Memorandum Opinion and Order filed on August 25, 2021.

This document ("Plan Document") is intended to provide a sufficient description of the Approved Rehabilitation Plan (the "Plan") to enable policyholders and interested parties to understand the Plan.

Necessarily, many of the details of the Plan will have to be resolved during the implementation period. It is not possible to anticipate all of the implications of every aspect of the Plan before it is put in place. Nonetheless, this Plan Document provides a detailed description of how the changes contemplated by the Plan are expected to be implemented. Many or most existing company practices will continue as the Plan is implemented, and those current practices are largely not discussed in this document.

The details of the actual choices for, and projected impact upon, each policyholder will not be known until after the Plan provisions are calculated by the Company's systems. Those calculations may produce materially different results depending on the passage of time and changes

in both general and policyholder-specific circumstances. The cost and delay attendant to making the calculations for every policyholder in advance are not justified given that the results will may not be sufficiently accurate to be meaningful. However, beginning at page 68 there are illustrations of Plan options for several representative policyholders. This Plan Document therefore provides relative and directional guidance about Plan options rather than precise policy-level details for each one.

UNTIL THE PLAN EFFECTIVE DATE POLICYHOLDERS WILL HAVE THE SAME RIGHTS, BENEFITS, OPTIONS, AND OBLIGATIONS AS THEY DO NOW UNLESS THE PLAN SPECIFICALLY PROVIDES OTHERWISE.

A. SUMMARY DESCRIPTION OF THE PLAN

The following description of the Plan is intended to provide policyholders the basic general information required for them to understand the options that will be available to them under the Plan. Much more detail about the Plan and related matters is provided in the sections that follow.

1. GOAL AND PHASES OF THE PLAN

Recognizing that SHIP faces a substantial Funding Gap (described on page 87), the aim of the Plan is to increase revenues and reduce liabilities so as to narrow or eliminate that gap through a combination of ***Policy Modifications*** for most of the approximately 39,000 policies in force as of the filing of this Second Amended Rehabilitation Plan. Although the Plan has certain default provisions that apply when policyholders fail to make effective choices, it is structured to maximize policyholder choice, based on each person's individual circumstances and preferences. In proposing the Plan, the Rehabilitator recognized that many policyholders have costly policies that provide far more coverage than the policyholders are reasonably likely to require. Accordingly, a key element of the Plan is to enable policyholders to remove coverages that are not essential or even necessary to cover reasonable long-term care expenses. That is expected to help narrow the Funding Gap and potentially reduce their own premium, or at least avoid part or all of a necessary premium rate increase.

The Plan is designed to operate in three phases. ***Phase One***, commencing now, is the principal phase and will strive to reduce substantially or eliminate the Funding Gap. In this phase it will be determined which policies require modification because their Current Premium is below the ***If Knew Premium*** for the benefits offered by the policies. The If Knew Premium is an accepted methodology for setting premiums for long-term care insurance ("LTCI") policies, more fully explained at page 27. Policyholders with Current Premium (see page 122) below the If Knew Premium will have to increase their premiums or reduce their benefits so that the premium will be adequate on an If Knew Premium basis. Policyholders whose Current Premium is at or above the If Knew Premium will not be required to modify their policies (increase their premiums or reduce their benefits) but may choose to make some such modifications if they prefer to do so, as explained below.

In ***Phase Two***, the results of Phase One will be evaluated and additional Policy Modifications may be necessary for certain policies. It is expected that modifications in Phase Two will largely be based on ***Self-sustaining Premiums*** as explained at page 27. The goal of Phase Two will be to eliminate any Funding Gap not eliminated in Phase One. Only policies that meet the following conditions may be modified in Phase Two:

a. Their premiums are not already Self-sustaining,

b. They are not ***Fully Covered*** (*i.e.*, they are not within the limits of, or otherwise not covered by, the applicable Guaranty Association - see page 123), and

c. The policyholders have not selected ***Option Two (a or b)*** or ***Option Three*** (described below) in Phase One.

In ***Phase Three***, the Company will complete the run-off of the LTCI business in force. If there are sufficient funds to do so, in Phase Three the Rehabilitator will make payments to policyholders and other creditors on account of any amounts owed to them apart from policy liabilities (addressed in Phase One and Two).

2. POLICYHOLDER ELECTIONS

This section describes the key elements of these policyholder options. They are described in full detail beginning on page 24. In Phase One every policyholder whose Current Premium (including the premium they would be paying but for a premium waiver) is below the If Knew Premium for the policy's benefits will be required to elect one of four options. Those whose Current Premium (including the premium they would be paying but for a premium waiver) is at or above the If Knew Premium may keep their current policies without modification or may elect Option Two or Option Three, described below.

a. Option One will be to continue paying the Current Premium or to maintain the premium waiver if one is in effect, but if Current or waived Premium is less than the If Knew Premium, have benefits reduced in accordance with Plan provisions so that the premium for the reduced benefits (including waived premium) is equal on an If Knew Premium basis to the Current Premium. The benefit reductions will be selected automatically by the Plan.

b. Option Two will be to select certain policy endorsements that provide selected essential benefits (sometimes greater than the benefits provided by Option One) at a lower premium than Option Four. This option, of which an enhanced alternative will also be available, will not be subject to further rate increases or benefit reductions in Phase Two of the Plan. Option Two is designed to provide reasonable coverage at reasonable premium rates.

c. Option Three will be a ***Non-forfeiture Option*** (NFO) through which the policyholder will receive a Reduced Paid-up (RPU) policy providing limited benefits but for which no future premiums will be charged. Under the Plan, this option will include more generous benefits than the typical industry non-forfeiture option or reduced paid-up policy, most notably in that it will offer as much as a 30-month benefit period unless the current policy has a shorter benefit period. Moreover, policyholders who select this option will never have to pay additional premiums and this policy will never lapse.

d. Option Four will be to retain the current policy benefits and pay the corresponding If Knew Premium (unless equal to or lower than the Current Premium that the policyholder is paying). For many policyholders this may require a substantial increase in premiums.

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

Before being required to make an election, each policyholder will receive information detailing the premiums and benefits of each option. Special rules apply to policyholders who are not currently paying premium due to a Premium Waiver provision in their or their spouses' policies. These are explained fully beginning at page 31. Generally, such policyholders who elect Option Two or Option Four and whose Current Premium (the premium they would be paying but for the waiver) is lower than the If Knew Premium, will be required to pay a Differential Premium. The Differential Premium consists of the difference between (1) the premium they would be paying if there were not a waiver in effect (the Current Premium), and (2) the If Knew Premium corresponding to the policy. See Section II.E.7, page 29. If the Premium Waiver terminates, such policyholders will be required to pay the full applicable If Knew Premium (or Self-sustaining Premium if in Phase Two). Substantially the same options will be offered to policyholders on claim.

3. NO WORSE THAN LIQUIDATION

Every policyholder will be offered at least one option in Phase One that will provide him or her potential benefits equal to or exceeding those that would be available from the applicable Guaranty Association in the event of liquidation, but generally no more than the current policy benefits.

a. Policyholders with Current Premium (including the premium they would be paying but for a premium waiver) at or above If Knew Premium in fact will not be required to make any changes in their policies. Thus they will be treated at least as well as they would in liquidation, and perhaps better if their policies offer benefits in excess of those that would be offered by Guaranty Associations in liquidation.

b. Option Two will provide at least the benefit value that the Guaranty Association would provide in liquidation for every policyholder whose current policy provides benefits in excess of those limits. In many cases, other options will also provide the benefits that would be available from Guaranty Associations in liquidation. For policyholders with current benefits below Guaranty Association limits, Option Two will provide at least the current level of benefits.

In that respect, the Plan is designed to place policyholders in no worse off a position than they would face in a liquidation of SHIP.

4. DEFAULT OPTIONS

For every policyholder there will be a Default Option which will apply automatically if no proper election is made. In Phase One, for every policyholder whose Current Premium is at or above the If Knew Premium, the Default Option will be to leave the policy unchanged. However, if the Current Premium is below the If Knew Premium, there will be a Default Option that will be identified in the election materials (and is illustrated on page 67). In general, the Default Option will be Option One (the downgrade) for policyholders on Premium Waiver. However, if the Non-forfeiture Option (NFO) would provide these policyholders better benefits than the downgrade, the NFO will be the Default Option. For policyholders who are paying premium, Option Two (the Basic Policy Endorsements - see Section III.A.2.d, page 48) will be the Default Option.

In Phase Two, for every policyholder whose Current Premium is at or above the Self-sustaining level, the Default Option will be to leave the policy unchanged. However, if the Current Premium is below the Self-sustaining level, there will be a Default Option similar to Phase One. In general, the Default Option will be Option One (the downgrade) for policyholders on Premium Waiver. However, if the Non-forfeiture Option (NFO) would provide these policyholders better benefits than the downgrade, the NFO will be the Default Option. For policyholders who are paying premium, Option Two (the Basic Policy Endorsements) will be the Default Option.

The Default Option will apply if the policyholder fails to make an election by the applicable deadline or submits an election form that does not clearly identify the policyholder's election (for example because two or more options are elected). For a policyholder whose Current Premium is equal to, or higher than, the If Knew Premium (or Self-sustaining level in Phase Two), the Default Option will be to leave the policy unchanged, and no changes will be made to the policy unless specifically elected, even if the policyholder does not submit a proper completed election form. The Rehabilitator believes that between 25% and 40% of policyholders may be in this category in Phase One.

5. CHANGES IN POLICYHOLDER ELECTIONS

Policyholders will not have the opportunity to change their elections after the applicable ***Policyholder Election Date*** (the deadline for policyholder option elections under the Plan). Before the Policyholder Election Date, policyholders may change their elections by submitting new

Policyholder Election Forms if they are received before the applicable Policyholder Election Date. A new valid Policyholder Election Form received before the Policyholder Election Date will replace and invalidate a valid or invalid Policyholder Election Form submitted previously. If time permits, the Rehabilitator will attempt to reach policyholders who submit defective election forms (for example because they make no valid election or make more than one election) to attempt to correct the error. However, if there is insufficient time before the Policyholder Election Date, or if the Rehabilitator cannot reach the policyholder, the result of submitting a defective election form will be that the Default Option will be selected automatically under the Plan.

6. PHASE TWO ELECTIONS

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

7. EFFECT OF ELECTIONS

Policyholder Elections under the Plan will be permanent. This means that if the Plan does not succeed in rehabilitating SHIP fully and the Company has to be placed in liquidation, the policies to which guaranty association coverage and limits (see Section VI.J, page 92) will apply will be those as modified as a result of the Policyholder Elections. The elections are not intended to, and will not, eliminate the Unfunded Benefit Liability described in the discussion of policy restructuring (Section VI.H, page 91).

B. KEY CONSIDERATIONS FOR POLICYHOLDERS

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

In determining which option to elect, each policyholder should consider what is a reasonable level of benefits to be provided by his or her policy given his or her likely future needs, and the

ability of the policyholder to pay for such benefits. For example, there are very material differences between the costs of a policy that provides 5% compound Inflation Protection, one that provides 2% simple Inflation Protection, and one that provides no Inflation Protection at all. Similarly, there are material differences between the costs of a policy with lifetime benefits, one with a five-year benefit period, and one with a two-year benefit period. Moreover, features like Premium Waivers, Restoration of Benefits, Return of Premium, short Elimination Periods, indemnity rather than reimbursement, and "traditional" benefit triggers can all add materially to the cost of a policy but may not be indispensable to every policyholder.

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

For those fortunate policyholders who can afford material rate increases, Option Four might be attractive in that it would enable them to retain the most generous benefits, even at high premium rates. Many of these policyholders would face very large rate increases when selecting Option Four. This is because, in many cases, the premiums being paid for those policies are substantially lower than what they should be relative to the benefits promised. Moreover, policyholders selecting Option Four would face the possibility of additional substantial rate increases or benefit reductions in Phase Two of the Plan.

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

It is not practical to offer enough options to meet precisely every policyholder's expectations or preferences. Doing so would make the Plan too complicated and costly. The Special Deputy

Rehabilitator has led a team that has devoted intense efforts to the development of a manageable array of options that recognizes the major differences in policyholders' circumstances. While no one option may be ideal for a particular policyholder, the differences among the options are such that it is hoped that every policyholder will find at least one option that will enable that policyholder to emerge from SHIP's rehabilitation with adequate long-term care protection at reasonable premiums.

C. COVID-19

In December 2019, a new virus emerged in Wuhan, China, identified in due course as severe acute respiratory syndrome coronavirus 2, resulting in a pandemic of coronavirus disease 2019 ("COVID-19"). As of the filing of the Second Amended Plan, at least 140 million people had been infected worldwide, resulting in at least 3 million deaths. In the U.S., the first cases were reported in January 2020, with total estimates by then exceeding 32 million and fatalities exceeding 570,000. COVID-19 is particularly threatening to the elderly and those with impaired respiratory systems or other underlying health conditions. While intense work continues around the globe, no effective cure has yet emerged. There has been substantial progress in efforts to develop and distribute several effective vaccines. At the time the Second Amended Rehabilitation Plan was filed, more than one quarter of the U.S. population had been fully vaccinated, more than 40% having received at least one of two vaccines. The emphasis on vaccinating the older population first had resulted in nearly three quarters of those over 65 having received at least one dose, more than 60% having been fully vaccinated. As a result, COVID-19 mortality in nursing home and assisting living facilities has plummeted, approaching pre-pandemic levels after having peaked in December 2020. All told, more than 1.1 million residents and staff had by then been infected with the virus, and more than 133,000 succumbed to it.

The full impact of the COVID-19 pandemic on the U.S. insurance industry remains to be determined. The life insurance industry makes the following observations. Between March 2020 and February 2021, the number of actual deaths was 120% higher than the number of expected deaths.[1] This led to a 14% increase in mortality rates among group life claimants in the first quarter of 2020.[2] Excess deaths were concentrated "among those in the preferred underwriting class, particularly those ages 60 and older."[3] However, this has not increased life insurance premiums or decreased policy offerings.[4]

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[1] Susan Rupe, What Record Mortality Rates Mean for the Life Insurance Industry, INSURANCE NEWS NET (Apr. 14, 5:00 PM), https://insurancenewsnet.com/conference-post/what-record-mortality-rates-mean-for-the-life-insurance-industry.

[2] Id.

[3] Id.

[4] Andrew Keshner, Has COVID-19 Made Life Insurance More Expensive? MARKET WATCH, (Apr. 12, 12:00 PM), https://www.marketwatch.com/story/has-covid-19-made-life-insurance-more-expensive-these-researchers-say-they-have-the-answer-2020-12-07.

The impact on health insurers differs somewhat. Due to unemployment caused by COVID-19, between 3.1 and 27 million Americans lost employer-sponsored health insurance in 2020.[5] Health spending also dropped considerably, because of the cancellation of elective surgeries.[6] This loss was concentrated in the first half of 2020 but persisted enough to cause a 2.7% drop in non-prescription medical spending from 2019 to 2020.[7] This drop in spending could result in higher-than-average premium rebates for insureds.[8] Overall, health insurers fared well, with average gross margins at the end of the third quarter of 2020 for individual market and fully-insured group market plans almost 25% higher than in 2019.[9] Medicaid Advantage plans saw a 35% average gross margin increase over the same time period.[10] As a result, 2021 health insurance premiums are expected to remain largely unchanged.[11]

For long-term care insurance, the effects of the pandemic have been mixed. COVID-19 seemed to reduce long-term care insurance costs by (1) shortening the amount of time some insureds used benefits either because they died or because they left long-term care facilities, or (2) preventing some insureds from starting to use long-term care services.[12] A Fitch Ratings report indicates that the long-term care insurance industry gained roughly $2.5 billion in net operating profits from 2019 to 2020.[13] Actuaries are unsure about what effect COVID-19 will have on long-term care insurance over the long run, as COVID-19 could have "accelerated the deaths of people who were likely to die

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[5] Lola Butcher, How Health Insurance is Faring Under COVID, THE WEEK (Apr. 14, 2:00 PM), https://theweek.com/articles/975895/how-health-insurance-faring-under-covid.

[6] Cynthia Cox, Krutika Amin, and Rabah Kamal, How Have Health Spending and Utilization Changed During the Coronavirus Pandemic, PETERSON-KFF HEALTH SYSTEM TRACKER (Apr. 12, 1:00 PM), https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/#item-start.

[7] Id.

[8] Id.

[9] Daniel McDermott, et al., Health Insurer Financial Performance Through September 2020, KFF (Apr. 14, 4:00 PM), https://www.kff.org/private-insurance/issue-brief/health-insurer-financial-performance-through-september-2020/.

[10] Id.

[11] Cox, *supra* note 12.

[12] Long-Term Care Insurance Dashboard: 2020, FITCH RATINGS, (Apr. 14, 4:00 PM), https://www.fitchratings.com/research/insurance/long-term-care-insurance-dashboard-2020-improved-results-view-of-reserve-adequacy-unchanged-06-04-2021.

[13] Id.

soon . . . and spared healthier older people."[14] This would mean that the surviving elderly population could spend more time using long-term care services.[15]

However, this seems to vary from insurer to insurer. A Milliman survey covering April to September 2020 found that the overall use of long-term care benefits remained unchanged.[16] While active life mortality increased for most responding insurers, 40% of responding insurers saw a decrease or no change.[17] The death rate for insureds already receiving benefits decreased by 5% or more for two-thirds of responding insurers.[18] An American Academy of Actuaries issue brief suggests that the bulk of COVID-19 deaths in long-term care facilities "may be associated with Medicaid funded-homes, which might not house a meaningful number of insureds."[19]

The implications of COVID-19 for SHIP and the Plan fall in three major areas.

CASE MANAGEMENT: Restrictions on travel and personal contact imposed as preventive measures have cause SHIP to revise, at least temporarily, the manner in which it confirms eligibility for benefits and other aspects of case management. Although current protocols emphasize other means of communication, the Company remains attentive to the needs of its insureds as well as to the important function of preventing fraud, waste and abuse. At this juncture, these changes are not expected to have a material effect on the Plan or on the options it will offer to eligible policyholders.

MORTALITY AND MORBIDITY: Although sufficient reliable data is not yet available, preliminary data indicates that COVID-19 may be causing a decrease in the number of SHIP insureds filing claims and an increase in the number of deaths among the aging population insured by SHIP. While these unfortunate developments may combine to reduce slightly SHIP's deficit, it is possible that, at least in part, they are temporary. The Rehabilitator cannot yet project what, if any permanent impact, these consequences will have on the Plan but they are not expected to be material.

SUSPENSION OF PREMIUM PAYMENTS: Many SHIP policyholders had delayed making their required premium payment. While SHIP had delayed lapsing or cancelling policies for non-payment of premiums because of the exceptional circumstances, protracted delays in making these payments

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[14] Keshner, *supra* note 5.

[15] Id.

[16] Allison Bell, Long-Term Care Insurers Reveal Early COVID-19 Effects, THINK ADVISOR (Apr. 14, 3:30 PM), https://www.thinkadvisor.com/2021/03/18/long-term-care-insurers-reveal-early-covid-19-effects/ (of the 4 insurers that responded, one saw a 5-10% increase in benefit use, two saw a less than 5% decrease in benefit use, and one saw no change).

[17] Id.

[18] Id.

[19] Impact of COVID-19 on Long-Term Care Insurance, AMERICAN ACADEMY OF ACTUARIES (Apr. 15, 10:15 AM), https://www.actuary.org/node/14151

could have aggravated substantially SHIP's financial difficulties. Some regulatory agencies had requested or required that insurers (including SHIP) accommodate some premium deferrals, but many or most of these deferrals are also expiring or will soon expire. The net effect of the delays, therefore are also not expected to be material. Continued non-payment of premium beyond the expiration of the deferral period is expected to result in an increased number of policy terminations. The Rehabilitator has already observed a slight increase in the number of policy terminations that appear not to be the result of increased insured mortality. However, in the aggregate they are not expected to be material to the Plan.

D. TIMELINE

The order placing SHIP in rehabilitation required the Rehabilitator to submit to the Court a preliminary plan for SHIP's rehabilitation by April 22, 2020, and a subsequent case management order provided for policyholders and other interested parties to comment on the Plan through September 15, 2020. Over 100 people have submitted comments, some formal but most informal, and a few parties have also been admitted as intervenors. The Approved Rehabilitation Plan reflects the analysis of those comments and continuing work by the rehabilitation team.

At page 35 is a sequence of past and expected events in the presentation and implementation of the Plan. While it is difficult to predict future events in a matter of this complexity and under the current exceptional circumstances, a hearing on the Plan was held beginning on May 17, 2021. On August 25, 2021, The Court filed a Memorandum Opinion and Order approving the Second Amended Rehabilitation Plan with the exception of Section VI.N. relating to the suspension of agents' commissions, which was addressed in a separate hearing on September 8, 2021, and approved on September 13, 2021, along with a settlement between certain intervening agents and the Rehabilitator. Implementation of the Plan commenced following the entry of the Court's Memorandum Opinion and Order. We anticipate that most policyholders will be sent Policyholder Election Packages around year-end and be asked to make their elections by around mid March, 2022, becoming effective in April of next year. The details of options available to some policyholders and these dates may differ because of changes in their circumstances (see Subsection II.L.3, page 37) or decisions made by the senior insurance regulator of the states in which their policies were issued (see Section VI.V, page 108). It is also possible that changes in circumstances generally may result in changes in these dates. This matter is complex and delays in this timetable remain possible.

E. RATIONALE FOR THE PLAN

The Plan hinges on two essential assumptions: (1) in order to maximize policyholder protection, the Plan must strive to reduce the Funding Gap by increasing revenue and reducing liabilities; and (2) while premium rate increases can increase revenue by some increment, elimination by policyholders of long-term care coverage they may not truly need or be able to afford, especially at adequate premium rates, will go much further in remedying the Company's dire financial situation. The Rehabilitator believes that the Plan structure, which is the product of extended analysis by industry experts, offers a reasonable prospect of success based on sound principles.

1. The Plan gives policyholders more control over their fates, allowing each to elect the path best suited to his or her circumstances.

2. All policyholders will have at least one option for preserving their current coverage and at least one option for preserving their Current Premium.

3. Target premiums under the Plan take rate increase history and product differences into account, improving the equity of the premium rate structure. Generally, policyholders whose policies were issued in states that have approved comparatively more rate increases over preceding years will face lower premium increases or benefit reductions under the Plan.

4. It is important to note that Plan premium rate increases are not based on state of issue or state of residence. They are based exclusively on the characteristics of each individual policy, including the difference between Current Premium and If Knew Premium (in Phase One) or Self-sustaining Premiums (in Phase Two).

5. In every case, policyholders will have at least one option (Option Two) calibrated to provide outcomes no less favorable than liquidation, including applicable Guaranty Association benefits.

6. The revenue from rate increases under the Plan will go to pay claims and expenses of implementing the Plan whereas, in liquidation, Guaranty Association rate increases have historically been used to reduce assessment burdens for member insurers and not to increase the ability to pay claims.

7. Though certainly not guaranteed, the Plan structure inherently creates the possibility of greatly reducing, if not eliminating, the Company's deficit.

F. PLAN PROJECTIONS

The magnitude of SHIP's Funding Gap or deficit as of the Effective Date is difficult to predict because it is dependent on several changing circumstances over which the Rehabilitator has little or no control. However, the Rehabilitator believes that, depending on policyholder elections, Phase One of the Plan could greatly reduce, if not eliminate, the Funding Gap. Solely for purposes of directional guidance, the Rehabilitator has prepared some hypothetical results that could be expected from operation of the Plan. For purposes of these projections, it is assumed that SHIP's Funding Gap as of the Effective Date will be $1.2 billion. It should be emphasized that these are hypothetical projections dependent on future events that may evolve in a manner different from the assumptions in the projections. Subject to these caveats, it is the belief of the Rehabilitator that the Plan would produce the following results:

1. If 100% of disabled SHIP LTC policyholders and 80% of active SHIP LTC policyholders elect Option Four (retaining the current policy benefits and paying the rate increases necessary to reach If Knew Premium), the Funding Gap will be reduced by about $500

million, less than 50%, and a substantial additional reduction will have to be generated by Phase Two of the Plan. This scenario assumes that the remaining 20% of active policyholders would select Options One, Two or Three.

2. If 100% of disabled policyholders and 65% of active policyholders elected Option Four (the remaining 35% of active policyholders electing one of the other Options), the Funding Gap would be reduced by $650 million, an additional $150 million, a bit over half of the deficit.

3. If 100% of disabled policyholders elected Option Four and 100% of active policyholders elected one of Options One, Two or Three, the Funding Gap would be reduced by between 73% (over $850 million) and 86% (over $1 billion).

4. In any of these scenarios, election of an option other than Option Four by a material number of disabled policyholders would materially improve the results of the Plan in reducing the Funding Gap.

5. If 100% of SHIP's active and disabled policyholders elect either Option Two or Option Three, the entire Funding Gap would be eliminated and Phase Two would be unnecessary. If they elected Option One, about 93% of the Funding Gap would be eliminated.

As these projections suggest, the probability of the Plan's success increases materially the more policyholders elect to give up their benefit-rich policies and elect more affordable options. That anticipated probability of success does not vary nearly as substantially by choices among Options One, Two or Three as it does by choices between any of the other options vs. Option Four.

G. ORDER OF DISBURSEMENTS

Apart from the amounts owed to policyholders for benefits under long-term care insurance policies for which it is directly responsible, SHIP has a variety of other debts. For purposes of the Plan all of SHIP's debts are classified as falling into one of five categories, described in more detail below. These categories are consistent with the order of distribution promulgated in 40 P.S. § 221.44, governing distributions in liquidation. While SHIP is not in liquidation, the rehabilitation plan is designed to provide creditor distribution priorities that respect the order therein promulgated and to avoid unintended advantages and disadvantages in the payment of SHIP's debts. Payments will not be made to debts in a particular category until all debts owed to a higher category have been paid in full or reasonable provision has been made for their full payment. Creditors who are not paid in full retain the right to assert claims for unpaid amounts owed to them. Creditors in each category will receive pro-rata distributions of the amounts owed to them as assets become available for the payment of debts in that category.

1. ADMINISTRATIVE EXPENSES

This category, corresponding to that established in 40 P.S. § 221.44(a), includes the costs of conducting SHIP's business, including development and implementation of the Plan. Payments to

vendors for goods or services procured by the Rehabilitator are within this category. That includes employee salaries and benefits, consultant and counsel fees, office and equipment leases, utilities, bills for operating supplies, and other debts incurred in the course of operating SHIP's business.

2. POLICYHOLDER LIABILITIES

This category, corresponding to that established in 40 P.S. § 221.44(b), includes all claims for benefits arising under long-term care insurance policies issued directly by SHIP or its predecessors: American Travelers Life Insurance Company, Conseco Senior Health Insurance Company, and Teachers Protective Mutual Insurance Company. It does not include policies reinsured by SHIP but not issued by SHIP or its predecessors. See Section VI.M.7, page 98. It also does not include claims arising under SHIP's 46,000 non-long-term care insurance policies, for which Conseco Life Insurance Company is responsible. See Section VI.M.5, page 98.

3. CERTAIN FEDERAL PRIORITY CLAIMS

This category, corresponding to that established in 40 P.S. § 221.44(c), includes all claims of the federal government other than those owed to it as a policyholder, which would fall in Category 2, above. However, the Rehabilitator does not believe that SHIP has any insurance policy obligations to the federal government.

4. GENERAL CREDITOR CLAIMS

This category, corresponding to those established in 40 P.S. § 221.44(d-h) includes all other debts owed by SHIP except those described in Category 5, below. It encompasses, among other debts:

a. all employee benefits accrued pre-rehabilitation for employees separated from the Company (including retiree claims - see Section VI.O, page 100),
b. claims of state and local governments,
c. agent and broker commissions (see Section VI.N, page 100),
d. claims of ceding insurers under reinsurance treaties (see Section VI.M.7, page 98),
e. surplus note contribution claims, and
f. other claims not specifically enumerated in this Section.

The Rehabilitator does not contemplate establishing a new claim filing procedure and instead creditors may continue submitting bills and invoices in the ordinary course of business.

5. EQUITY CLAIMS

This category, corresponding to that established in 40 P.S. § 221.44(1). Includes the claims of shareholders and owners. As to SHIP, this would only be the claims of Conseco and the Senior Health Care Oversight Trust.

II. GENERAL PLAN DETAILS AND TECHNICAL INFORMATION

This Section of the Plan Document provides detailed and technical explanations of Rehabilitation Plan provisions for modification of SHIP's long-term care insurance policies. As modeling and analysis continue, additional refinements are possible. However, the fundamental Plan structure is unlikely to change unless the Court requires it. The following notes may aid in understanding this structure.

A. PLAN PHASES

The Plan is designed to occur in three phases. In ***Phase One,*** all LTC policies that are not in Non-forfeiture Option status will be evaluated and the holders of those the premiums of which are below the If Knew Premium level will be required to elect options to modify premiums or benefits, or some combination of the two. The results of this phase for the Company can vary materially depending on Policyholder Elections. They will be monitored and evaluated after Phase One becomes effective to gauge the results. In due course a decision will be made as to whether and, if so, how to implement Phase Two. ***Phase Two*** will be aimed at narrowing or eliminating any remaining deficit and its timing will depend on the results achieved in Phase One. Under the terms of the Plan, in Phase Two only policies the holders of which have not elected Option Two (Basic Policy Endorsements - see section III.A.2.d) or Option Three (Non-forfeiture Option - see Section III.A.3), that are not Self-sustaining (see definition at page 126), and which would not be Fully Covered by Guaranty Associations, will be affected. Holders of these remaining policies will again be asked to "right-size" them by modifying premiums or benefits, or a combination of the two. For that purpose, they will be offered options similar to those offered in Phase One. Depending on the results of Phase One, Phase Two may also include additional remedial measures. In ***Phase Three*** SHIP will conclude the run-off of its business in force, as modified by the Plan. In the event that funds are available, payment will be made to agents, ceding companies, policyholders, and other creditors on account of sums owed to them.

B. POLICYHOLDER CATEGORIES

1. For Plan implementation purposes, policyholders are sorted into eight main categories, four each in Phase One and in Phase Two:

    (1) Active - premium paying;
    (2) Active - not premium paying (further segregated between lifetime or dual Premium Waiver);
    (3) Disabled - premium paying; and
    (4) Disabled - not premium paying.

2. There may be some policyholders who do not fit neatly into the Plan's defined policyholder categories in each Phase, though none have yet been identified. If so, those will be addressed on an *ad hoc* basis.

C. POLICYHOLDER OPTIONS

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

   a. ***Option One*** - Keep the Current Premium (or Premium Waiver) and downgrade the policy to specified reduced benefits in a manner determined automatically by the Plan. The ***Downgrade Process*** is explained beginning at page 43. This will be solely a benefit reduction option;

   b. ***Option Two*** - Elect ***Basic Policy Endorsements*** (making the policy one designed to provide reasonable benefits and premiums - see Section III.A.2.d, page 48) at If Knew Premium (as defined below) in Phase One or at Self-sustaining Premium if elected in Phase Two. The Basic Policy Endorsements convert the existing policy to one with generally more affordable premiums than would be charged for the current policy benefits on an If Knew basis and more limited benefits when compared to the current policy. This option may entail both premium increases and benefit reductions for many policyholders, but premium increases will almost always be lower than under Option Four. For some policyholders it may entail a premium reduction. Many policyholders will be offered two variations of this option, a standard version and an enhanced alternative. Details of its provisions are laid out in Section III.A.2.d, page 48, below. As explained below, policyholders who elect this option in Phase One will not be asked to make Policy Modifications in Phase Two;

   c. ***Option Three*** - Elect a limited benefit Non-forfeiture Option, a reduced paid up policy on which no additional premium will ever be paid (see Section III.A.3, page 50); and

   d. ***Option Four*** - Keep the current policy benefits and accept a premium increase. The new premium will be (as defined below) the ***Phase One Premium*** (see page 127) in Phase One and the Self-sustaining Premium in Phase Two. This will be solely a premium increase option.

2. In summary, under the Plan, policyholders whose Current Premiums are below the If Knew Premium for their policies will be able to: (a) keep their Current Premium with downgraded benefits, (b) choose Basic Policy Endorsements, (c) take a NFO, or (d) to keep their current

benefits and pay additional premium. These will be the only options available under the Plan. Other options that are sometimes available in particular states in response to approved rate increases are not offered under the Plan.

3. As noted above, a Default Option will apply if a policyholder required to do so fails to make a valid election by the applicable deadline. For policyholders who are paying premium, Option Two (the Basic Policy Endorsements) will be the Default Option. For policyholders on Premium Waiver, the Default Option will be Option One (the downgrade) unless the NFO would provide these policyholders better benefits.

4. In Phase One, the estimated 25% to 40% of policyholders whose Current Premium on the Determination Date (see page 122) was at or above the If Knew Premium for the benefits offered by their policies need not modify their policies, and their policies would not be changed by selecting Option One or Option Four. Such policyholders may choose to do nothing, or they may select Option Two or Option Three if they wish to do so to accommodate their individual circumstances, for example to reduce their premiums or to avoid the possibility of a Phase Two rate increase. The Default Option for these policyholders will be that their policies remain unchanged.

5. NOTE THAT A POLICYHOLDER WITH PREMIUM AT OR ABOVE IF KNEW PREMIUM MAY NONETHELESS HAVE A NON-SELF-SUSTAINING POLICY (SEE PAGE 126) AND THEREFORE BE REQUIRED TO MAKE AN ELECTION IN PHASE TWO. SUCH A POLICYHOLDER WILL NOT HAVE TO MAKE A PHASE TWO ELECTION IF HE OR SHE HAS SELECTED OPTION TWO OR OPTION THREE IN PHASE ONE OR IF HIS OR HER POLICY IS FULLY COVERED (SEE PAGE 123).

6. Subject to the orders of the Commonwealth Court, the Plan contemplates that Basic Policy Endorsements elected in Phase One (Option Two) will be immune from Phase Two changes unless the Company is placed in liquidation. Policyholders who elect this option in Phase One generally will not face premium rate increases or additional benefit reductions in Phase Two of the Plan.

7. However, certain policyholders paying the lower ***Phase One Differential Premium*** or ***If Knew Differential Premium*** due to a Premium Waiver may be required to begin paying the full Phase One Premium or If Knew Premium if the Premium Waiver no longer applies (for example because a policyholder on claim recovers). Similarly, in Phase Two certain policyholders paying the ***Self-sustaining Differential Premium*** due to a Premium Waiver may be required to begin paying the full Self-sustaining Premium if the Premium Waiver no longer applies (again, for example, because a policyholder on claim recovers). See Section III.A.2.c, page 48.

8. Non-forfeiture Options elected in Phase One will not be subject to change thereafter, including in Phase Two or if the Company is placed in liquidation.

9. It is important to note, and policyholders will be advised before making such elections, that policies for which Option One or Option Four are chosen in Phase One may be subject to additional modifications in Phase Two. Moreover, the timing and details of the modifications that may be required in Phase Two will not be known to policyholders when they make their Phase One elections. In particular, policyholders will be advised that options to retain benefits that generate low premium rate increases in Phase One may result in additional premium rate increases or benefit reductions in Phase Two due to differences in the methodologies used to calculate premium rates in each phase.

10. The exceptions to this possibility of changes in Phase Two are the election of Basic Policy Endorsements or NFO (Options Two and Three, respectively) in Phase One. As noted below (see Section III.A.2.c, page 48), so long as the Plan remains in effect, and unless the Commonwealth Court orders otherwise, the Basic Policy Endorsements elected in Phase One will be immune from Phase Two changes except that (as explained above in Section II.C.6) certain policyholders on premium waiver (or their spouses) may be required to pay full Phase One Premium or If Knew Premium (instead of differential premium) when the waiver ceases to apply. The NFO is expected to remain permanent through policy termination.

11. The approximately 8,000 policyholders who have already chosen to replace their policies with Non-forfeiture Options before the Plan is implemented will not be asked, or have the ability, to make any changes to their policies as part of the Plan.

12. Beginning on the applicable Effective Date and while the Rehabilitation Plan is in effect, policyholders who fail to pay their premiums when due, or who otherwise terminate or lapse their policies voluntarily, will receive a notice that, as of the date on which the unpaid premium was due, or as of the date of their termination request or lapse notice, their policies will be converted to Non-forfeiture Options. However, they may request in writing that their policies be fully terminated. This would not apply to policyholders who have converted their policies to NFOs, from whom no premium is due.

D. CLAIM STATUS

For purposes of Policyholder Elections:

1. After the Plan is approved, a policyholder will be deemed to be on claim if he or she is receiving health care services that would be reimbursable by the Company were it not for an ***Elimination Period*** (EP) that has not been satisfied. Such a policyholder will be expected to begin receiving indemnity or reimbursement payments as soon as the EP is satisfied.

2. The Company may also determine that a policyholder has been on claim as of an earlier date when that policyholder has been receiving health care services reimbursable by the Company but has not reported such services to the Company. Such a policyholder is expected to be reimbursed for prior covered services when they are reported to the Company, subject to policy terms and conditions and applicable law.

E. PREMIUM RATE DETERMINATIONS

1. The Plan contemplates using different target premium rates in each phase. In the first phase, the target premium will be the Phase One Premium (a variation of If Knew Premium that can be no less than the Current Premium) for policyholders electing Option Four (retain their current benefits). Since in Option One, the premium remains the same, benefits are reduced to what that premium would "buy" at If Knew Premium rates as explained on page 42. For policyholders selecting Option One (retain Current Premium) or Option Two (Basic Policy Endorsements), the target premium will be the If Knew Premium for the policy's benefits. In Phase Two the target premium will be the Self-sustaining Premium.

2. The **If Knew Premium** rate is the rate that, if charged from inception, would have produced the greater of the initial target loss ratio or the minimum loss ratio applicable to the policy form. For the sake of simplicity, under the Plan this will be assumed to be 60%. If Knew Premium rates are intended to price policies adequately on a lifetime basis, but not to recoup losses due to inadequate pricing in the past.

3. For each policy for which the Current Premium is more than the If Knew Premium, the Phase One Premium will be the Current Premium. In short, in Phase One that policyholder can (but is not required to) retain the current policy at Current Premium without change. Correspondingly, for policies with a Current Premium lower than the If Knew Premium (which in this case would be the Phase One Premium), the downgrade required to maintain the Current Premium will be a reduction in benefits to a level that produces an If Knew Premium equal to the Current Premium as explained beginning on page 42.

4. Self-sustaining Premium is the premium calculated after evaluating the results of Phase One by determining the amount of premium required to eliminate a policy's ***Shortfall Amount*** in Phase Two.

    a. The Shortfall Amount is the difference between the policy's ***Projected Benefit Amount*** (PBA) and its ***Projected Credit Amount*** (PCA) where the difference is more than zero. The Shortfall Amount can also be expressed as a policy's ***Gross Premium Reserve*** (GPR) less its ***Allocated Assets***. If the difference is zero or less there is no shortfall and the policy is Self-sustaining.

    b. The PBA is the present value as of the valuation date of the sum of (1) unpaid expected policy benefits and (2) unpaid expected policy expenses. For purposes of this determination "expected" consists of best estimate assumptions.

    c. The PCA is the sum of (1) the present value as of the valuation date of expected premiums, adjusted for future premium increases reasonably expected to be put into effect and (2) the assets allocated to that policy as described below in subparagraph

II.E.4.e, page 28. Again, for purposes of this determination "expected" consists of best estimate assumptions.

d. ***Allocable Assets*** is a notional determination consisting of the Company's invested assets less reserves for costs of administration, contingencies, and certain debts of higher priority. The ***Asset/Premium Ratio*** is the ratio of Allocable Assets to the aggregate Accumulated Premiums for all LTC policies. ***Accumulated Premium*** is the total Gross Premiums paid, and premiums waived, under a policy or group of policies from inception until the valuation date.

e. **Allocated Assets** are the portion of the Company's Allocable Assets notionally allocated to a particular policy in accordance with the terms of, and solely for the purposes of calculations described in, the Plan. Such asset allocations are nominal and do not give a policyholder a right to any Allocated Assets or any particular sum of money. The assets allocated to each policy equal the product of the policy's Accumulated Premium times the Asset/Premium Ratio. This approach is designed to allocate assets equitably among policyholders solely for the purpose of calculating Phase Two premiums.

TABLE 1: ILLUSTRATION OF ASSET ALLOCATION		
1	Total Invested Assets	$1,500,000,000
2	Reserve for Costs of Administration	-$200,000,000
3	Contingencies	-$10,000,000
4	Priority Debts	-$50,000,000
5	**Total Allocable Assets (L1 - (L2...L4))**	**$1,240,000,000**
6	Total Accumulated Premium	$3,480,000,000
7	**Asset/Premium Ratio (L5/L6)**	**35.63%**
8	Accumulated Premium - Hypothetical Policy	$50,000
9	**Allocated Assets Hypothetical Active Policy (L7 X L8)**	**$17,816**

5. For policyholders on claim in Phase Two, the Self-sustaining Premium will be determined as if they were not on claim. For this purpose, assets will be allocated notionally to policies on claim as explained above.

6. Although this Plan Document assumes that in Phase Two determinations will be based on Self-sustaining Premiums, it is possible that, depending on the outcome of Phase One and other relevant considerations, in Phase Two the Plan will utilize an alternative premium

structure. That determination will be made before policyholders are required to make elections in Phase Two and the results of that determination will be included in information provided to policyholders before they are required to make such elections.

7. In certain instances the Plan uses a Differential Premium, which in each case is the difference between the target premium (Phase One Premium, If Knew Premium, or Self-sustaining Premium, depending on the option elected and whether this occurs in Phase One or Phase Two) and the Current Premium the policyholder would be paying if not on waiver. This element of the Plan is intended to avoid having premium-paying policyholders subsidize policyholders on premium waiver unfairly. Because the Phase One Differential Premium calculation is also based on If Knew Premium, policies on waiver that would require their holders to pay premium at or above If Knew Premium but for the waiver would not require Differential Premium. Thus, Differential Premium would only be charged to policies the waived premium of which would be deemed inadequate under Plan provisions. Differential Premium can never be less than zero. In cases in which the Current Premium is higher than the target rate, there would be no Differential Premium.

   a. Thus, in Phase One the Plan requires policyholders not paying premium, who elected Option Four (retain current benefits), to pay the Phase One Differential Premium consisting of the Phase One Premium less the Current Premium they would be paying if they were not on waiver (but not less than zero).

   b. Policyholders not paying premium who chose Option Two (Basic Policy Endorsements) in Phase One and whose current (waived) premium before making that election was lower than the If Knew Premium for the Basic Policy Endorsements will be required to pay the If Knew Differential Premium. This is the difference between the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements and the Current (waived) Premium for the policy, both of which are set as if the policyholder did not have a Premium Waiver in effect.

   c. Similarly, in Phase Two the Plan requires policyholders not paying premium who selected Option Two (Basic Policy Endorsements) or Option Four (retain current benefits) to pay the Self-sustaining Differential Premium consisting of the Self-sustaining Premium less the Current Premium they would be paying if they were not on waiver (but not less than zero).

TABLE 2: DIFFERENTIAL PREMIUM

		CASE 1	CASE 2
1	CURRENT PREMIUM	$2,300	$3,200
2	IF KNEW PREMIUM	$2,250	$3,500

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

8. For a policy's Shortfall Amount to be eliminated completely, the policyholder would need to pay the entire Self-sustaining Premium. The result of policyholders on premium waiver only paying Self-sustaining Differential Premiums is that the premiums charged for these policies are insufficient to cover their Shortfall Amount. To address the remaining shortfall that is not covered by these policies, a ***Self-sustaining Adjustment Factor*** will be calculated.

   a. The Self-sustaining adjustment factor will be a multiplicative adjustment applied to all policies' Self-sustaining premiums. It will be calculated to ensure that the sum of total premiums paid are sufficient to cover the total Shortfall Amount.

   b. The Self-sustaining Adjustment Factor will be calculated for all policies in the aggregate. The same adjustment will be applied to all policies' Self-sustaining Premiums.

   c. Policies on premium waiver are required to pay the Self-sustaining Differential Premium consisting of the Self-sustaining Premium less the Current Premium they would be paying if they were not on waiver (but not less than zero). The Self-sustaining Adjustment Factor will be calculated to ensure that the sum of Self-sustaining Premiums paid by premium-paying policyholders and Self-sustaining Differential Premiums paid by policyholders on waiver are sufficient to cover the total Shortfall Amount.

F. PENDING RATE INCREASES

There are a number of LTC policies for which SHIP has sought regulatory approval of premium rate increases that has been granted but the approved premium rate increases have not yet become effective. The following guidelines apply to such pending rate increases.

1. The Plan will assume that the approved premium rate increases will be implemented on the earlier of (a) the date on which they would have been implemented absent the Plan, and (b) the Plan Effective Date for each policy.

2. The ***Policyholder Election Package*** (see page 128) will describe premium rates for each option under the Plan reflecting implementation of the approved rate increases. Thus, for

some policyholders the Current Premium shown in the Policyholder Election Package will be higher than the policyholder's actual current premium by the amount of the pending approved premium rate increase. This will be true for policyholders for whom, if the Plan were not implemented, the approved premium rate increase would not take effect until after the Plan Effective Date.

G. PREMIUM WAIVERS

1. SHIP LTC policies may contain one or more ***Premium Waiver*** provisions under which a policyholder is permitted to discontinue paying premiums and maintain the policy in force during a period of covered care or under circumstances specified in the policy.

   a. Under a ***Claim Waiver of Premium*** (WOP) provision, a policyholder who receives benefits under his or her policy for a specified period of time (such as 90 days) is no longer required to pay premiums for coverage after that time period as long as the policyholder remains eligible for benefits and/or receives a specified level of care. Once the policyholder's eligibility for benefits ends, the policyholder is required to resume paying premiums in order to keep the policy in force.

   b. Under a ***Dual Waiver of Premium*** (DWOP) provision, also called "Spousal Waiver of Premium," a policyholder may suspend premium payments during the time that a spouse qualifies for waiver of premium.

   c. The ***Lifetime Waiver of Premium*** provision permits suspension of premium payments upon the death of a covered spouse after a qualifying period (typically five, seven, or ten years). The Lifetime Waiver of Premium provision, as the name implies, is permanent.

2. The Plan affects these Waiver of Premium provisions in specific ways. Policyholders who took a Non-forfeiture Option before the Plan became effective, or who do so under the Plan, do not pay premium and are not affected by Waiver of Premium provisions.

   a. **Claim Waiver of Premium.** Policyholders on Claim Waiver of Premium on the Policyholder Election Date will be treated as if that waiver continues with respect to the premium in effect at that time (the Current Premium).

      (1) If such policyholders elect Option One (downgrade), which does not entail a premium increase, the Current Premium remains waived and no Differential Premium is applicable. If such policyholders recover, their Current Premium must again be paid but their policies will remain downgraded.

      (2) If policyholders on Claim Waiver make an election under the Plan that increases their premiums (Option Two or Option Four, see page 24), the waiver does not apply to the increase and they will be required to pay

Differential Premium consisting of the difference between the premium under the elected Plan option and the Current (waived) Premium. When such policyholders recover and the Claim Waiver of Premium terminates, they must begin paying the full Plan premium. If such policyholders go on claim again following a specified period of recovery and their policy retains the Claim Waiver of Premium provision, the full ***Plan Premium*** (Phase One Premium, If Knew Premium, or Self-Sustaining Premium, depending on the circumstances) will be waived while they are on claim.

(3) Policyholders who elect Option Three, the NFO, are unaffected by Premium Waiver provisions because they do not pay premium.

b. **Dual Waiver of Premium.** Policyholders whose premiums are waived under Dual Waiver of Premium (DWOP) provisions will be treated in the same way as policyholders under Claim Waivers of Premium. However, it is the status of the spouse on claim that determines whether they pay the Differential Premium or the full Plan premium when they select Option Two or Option Four.

(1) If the policyholder has selected Option One, is not paying any premium due to the Spousal Waiver, and his or her spouse recovers, he or she must begin paying the Current Premium but his or her policy will remain downgraded.

(2) If the policyholder has selected Option Two, is paying only the If Knew Differential Premium due to the waiver, and his or her spouse recovers, the policyholder must begin paying the full If Knew Premium.

(3) If the policyholder has selected Option Four, is paying only the Phase One Differential Premium due to the waiver, and his or her spouse recovers, such policyholder must begin paying the full Phase One Premium.

(4) If the policyholder is on Dual Waiver, has a policy with Claim Waiver of Premium, selects Option Four, is paying Phase One Differential Premium or If Knew Differential Premium, and goes on claim after the Effective Date, the Differential Premium will then be waived under the Claim Waiver of Premium provision so that the policyholder will not have to pay any premium while on claim, even if the spouse recovers during that period. Once the policyholder recovers, he or she will be required to resume paying the Differential Premium if the spouse remains on claim and the dual waiver of premium is still effective. If the spouse has also recovered or the dual waiver of premium is otherwise no longer effective, the policyholder will be required to pay the full Phase One Premium or If Knew Premium upon recovery. If both policyholders whose policies contain a Dual Waiver provision select Option Four while neither is on claim, and one goes on claim after the

Effective Date, the full Phase One Premium for both policies would be waived.

c. **Lifetime Waiver of Premium.** Policyholders who are on Lifetime Waiver of Premium on the Policyholder Election Date will retain that waiver after the Plan Effective Date.

(1) If such a policyholder elects Option Four, the Lifetime Waiver of Premium does not apply to the increased portion of the premium and he or she will be required to pay Differential Premium consisting of the difference between the Current Premium and the premium under Option Four (the If Knew Premium). Of course, if the If Knew Differential Premium for that policyholder is zero, he or she need not pay any additional premium.

(2) If an active policyholder is on lifetime waiver, has a policy with Claim Waiver of Premium benefit, selects Option Four, and goes on claim after the Effective Date, the Differential Premium will then be waived under the Claim Waiver of Premium provision so that the policyholder will not have to pay any premium while on claim.

H. CERTAIN "NON-CORE" POLICY BENEFITS UNAFFECTED

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

1. Bed Reservation Benefit,
2. Respite Care,
3. Caregiver Training,
4. Medic Alert,
5. Prescription Drug Benefit,
6. Homemaker Services,
7. Personal Needs Benefit,
8. Accidental Death Benefit,
9. Helping Hands Benefit,
10. Adult Foster Care,
11. Ambulance Services,
12. Transportation Benefit,
13. Home Delivered Meals,
14. Assistive Equipment, and
15. Remodeling.

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

I. RATE APPROVALS

1. Rate increases and Policy Modifications will be submitted to Commonwealth Court of Pennsylvania for approval as part of the Plan. The Rehabilitator will not seek separate approval of rate increases or benefit reductions from insurance regulators in the states in which the policies were issued.

2. The rate increases will not necessarily be limited by, or adhere to, filed rate cards. Rate cards are issued by insurers and approved by regulators to describe the premium rates applicable under specified circumstances or for specific types of coverage. They are inapplicable to the Plan.

3. Premium increases and Policy Modifications will not be submitted to individual insurance departments for approval. The Rehabilitation team believes that this is consistent with the established insurance rehabilitation practice in the U.S. under which the domiciliary regulator as domiciliary rehabilitator may, with only rehabilitation court approval and no approval from individual states, implement a rehabilitation plan, including one that might modify or terminate insurance policies issued by the delinquent insurer throughout the country. If its premium rates were subject to approval in each state, the Plan could not meet its goal of eliminating "subsidies" by having policyholders with substantially similar policies generally pay substantially similar premium regardless of the state in which the policyholder resides or in which the policy was issued. Moreover, the delay and expense of "traditional" state-by-state rate or benefit approval would make the Plan unfeasible. Finally, the state-by-state approval process might perpetuate or increase the nation-wide premium rate variations the Plan strives to eliminate.

J. NFOs AND PAID-UP POLICIES

The Plan will not affect the approximately 8,000 policyholders who have already taken NFOs. Their policies will never pay premium and their benefits will not be reduced further by the Plan. The Plan also will not affect paid-up policies for which only a specified number of premium payments were required, including those for which some of those payments remain to be made.

K. PARTNERSHIP-QUALIFIED POLICIES

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

L. PLAN TIMING

1. The Plan is designed for implementation of Phase One as rapidly as possible, with more time available for implementation of Phase Two. At the conclusion of Phase One and continuously thereafter its results will be evaluated and, in due course, a determination will be made as to whether and, if so how, Phase Two should be implemented.

2. Table 3 provides a high-level sequence for the Plan.

TABLE 3: PLAN SEQUENCE	
1.	April 22, 2020 - Filing of Proposed Rehabilitation Plan and request for approval of notice
2.	June 12, 2020 - Case Management Order
3.	July 31, 2020 - Deadline for intervention applications
4.	August 21, 2020 - Deadline for responses to intervention applications
5.	September 15, 2020 - Deadline for Objections and Comments
6.	October 21, 2020 - Filing of Amended Proposed Rehabilitation Plan
7.	October 30, 2020 - Deadline for authorized interveners to file description of intended testimony and exhibits
8.	February 25, 2021 Scheduling Order
9.	May 3, 2021 Deadline for filing of Final Plan Amendments
10.	May 17, 2021 Hearing on Rehabilitation Plan
11.	July 31, 2021 Determination Date
12.	August 25, 2021 Memorandum Opinion and Order approving the Plan
13.	[TBD] Final Approval Date (assuming approval)
14.	Plan Preparation Period

15.	Begin Policyholder Transition Period
16.	[TBD] Policyholder Election Package
17.	[TBD] Policyholder Election Deadline
18.	Evaluation of Policyholder Elections
19.	[TBD] End Policyholder Transition Period
20.	[TBD] Initial Plan Effective Date
21.	[TBD] Supplemental Policyholder Election Package
22.	[TBD] Supplemental Policyholder Election Date
23.	[TBD] Supplemental Plan Effective Date
24.	Evaluation of Phase One
25.	[TBD] Decision on Phase Two
26.	[TBD] Phase Two Policyholder Election Package
27.	[TBD] Phase Two Policyholder Election Deadline
28.	[TBD] Phase Two Effective Date
29.	Evaluation of Plan performance
30.	[TBD] Phase Three, if justified.

a. The Plan has been submitted to the Commonwealth Court for approval, modification, or disapproval. Policyholders and interested parties have been provided an opportunity to offer comments about, or object to, the Plan. The Commonwealth Court held a hearing on the Plan beginning on May 17, 2021. Following the hearing, participating parties submitted post-hearing briefs to the Court. On August 25, 2021, the Court filed her Memorandum Opinion and Order approving the Plan with one exception relating to agents' commissions. [**AGENTS UPDATE**] The date upon which such approval becomes final (including exhaustion of appeals, if any) will be the ***Final Approval Date***. The ***Plan Preparation Period***, commenced with the Court's approval and will end with the ***Initial Plan Effective Date.*** During the Plan Preparation Period:

(1) SHIP's LTC insurance policies will be restructured as described in Section VI.H, page 91. This restructuring will not affect the options available to policyholders under the Plan.

(2) The Company will make all the determinations and perform the calculations required to construct the options available to each policyholder. All determinations will be made as of the July 31, 2021, ***Determination Date*** which may vary for some policyholders but which will always be before the Policyholder Election Date defined below.

(3) The Policyholder Election Package (containing the information required for policyholders to make their elections) and the ***Policyholder Election Forms*** (upon which they will do so) will be prepared and distributed.

(4) Except as noted below in Section II.L.3, page 37, the Policyholder Elections must be made by the Policyholder Election Date and will be collected and evaluated by the Company as received.

(5) On the ***Initial Plan Effective Date*** all the Policyholder Elections, other than those addressed in Subsection II.L.3.c and Section VI.V, page 108, below, will be implemented and the premium and policy changes will take effect.

(6) The Initial Plan Effective Date may vary from policyholder to policyholder. For each policyholder the Initial Plan Effective Date will be the policy's ***Monthiversary Date*** occurring during the ***Initial Plan Effective Month***. See definitions, pages 125 and 126.

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

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

a. Policyholders who have qualified for a Premium Waiver which has not yet become effective as of the Policyholder Election Date due to a waiting period or premium paying modal factor will be treated as if they were not paying premium on the Policyholder Election Date and will be required to elect from among the options available to policyholders not paying premiums. If their policies have ***Dual Waiver of Premium*** (DWOP) the same will be true for their spouses. If such policyholders (or their spouses eligible for DWOP) elect Option Two (Basic Policy Endorsements - see Section II.C.1.b, page 24), or Option Four (retain current benefits at Phase One

Premium - see Section II.C.1.d, page 24), they will be required to pay the full Phase One Premium or If Knew Premium, respectively, until the waiver becomes effective and to pay the Phase One Differential Premium or If Knew Differential Premium, respectively, thereafter.

b. Policyholders who have been deemed eligible for benefits, but the benefits are pending and they have therefore not yet gone on claim, will be treated as if they were on claim and be required to elect from among the options available to policyholders on claim, including the availability of Premium Waiver. Note that during the ***Policyholder Transition Period***, when policyholders whose policies contain DWOP are deemed eligible for benefits which are pending and therefore have not yet gone on claim, and are treated as if on claim, their spouses will also be treated as if on Dual Waiver of Premium.

c. Policyholders and the DWOP spouses of such policyholders who, during the Policyholder Transition Period, experience any of the following ***Transitional Events***:

(1) discontinue paying premium due to the activation of a Premium Waiver other than those described in subparagraph (a), above),

(2) go on claim (other than those described in subparagraph (b), above),

(3) recover and cease being on claim, or

(4) resume paying premium due to the deactivation of a Premium Waiver,

will all be required to elect new options from among those available to policyholders in their new circumstances. They will be provided new Policyholder Election Forms after the Policyholder Election Date, will have an opportunity to make new elections from among options applicable to policyholders in their new circumstances, and will have those elections implemented on a ***Supplemental Plan Effective Date***. If such a policyholder experiences a Transitional Event during the Policyholder Transition Period but the Company doesn't learn of it until after the policyholder has submitted an apparently valid Policyholder Election Form or after the Initial Plan Effective Date, the policyholder's election will be invalidated by the Transitional Event and the policyholder will be required to submit a new Policyholder Election Package before the Supplemental Plan Effective Date. If the Company learns of the Transitional Event after the Supplemental Plan Effective Date then the policy will be modified to implement the Default Option that would have applied had the Company learned of the Transitional Event before the Supplemental Plan Effective Date and the policyholder failed to make a valid election.

M. POLICYHOLDER INFORMATION

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

2. Phase Two - Before being required to make any elections in Phase Two of the Plan, each policyholder eligible to make elections in this Phase will receive a ***Phase Two Policyholder Election Package*** that includes notice and details of Phase Two of the Plan. These details will include the premium amount and/or benefit reductions that will apply to the policyholder's specific policy under each applicable option of the Plan in Phase Two.

N. CALCULATION NOTES

1. The assets allocated on an Accumulated Premium basis for determination of Self-sustaining Premium for purposes of Phase Two calculations will be those remaining after provision is made for administrative costs and contingencies as more fully explained above at Section II.E.4.d, page 28.

2. Whenever the Plan calls for adjustment of the ***Maximum Benefit Period*** (MBP) it will be calculated in increments of whole days.

3. Whenever the Plan calls for matching an existing premium rate, it may be by rounding the premium to the nearest dollar.

4. In calculating the Phase One Premium, the If Knew Premium, and other Plan provisions, periods on claim (including those followed by recovery) prior to the Initial Plan Effective Date will be taken into account and reduce the remaining benefit period. The operative benefit period for the policy will be what remains on the applicable Plan Determination Date. Thus, a policyholder whose initial Maximum Benefit Period was eight years when the policy was issued, but who has used five years of benefits (whether in one or more periods on claim) that were not restored or eligible for restoration, and therefore has three years remaining as of the Determination Date, will be deemed to have a Maximum Benefit Period of three years for Plan calculation purposes. The Phase One Premium and If Knew Premium will be calculated using the remaining benefit period. Thus, for this hypothetical policyholder, the premium will be calculated for a policy with a three year MBP.

5. In calculating reductions of the Maximum Benefit Period, for policies with two different pools of money, one (typically of two years) for Home Health Care and one (often longer, part of which may have been utilized) for Assisted Living Facility Care or Nursing Home Care:

   a. The Plan will treat the policy as having a single benefit period equal to the longer of those provided by the pools. The benefit periods provided by the pools will not be aggregated. Thus, the Maximum Benefit Period for Assisted Living Facility Care cannot be increased by adding the unused benefit period for Home Health Care or *vice versa*.

   b. Benefits paid under the policy, regardless of site of care, will reduce the new single benefit period.

   c. Pools shorter than four years will not be adjusted by the Plan. If benefits have reduced the benefit period below four years as of the Effective Date, it will remain at that level for Plan calculation purposes.

6. Policies that share a pool of benefits before the Policyholder Election Date, so that a policyholder whose benefit period is exhausted may continue receiving benefits under the shared pool until it is exhausted, will be treated for purposes of calculating premiums under the Plan as having a benefit period equal to the sum of the policy's benefit period and half of the shared pool's benefit period. Such policies will continue sharing a pool after the Plan. Elections made under the Plan will affect only the policy's benefit period, not the value of the shared pool. When such a policyholder goes on claim after the applicable Plan Effective Date, the claim will reduce the policy's benefit period first and then the shared pool. Policyholders sharing a pool need not make the same elections under the Plan.

   a. For a policyholder who elects Option One, the downgrade will affect only the policy's benefit period (which cannot be reduced below four years unless it is already below that) and not the shared pool.

   b. For a policyholder who elects Option Two, the policy's benefit period may be reduced but it will retain the possibility of benefits under the shared pool.

   c. The premium for a policyholder who elects Option Four will be calculated as if the policy had a benefit period equal to the sum of the policy's current benefit period plus half of the shared pool.

7. In determining a policy's ***Maximum Policy Value*** (MPV), which is the product of a policy's Maximum Benefit Period (MBP) times its ***Maximum Daily Benefit*** (MDB), changes attributable to claims and benefits (such as inflation protection) will be taken into account. For Plan purposes, MPV will be calculated as if the policyholder went on claim on the Plan

Effective Date. A policy with an unlimited benefit period will be deemed to have an unlimited MPV. The MPV for current (pre-election) benefits will be used to determine the floor for the Basic Policy Endorsements. A policy's MPV will be newly determined after giving effect to modifications resulting from policyholder elections and the resulting MPV will be used to determine whether the policy is subject to change in Phase Two.

8. The Plan contemplates that the minimum premium for Basic Policy Endorsements in Phase Two will be 110% of the Basic Policy If Knew Premium to discourage delaying the selection of Basic Policy Endorsements to Phase Two. See Sections IV.B.2.c, IV.C.1.b, IV.C.2.b.(4), IV.E.2.b, and IV.D.2.

9. Premium paying modalities (*i.e.,* monthly or quarterly payments) in effect before the Plan will be unchanged by the Plan unless necessary to give effect to a policyholder's election. If a policyholder is not paying premium prior to the applicable Plan Effective Date due to a waiver, and under the Plan he or she must begin paying a premium (such as a Differential Premium), the premium modality in effect prior to the waiver becoming effective will apply to the premium under the Plan.

10. Fees charged before commencement of the rehabilitation to premium payments based on modality (such as additional fees for monthly premiums) will continue to apply to premiums paid under the Plan on the same basis.

O. DRAFTING NOTES

1. As endorsements are drafted to implement policy changes, provisions not intended to be substantively affected will be left unchanged unless editing is necessary to implement the modifications selected.

2. As a result, for example, if a policy has an unlimited benefit period and a Restoration of Benefit provision, shortening the benefit period will not remove the Restoration of Benefit provision. However, the Restoration of Benefits provision cannot extend the benefit period beyond the newly shortened Maximum Benefit Period. Similarly, policies with limits in terms of days-of-care will remain so and not be converted to pool-of-money policies except by operation of the Downgrade Process or if the Basic Policy Endorsement is elected.

3. Replacement language to implement modifications will strive to eliminate ambiguities and add clarity.

4. If the language of the current policy does not differentiate clearly between Nursing Home and Assisted Living Facilities (ALF) coverage so that SHIP is now covering ALF care within the Nursing Home provision in those policies, electing the Basic Policy Endorsements will not eliminate ALF coverage but the Maximum Daily Benefits for ALF care will be limited to 75% of the policy's MDB for Nursing Home benefits.

III. DETAILS OF PHASE ONE OF THE PLAN

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

Policyholders who, as of the Phase One Policyholder Election Date, are paying premiums and are not disabled or eligible for benefits will have the following options.

1. OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS.

   a. Such policyholders can keep their Current Premium but will have policy benefits reduced if the Current Premium is less than the If Knew Premium for their policy benefits.

   b. The ***Downgrade Target Premium*** (see page 123) for this option is the Phase One Premium, which is the higher of the Current Premium and the If Knew Premium. For policyholders whose Current Premium equals or exceeds the If Knew Premium for their policies, no downgrade will be necessary because they are already paying the Downgrade Target Premium and Options One and Four will produce the same result - no change in their policies. For policyholders that elect Option One and whose Current Premium is lower than the If Knew Premium for their current policies, the benefit reductions will be calibrated to produce benefits for which the premium on an If Knew Premium basis will be within 2% of the Current Premium, *i.e.*, no lower than 98% nor higher than 102% of the Current Premium. A description of the Downgrade Process follows Table 4.

TABLE 4: IS DOWNGRADE NECESSARY?

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

c. DOWNGRADE PROCESS: A single combination of one or more of the benefit reductions described in Section III.A.1.f, page 45 below, will be selected by the Rehabilitator in accordance with the Plan provisions to reduce the policy's benefits to a combination with an If Knew Premium within 2% of the Current Premium. Policyholders will not have the ability to select specific benefit reductions.

(1) Not all of the benefit reductions on the list below will be applicable to all policies. For example, eliminating inflation protection features would not be applicable to a policy that has no such benefits. Similarly, shortening the Maximum Benefit Period would not be applicable to a policy with a benefit period that does not exceed four years. Thus, the list of potentially applicable benefit reductions may vary from policy to policy.

(2) Each benefit reduction option is expected to have a materially different effect on premiums, some reducing the required If Knew Premium more than others. The result of a particular benefit reduction may vary among different policies. Benefit reductions will be selected sequentially, beginning with the first potentially applicable benefit reduction for the policy in question. However, in some cases the Rehabilitator may skip over one or more possible benefit reductions (for example, because they are inapplicable, produce too large a reduction, or are non-scalable) in order to produce the If Knew Premium closest to the Current Premium.

(3) The Rehabilitator may also adjust a potentially applicable scalable benefit reduction up or down to simplify the process, for example by enabling fewer benefit reductions to be effected to achieve the desired premium level. Efforts will be made to minimize the number of benefit reductions applied to each policy.

(4) Except as noted in the next paragraph, benefits will not be scaled above or below ***Plan Limits***. Plan Limits for benefit period are a minimum of four years (unless the policy already has a lower MBP) and a maximum of 6 Years. Plan Limits for Daily Benefit are:

(a) For Nursing Home Care, a minimum of the lesser of (a) 80% of current level or (b) $300, and a maximum of $600;

(b) For Facility Care, a minimum of the lesser of (a) 80% of current level or (b) $225, and a maximum of $450; and

(c) For Home Health Care, a minimum of the lesser of (a) 80% of current level or (b) $150, and a maximum of $300.

(5) In order to achieve the Downgrade Target Premium (which is equal to the Current Premium), for some policyholders for whom other Benefit Reductions have not achieved the desired premium level, the MBP may be reduced below Plan Limits. For those policyholders for whom the Downgrade Option (Option One) is the default, the NFO serves as a safety net against reduction of the Maximum Benefit Period below the lesser of the current Benefit Period and 30 months. For other policyholders who select Option One and it produces a lower Benefit Period than the NFO or other Options, electing one of the other Options may be preferable.

d. The default mode will be to evaluate the potentially applicable benefit reductions in the order in which they are included in the Plan.

(1) If the first potentially applicable benefit reduction produces an If Knew Premium that is higher than 98% of the Current Premium it will be selected.

(a) If that first potentially applicable benefit reduction produces an If Knew Premium that is between 98% and 102% of the Current Premium, that will be the only benefit reduction and downgrade necessary for the policy in order to implement Option One.

(b) If the benefit reduction produces an If Knew Premium above 102 % of the Current Premium, is scalable, and can be scaled down sufficiently to produce an If Knew Premium no higher than 102% of the Current Premium without going below Plan Limits for MDB and MBP, then it will be scaled down sufficiently to achieve that result and that will be the only benefit reduction for the policy.

(2) If the first potentially applicable benefit reduction will not suffice (with or without scaling, if applicable) to reach an If Knew Premium within 2% of the Current Premium, the next potentially applicable benefit reduction will then be evaluated in the same manner, taking into account the effect of the previously selected potentially applicable benefit reduction.

(3) If the result is still an If Knew Premium that is higher than 102% of the Current Premium, that reduction will also be selected and the next potentially applicable benefit reduction will then be evaluated, again taking into account the effects of the previously selected potentially applicable benefit reductions.

(4) This process will continue until the resulting If Knew Premium is within 2% of the Current Premium. If it is within 2% of the Current Premium the process is complete and the potentially applicable benefit reductions selected will constitute the downgrade option for that policy.

(5) If the benefit reductions selected, in combination, produce an If Knew Premium that is lower than 98% of the Current Premium, the policy's MDB and MBP can be increased (subject to Plan Limits) to produce (in combination with previously selected benefit reductions) an If Knew Premium within 2% of the Current Premium. If raising the MDB and MBP (in combination with previously selected benefit reductions) still does not produce an If Knew Premium within 2% of the Current Premium, the policy's premium can be reduced so that the resulting If Knew Premium is within 2% of the Current Premium.

(6) If all of the benefit reductions selected in combination produce an If Knew Premium that is higher than 102% of the Current Premium, then in addition, the Maximum Benefit Period will be shortened to the extent necessary to produce an If Knew Premium within 2% of the Current Premium.

(7) In the unlikely event that after all these steps the If Knew Premium for the reduced benefits remains higher than 102% of the Current Premium, there will be no further reductions and those will be the downgraded benefits and the premium charged for those benefits will be the Current Premium.

e. Each policyholder will only receive one downgrade option, calculated as described in this Section. The Rehabilitator may develop algorithms, tables or other tools that will facilitate implementation of this process through classification of the existing policies. Policy provisions not identified in this Section will not be affected by the Downgrade unless necessary to implement the specified option.

f. ***Benefit Reductions*:**

(1) ***Benefit Reduction One*:** Elimination of Restoration of Benefits (ROB) provisions. This is a binary and non-scalable benefit reduction.

(2) ***Benefit Reduction Two:*** Elimination of Extension of Benefits provisions. This is a binary and non-scalable benefit reduction.

(3) ***Benefit Reduction Three:*** For policies with less restrictive triggers, adoption of the ***TQ Trigger***. See Section III.A.2.d.(7), page 49. This is a binary and non-scalable benefit reduction.

(4) ***Benefit Reduction Four:*** Discontinuation of Return of Premium (ROP) provisions. As of the Plan Effective Date, policies with Return of Premium benefit to which this reduction applies will cease accruing returnable premium. However, for policies which provide that returnable premiums accrue over several years and are then paid, or which make some past premium returnable upon specified events, ROP benefits accrued prior to the

Effective Date will not be lost and will be calculated up to the applicable Plan Effective Date. Such returnable premium accrued prior to the Effective Date will be repaid at or around the time when the payment would have been due absent modification under the Plan. This is a binary and non-scalable benefit reduction.

(5) ***Benefit Reduction Five*****:** Removal of inflation and "locking" of MDB at their current levels. This is a binary and non-scalable benefit reduction.

(6) ***Benefit Reduction Six*****:** Conversion of indemnity to reimbursement. See Section VI.B.12, page 85. This is a binary and non-scalable benefit reduction.

(7) ***Benefit Reduction Seven*****:** Reduction of the policy's MDB to the lesser of 80% of current level and $300 for Nursing Home Care; the lesser of (a) 80% of current level or (b) $225 for Facility Care; and the lesser of (a) 80% of current level or (b) $150 for Home Health Care. This is a scalable benefit reduction (that can be increased or decreased) so long as the resulting MDB is within Plan Limits.

(8) ***Benefit Reduction Eight*****:** Extension of the EP to 90 days. If the current EP is 90 days or more it will not be modified. The EP will apply to each period of care. This will be treated as a binary and non-scalable benefit reduction.

(9) ***Benefit Reduction Nine*****:** Reduction of the policy's MBP to no more than four years (from the applicable Plan Effective Date). If the current MBP is less than four years it will not be modified. As long as the resulting MBP is above the lesser of (a) the current period, or (b) four years, this is a scalable benefit reduction.

(10) ***Benefit Reduction Ten*****:** Elimination of all Waiver of Premium provisions. For purposes of the Plan this is a binary and non-scalable benefit reduction. The Plan will not allow elimination of fewer than all available Premium Waiver provisions. The elimination will be prospective only and will not apply to the current waiver. It will apply to any waiver that would otherwise first have become effective after the downgrade.

(11) ***Benefit Reduction Eleven:*** Conversion to pool of money (unless the policy is already pool of money) and reduction of the Maximum Benefit Period to the amount required to achieve the Current Premium.

g. The Downgrade is generally the Default Option for policyholders on Premium Waiver. In those cases, for those policyholders for whom the benefits that result from the Downgrade Process are lower than the benefits offered by the NFO, the NFO will be deemed the Default Option.

TABLE 5: DOWNGRADE PROCESS

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

1. Hypothetically, Benefit reductions One, Two, Three, and Four (BR1, BR2, BR3, and BR4) are inapplicable because the policy already has TQ Triggers, and no EOB, ROB or ROP benefits. Benefit Reduction Five (BR5) - Removal of inflation and "locking" of MDB at current level - hypothetically produces an If Knew Premium of $2,720, a 15% reduction. The If Knew Premium is still above $2,040, 102% of the Current Premium. This benefit reduction would be selected.

2. Benefit Reduction Six (BR6) would be inapplicable because this is already a reimbursement policy. Benefit Reduction Seven (BR7) - reduction of MDB to the lesser of 80% of current level or $300 - is evaluated in combination with previously selected BR5 and the result of reducing the MDB is hypothetically an If Knew Premium of $2,144 (a combined 33% reduction). The If Knew Premium remains above $2,040, 102% of the Current Premium. BR7 would also be selected and BR8 would be the next to be evaluated.

4. Benefit Reduction Eight (BR8) - Extension of the EP to not less than 90 days - is then evaluated in combination with BR5 and BR7, and the result of extending the EP to 90 days (in combination with BR5 and BR7) is hypothetically an If Knew Premium of $1,920 (a combined reduction of 40%). This reduces the premium below the target of 37.5%.

5. BR7 is then scaled up by increasing the MDB (but not above $600) to the point at which the If Knew Premium is $2,000, equal to the Current Premium, amounting to a 4% increase in the If Knew Premium of $1,920 produced by BR5, BR7, and BR8.

2. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT CORRESPONDING IF KNEW PREMIUM.

a. Active-paying policyholders will have the option to have their current policy endorsed to provide benefits substantially similar to a newly designed Basic Policy.

b. The new premium for the policy will be the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements.

c. **THIS OPTION WILL BE IMMUNE FROM PHASE TWO CHANGES. Policyholders who elect this option will not face premium rate increases or benefit reductions in Phase Two of the Plan.** However, under certain circumstances a policyholder who is paying the If Knew Differential Premium for the Basic Policy Endorsements because he or she is on Premium Waiver may be required to pay the full If Knew Premium if the waiver ceases to apply, for example due to recovery of the policyholder on claim.

d. Key provisions of the Basic Policy Endorsements are:

(1) MBP equal to the lesser of (a) the current benefit period, and (b) four years (beginning on the applicable Plan Effective Date);

(2) Minimum EP equal to the longer of (a) 90 calendar days, or (b) the current EP;

(3) Removal (discontinuation) of Return of Premium (ROP) benefit. As of the Plan Effective Date, policies with Return of Premium benefit will cease accruing returnable premium. However, for policies which provide that returnable premiums accrue over several years and are then paid, or which make some past premium returnable upon specified events, ROP benefits accrued prior to the Effective Date will not be lost and will be calculated up to the applicable Plan Effective Date. Such returnable premium accrued prior to the Effective Date will be repaid at the time when the payment would have been due absent modification under the Plan.

(4) Removal of Extension of Benefits provisions.

(5) For policies with annual inflation adjustment in MDB above 1.5%, reduction of the adjustment to 1.5%, retaining the original type (simple or compound);

(6) Reduction and adjustment of MDB by site of care. The MDB for Nursing Home Care will be the lesser of 80% of the MDB for such care in the current policy and $300. The MDB for Facility Care other than Nursing Home Care will be the lesser of 80% of the MDB for such care in the current policy and

$225. The MDB for Home Health Care will be the lesser of 80% of the MDB for such care in the current policy and $150;

(7) Adoption of ***Tax Qualified*** (TQ) Triggers. Tax Qualified or TQ Triggers require that a person 1) be expected to require care for at least 90 days, and be unable to perform 2 or more Activities of Daily Living (ADL - eating, dressing, bathing, transferring, toileting, and continence) without substantial assistance (hands on or standby); or 2) for at least 90 days, need substantial assistance due to a severe cognitive impairment. In either case a licensed healthcare professional must certify a plan of care;

(8) Conversion of reimbursement policies to indemnity;

(9) Conversion of "Days of Care" policies to "Pool of Money;"

(10) Removal of Restoration of Benefits (ROB) provisions; and

(11) Elimination of all Premium Waivers.

e. This will be the Default Option for policyholders in this category (active-paying) whose Current Premium is lower than the If Knew Premium.

f. Unless the benefits of their current policies are lower, policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher If Knew Premium with the terms described above but caps at a five-year benefit period and 2% inflation. In Phase Two the premium for the Enhanced Basic Policy Endorsements will be at Self-sustaining Premium rates. For a policyholder whose current policy has a Maximum Benefit Period of less than five years but inflation above 2%, the Enhanced Basic Policy Endorsements will only affect the inflation benefit. For a policyholder whose current policy has inflation below 2% but a Maximum Benefit Period of more than five years, the Enhanced Basic Policy Endorsements will only affect the Maximum Benefit Period. The inflation type (simple or compound) will be the same as the current policy.

g. Except as noted in the next paragraph, and with the exception of the change from reimbursement to indemnity, benefits in the Basic Policy Endorsements (even in the Enhanced Basic Policy Endorsements) cannot exceed those in the current policy. If a particular component of the Basic Policy Endorsements provides more coverage than the current policy's corresponding provision, that provision of the current policy will not be modified by endorsement. Thus, for example, if the MBP of the current policy is three years, the Basic Policy Endorsements for that policy will incorporate a Maximum Benefit Period of three, not four or five, years.

h. For those policies with an MPV that is currently above their applicable Guaranty Association (GA) limits, the endorsed policy's MPV will be adjusted so that it is at least equal to the applicable GA limit. For those policies with an MPV below the applicable GA limits, the MPV of the endorsed policies will be adjusted so that it is at least equal to the current MPV. The adjustments will be made by lengthening the MBP.

3. OPTION THREE - NFO.

a. Active-paying policyholders can elect a Non-forfeiture option (NFO) policy under which the MBP will be the lesser of 2.5 years and the policy's current MBP.

(1) Like the Basic Policy Endorsements, this will be an indemnity policy (not reimbursement);

(2) It will not have Extension of Benefits provisions;

(3) It will not have Return of Premium provisions;

(4) It will not have Restoration of Benefits provisions;

(5) It will convert "Days of Care" policies to "Pool of Money;"

(6) It will have a minimum 90-day elimination period;

(7) It will have TQ triggers;

(8) It will not have an inflation protection feature; and

(9) The Maximum Daily Benefit (MDB) will be reduced and adjusted for site of care. The MDB for Nursing Home Care will be the lesser of 80% of the MDB for such care in the current policy and $300. The MDB for Facility Care other than Nursing Home Care will be the lesser of 80% of the MDB for such care in the current policy and $225. The MDB for Home Health Care will be the lesser of 80% of the MDB for such care in the current policy and $150.

b. In those rare cases in which the specific policy provides for an NFO that has greater benefits than the Plan NFO, the policy-specific NFO will be offered instead.

c. No additional premiums will be due for this policy and it will never lapse.

d. Generally, this policy offers more benefits than traditional NFOs. It cannot be upgraded later.

e. The selection of indemnity, rather that reimbursement, modality for Options Two and Three is expected to be of significant value to policyholders.

4. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY PHASE ONE PREMIUM.

a. Active-paying policyholders can elect to keep their current benefits and their premiums will increase to the corresponding Phase One Premium. See Section I.A.1.a.(1)(a)i)a)69), page 127, above. Policyholders whose Current Premiums equal or exceed the If Knew Premium for their policies will continue to pay their Current Premiums. For those policyholders, this option, like Option One, does not result in any change.

b. Policyholders selecting this option may also face substantial rate increases or Benefit reductions in Phase Two.

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

Policyholders who, as of the Phase One election date, are NOT paying premiums due to the applicability of a premium waiver provision, but who are not disabled or eligible for benefits will have the following options.

1. LIFETIME WAIVER - Policyholders not paying premium due to Lifetime Waiver of Premium (because of the death of a spouse) will have essentially the same four options as premium paying active lives (see Section, III.A, page 42) with the following modifications:

a. OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS. If the Current (waived) Premium is equal to or greater than the If Knew Premium, the policyholder need not make any election, there will be no default downgrade, and Options One and Four will produce the same result - no change in their policies. If the Current Premium is less than the If Knew Premium the policy will be downgraded as follows.

(1) Due to the Premium Waiver the policyholder will continue not paying premium.

(2) The Downgrade Process will be the same as for premium-paying active lives (see Section III.A.1.c, page 43, above).

(3) The specific possible benefit reductions will be the ones described in Section III.A.1.f, page 45, above.

(4) The benefit reductions will be calibrated to the Current Premium as explained in Section III.A.1.b, page 42.

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

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

(1) The If Knew Differential Premium for this option is the difference between the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements and the Current (waived) Premium for the policy, both of which are set as if the policyholder did not have a Premium Waiver in effect. If the If Knew Differential Premium is less than zero, the policyholder will not be required to pay any additional premium for the Basic Policy Endorsements.

(2) Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher If Knew Premiums. See Section III.A.2.f, page 49.

(3) Policyholders who elect this option in Phase One will not face premium rate increases or additional benefit reductions in Phase Two of the Plan.

(4) If the current policy provides benefits (has an MPV) above the applicable Guaranty Association limits, the Guaranty Association floor on benefit reductions will be applied to these policyholders as described in Section III.A.2.h, page 50. If the current policy has an MPV below the applicable GA limits, the benefits of the endorsed policy will be adjusted so that the resulting MPV is at least equal to the current MPV.

c. OPTION THREE - NFO (see Section III.A.3, page 50).

d. OPTION FOUR - KEEP THE CURRENT BENEFITS AND PAY PHASE ONE DIFFERENTIAL PREMIUM.

(1) The If Knew Differential Premium for this option is the difference between the If Knew Premium and the Current (waived) Premium for the policy, both of which are set as if the policyholder did not have a Premium Waiver in effect. If the If Knew Differential Premium is less than zero, the policyholder will not be required to pay any additional premium.

(2) Policyholders who elect this Option may also face substantial rate increases in Phase Two.

2. DUAL WAIVER - The options for a policyholder not on claim but not paying premium due to a Dual Waiver (because his or her spouse is on claim) will be the same as for a policyholder not on claim with a Lifetime Waiver except that the premium he or she must pay will be determined in part by the spouse's claim status. The default for these policyholders will be Option One (Downgrade). However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, Option Three, the NFO, will be the Default Option.

a. OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS. The policyholder will retain the Current Premium Waiver. If the Current Premium the policyholder would be paying in the absence of waiver is equal to or greater than the If Knew Premium the policyholder need not make an election and the policy will not be downgraded by default. If the If Knew Premium is greater than the Current Premium the policyholder would be paying in the absence of waiver, the policy will be downgraded as follows:

(1) The Downgrade Process will be as described in Section III.A.1.c, page 43 subject to the following provisions.

(2) The same possible benefit reductions will apply, as described in Section III.A.1.f, page 45. Benefit reductions for each policyholder to whom this option applies will be calibrated to produce an If Knew Premium within 2% of the Current Premium for the policy (see Section III.A.1.b, page 42). However, because of the waiver, the policyholder will not be required to pay any premium.

(3) If the disabled spouse resumes paying premiums, the active spouse will also be required to resume paying premiums at the premium rate he or she would be paying if not on waiver, but if the policy has been downgraded it will remain downgraded.

b. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT IF KNEW DIFFERENTIAL PREMIUM.

(1) The policy will be modified through the Basic Policy Endorsements (See Section III.A.2.d, page 48). The policyholder will be required to pay the If Knew Differential Premium. The If Knew Differential Premium for this Option is the difference between the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements and the Current (waived) Premium for the policy, both of which are set as if the policyholder did not have a Premium Waiver in effect. If the If Knew Differential Premium is less than zero, the policyholder will not be required to pay any additional premium for the Basic Policy Endorsements.

(2) Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher If Knew Premiums. See Section III.A.2.f, page 49.

(3) If the current policies provide benefits above the applicable Guaranty Association limits, the Guaranty Association floor on benefit reductions will be applied to these policyholders as described in Section III.A.2.h, page 50. For those policies with an MPV below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that the resulting MPV is at least equal to the current MPV. The adjustments will be made by lengthening the MBP.

(4) Policyholders who elect this option in Phase One will not face premium rate increases or additional benefit reductions in Phase Two of the Plan, except as noted below.

(5) If the disabled spouse recovers, the active spouse will be required to begin paying the full If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements.

c. OPTION THREE - NFO.

(1) The policyholder can select a NFO. See Section III.A.3.

d. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY PHASE ONE DIFFERENTIAL PREMIUM: The policyholder will retain the current policy benefits and pay the Phase One Differential Premium (see Section II.E.7.b, page 29). However, if the disabled spouse recovers, the active spouse will be required to begin paying the full Phase One Premium. As noted, if the Current (waived) Premium is equal to or greater than the If Knew Premium, the policyholder will not be required to make an election or pay a Differential Premium.

C. DISABLED LIVES PAYING PREMIUM (*ON CLAIM - PAYING*)

Policyholders on claim, who are paying premiums, will have the same options as active lives paying premiums (see Section III.A, page 42), subject to the following conditions:

1. OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS.

a. Policyholders will preserve their Current Premium. For policyholders whose Current Premiums equal or exceed the If Knew Premium for their policies, no election will be necessary and no default downgrade would apply because they are already paying the Downgrade Target Premium and Options One and Four will produce the same result - no change in their policies. However, if the Current Premium is less than the

If Knew Premium, the policy will be downgraded using the Downgrade Process and benefit reductions described in Sections III.A.1.c, page 43, and III.A.1.f, page 45, above, subject to the following provisions.

b. The following Benefit Reductions would apply to new benefit periods after recovery:

(1) The changes in triggers described in Benefit Reduction Three;
(2) The change to reimbursement described in Benefit Reduction Six;
(3) The extension of elimination period described in Benefit Reduction Eight; and
(4) The elimination of premium waiver provisions in Benefit Reduction Ten.

c. The reductions will be calibrated to produce an If Knew Premium within 2% of the Current Premium for the policy (see Section III.A.1.b, page 42).

d. Note that the Downgrade Process does not increase the premium being paid prior to the downgrade, although in a few cases it may be reduced slightly.

2. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT IF KNEW PREMIUM. The policy will be endorsed as described in Section III.A.2.d, page 48, at If Knew Premium.

a. For those policies with an MPV that is currently above their applicable Guaranty Association limits, the endorsed policy's benefits will be adjusted to produce an MPV at least equal to the applicable Guaranty Association limits. For those policies with MPV below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that the resulting MPV is at least equal to the current MPV. The adjustments will be made by lengthening the MBP.

b. Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher If Knew Premiums. See Section III.A.2.f, page 49.

c. Changes in EP and benefit trigger would apply to subsequent periods of care following recovery.

d. This will be the default for these policyholders if their Current Premium is lower than the If Knew Premium.

3. OPTION THREE - NFO. See Section III.A.3.

4. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY PHASE ONE PREMIUM. Policyholders can elect to keep their current benefits and their premiums will increase to the Phase One Premium. Policyholders whose Current Premiums equal or exceed the If Knew Premium for their policies will continue to pay their Current Premiums. Policyholders who elect this Option may also face substantial rate increases in Phase Two.

5. In some cases, options like the Downgrade or Basic Policy Endorsements may result in a reduction of the benefits being received by the policyholder on claim at the time of the election. It is also possible that the If Knew Premium for the Basic Policy Endorsements will be lower than the policyholder's Current Premium.

D. DISABLED LIVES NOT PAYING PREMIUM (*ON CLAIM - WAIVER*)

Policyholders who, as of the Phase One Policyholder Election Date, are not paying premiums due to a premium waiver provision and are disabled or eligible for benefits will have the following options.

1. OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS.

a. These policyholders will preserve their Premium Waiver but, if the Current Premium they would be paying in the absence of waiver is less than the If Knew Premium, the policies will be downgraded. The Downgrade Process will be as described in Section III.A.1.c, page 43, and the benefit reductions described in Section III.A.1.f, page 45, above.

b. This is the Default Option for policyholders on claim with waiver of premium in Phase One. However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, the NFO (Option Three) will be the Default Option.

c. The reductions will be calibrated to produce an If Knew Premium within 2% of the Current Premium for the policy (see Section III.A.1.b, page 42). However, because of the waiver, the policyholder will not be required to pay any premium.

d. If the policyholder is required to resume paying premiums, the premiums will be at the rate the policyholder would be paying if not on waiver, but the policy will remain downgraded. Note that the Downgrade Process does not increase the premium being paid prior to the downgrade.

e. The following Benefit Reductions would apply to new benefit periods after recovery:

(1) The changes in triggers described in Benefit Reduction Three;
(2) The change to reimbursement described in Benefit Reduction Six;
(3) The extension of elimination period described in Benefit Reduction Eight; and
(4) The elimination of premium waiver provisions in Benefit Reduction Ten.

f. The reductions will be calibrated to produce an If Knew Premium within 2% of the Current Premium for the policy (see Section III.A.1.b, page 42).

2. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT IF KNEW DIFFERENTIAL PREMIUM.

a. These policyholder will have the option to have the current policy endorsed to provide benefits substantially similar to a newly designed Basic Policy. See Section III.A.2.d, page 48, above.

b. Policyholders will also be offered an "Enhanced Basic Policy Endorsement"at higher If Knew Premiums. See Section III.A.2.f, page 49.

c. Changes in EP and benefit trigger would apply to subsequent periods of care following recovery.

d. With the exception of the change from reimbursement to indemnity, no component of the endorsed policy can be richer than the current policy.

e. If the Current Premium the policyholder would be paying but for the waiver is less than the If Knew Premium for this policy, the policyholder must begin paying the If Knew Differential Premium. The If Knew Differential Premium for this option is the difference between the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements and the current premium for the policy, both of which are set as if the policyholder did not have a premium waiver in effect. As noted, if the If Knew Differential Premium is less than zero, the policyholder will not be required to pay any additional premium for the Basic Policy Endorsements.

f. If the disabled policyholder recovers, the waiver of premium benefit will no longer be applicable or available in the future, and he or she will be required to begin paying the full If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements, even if it is lower than the current waived premium.

g. Although they will be required to pay the full If Knew Premium rather than the Differential Premium upon recovery, policyholders who elect this option in Phase One will not face other premium rate increases or additional benefit reductions in Phase Two of the Plan.

h. For those policies with an MPV that is currently above their applicable GA limits, the endorsed policy's benefits will be adjusted to produce an MPV at least equal to the applicable Guaranty Association limits. For those policies with MPV below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that they produce MPVs at least equal to the current MPVs. The adjustments will be made by lengthening the MBP.

3. OPTION THREE - NFO. Policyholders can elect a Non-forfeiture Option (NFO). See Section III.A.3.

4. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY PHASE ONE DIFFERENTIAL PREMIUM. If the Current Premium the policyholder would be paying in the absence of waiver is equal to or greater than the If Knew Premium, the policyholder will not be required to make an election or pay a Differential Premium.

   a. Policyholders on claim with Premium Waiver (whose waived premium is below the If Knew Premium) can keep their current policy benefits.

   b. Their Premium Waiver (including Lifetime and Dual) will apply only to the Current Premium they would be paying absent the waiver. If the Current Premium the policyholders would be paying but for the waiver is less than the If Knew Premium for this policy, they will be required to begin paying the corresponding Phase One Differential Premium. (See Section II.E.7.b, page 29).

   c. If the policyholders recover, they will be required to begin paying the full Phase One Premium.

IV. DETAILS OF PHASE TWO OF THE PLAN

Phase Two will be implemented as and when deemed necessary by the Rehabilitator depending on the results of Phase One. As currently contemplated, it will be similar in structure to Phase One though based on Self-sustaining premiums rather than If Knew Premium. THE DETAILS OF PHASE TWO CALCULATIONS ARE SUBJECT TO CHANGE AND REFINEMENT DEPENDING ON THE RESULTS OF PHASE ONE AND INTERVENING EVENTS. POLICYHOLDERS WHO WERE REQUIRED TO PAY MODERATELY HIGHER PREMIUMS FOR OPTION FOUR IN PHASE ONE MAY BE REQUIRED TO PAY MATERIALLY HIGHER PREMIUMS TO PRESERVE THEIR COVERAGE IN PHASE TWO.

A. APPLICATION

1. Throughout the period that follows implementation of Phase One, the Company's financial condition will be monitored with emphasis on projected changes in the Company's deficit.

2. The evaluation of the Company's condition will include a determination of the magnitude of additional remedial measures required to eliminate any projected remaining deficit. The evaluation will include projections of the effect of Phase One over time.

3. A decision will then be made as to whether, when, and how Phase Two should be implemented.

4. Phase Two adjustments will only be made to policies that:

   a. Are not Fully Covered by the applicable Guaranty Association limits (*i.e.,* have Uncovered Benefits),

   b. Are not Self-sustaining (because the sum of projected benefits and expenses exceeds the sum of allocated assets and projected premium), and

   c. Did not elect Option Two (Basic Policy Endorsements) or Option Three (NFO) in Phase One.

5. Phase Two adjustments will be calculated after the results of Phase One adjustments have been incorporated.

6. While policy modifications in Phase Two will largely be based on Self-sustaining Premiums rather than If Knew Premium, it is possible that, depending on the outcome of Phase One and other relevant considerations, an alternative premium structure will be used in Phase Two. That determination will be made before policyholders are required to make elections in Phase Two and the results of that determination will be included in information provided to policyholders before they are required to make such elections.

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

Policyholders who, as of the Phase Two Policyholder Election Date, are paying premiums and are not disabled or eligible for benefits will have the following options.

1. OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS.

   a. Such policyholders not on claim paying premium can elect in Phase Two to keep the premium rate resulting from Phase One and reduce benefits to eliminate the policy shortfall.

   b. The benefit reduction process and options will be the same as in Phase One (see Section III.A.1.c page 43) but the current benefits will be reduced so that they produce a Self-sustaining Premium that is within 2% of the policyholder's Current Premium.

   c. As in Phase One, each policyholder will only receive one downgrade option, calculated as described in Section III.A.1.c.

2. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING PREMIUM.

   a. Active-paying policyholders can choose to have their current policy endorsed to provide benefits substantially similar to a newly designed Basic Policy. See Section III.A.2.d, page 48.

   b. This is the Default Option for premium paying active lives in Phase Two.

   c. Premiums will be set to the corresponding Self-sustaining Premium level. The premium for this option will be no less than 110% of the Basic Policy If Knew Premium for this policy reflecting the cost of delay in making this election until Phase Two.

   d. Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 49.

   e. With the exception of the change from reimbursement to indemnity, post-endorsement benefits cannot exceed those in the current policy. If a particular component of the Basic Policy Endorsements provides more coverage than the current policy's corresponding provision, that provision of the current policy will not be modified by endorsement.

   f. For those policies with an MPV that is currently above their applicable GA limits, the endorsed policy's benefits will be adjusted to produce an MPV at least equal to the applicable Guaranty Association limits. For those policies with an MPV below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that they produce MPVs at least equal to the current MPVs. The adjustments will be made by lengthening the MBP.

3. OPTION THREE - NFO. Such policyholders can elect a Non-forfeiture Option. See Section III.A.3.

4. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING PREMIUM.

   a. These policyholders can elect to maintain the current policy benefits but will be required to pay Self-sustaining Premiums.

   b. As noted previously, the Self-sustaining Premium is the premium calculated to eliminate any Shortfall Amount in the policy. The shortfall is the excess of the sum of projected benefits and expenses (the PBA) over the sum of projected premiums and Allocated Assets (the PCA). See Section II.E.4, page 27, above.

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

Policyholders who, as of the Phase Two Policyholder Election Date, are not paying premiums due to a premium waiver provision, but who are not disabled or eligible for benefits will have the following options.

1. LIFETIME WAIVER - Such policyholders on lifetime waiver (due to the death of a spouse) will have essentially the same four options as premium paying policyholders not on claim (See Section IV.B, page 59) with the following modifications:

   a. OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS. This will be the Default Option for these policyholders. However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, the NFO (Option Three) will be the Default Option.

      (1) Due to the Premium Waiver the policyholder will continue not paying premium.

      (2) The Downgrade Process will be the same as for premium-paying active lives in Phase One (see Section III.A.1.c, page 43, above).

      (3) The specific possible benefit reductions will be the ones described in Section III.A.1.f, page 45, above,

      (4) In this case the benefit reductions will be calibrated such that the projected benefits and expenses (the PBA) are equal to the sum of projected premiums and the assets allocated to the policy on an accumulated premium basis (the PCA).

   b. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING DIFFERENTIAL PREMIUM. If the current policies provide benefits above the applicable Guaranty Association limits, the Guaranty Association floor on benefit reductions will be applied to these policyholders as described in Section III.A.2.h, page 50. For those policies with MPV below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that they produce MPVs at least equal to the current MPVs. The adjustments will be made by lengthening the MBP.

      (1) The Self-sustaining Premium used for the calculation for this option will be no less than 110% of the Basic Policy If Knew Premium for this policy reflecting the cost of delay in making this election until Phase Two.

(2) Policyholders will also be offered an "Enhanced Basic Policy Endorsement". See Section III.A.2.f, page 49 at higher Self-sustaining Differential Premiums. The Self-sustaining Premium used for the calculation for this option will be no less than 110% of the Basic Policy If Knew Premium for this policy reflecting the cost of delay in making this election until Phase Two.

c. OPTION THREE - NFO (see Section III.A.3, page 50).

d. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING DIFFERENTIAL PREMIUM. The new premium will be the Self-sustaining Differential Premium described in the next paragraph.

e. The ***Self-sustaining Differential Premium*** is the difference between (1) the corresponding Self-sustaining Premium set as if the policyholder were not on claim and (2) the Current Premium the policyholder would be paying if he or she were not on Premium Waiver. The Self-sustaining Differential Premium will never be less than zero.

2. DUAL WAIVER - The options for a policyholder not on claim but not paying premium due to a dual waiver (because his or her spouse is on claim) will be the same as for a policyholder not on claim with a lifetime waiver except that the premium he or she must pay will be determined in part by the spouse's claim status. The default for these policyholders will be Option One (Downgrade). However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, the NFO (Option Three) will be the Default Option.

a. OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS. The policyholder will retain the Current Premium Waiver but the policy will be downgraded.

(1) The Downgrade Process will be as described in Section III.A.1.c, page 43 subject to the following provisions.

(2) The Benefit Reductions will apply, as described in Section III.A.1.f, page 45. Benefit reductions for each policyholder to whom this option applies will be calibrated to produce a Self-sustaining Premium equal to the premium the policyholder would be paying if not on waiver (the Current Premium). However, because of the waiver, the policyholder will not be required to pay any premium.

(3) If the disabled spouse resumes paying premiums, the active spouse will also be required to resume paying premiums at the premium rate he or she would be paying if not on waiver, but the policy will remain downgraded.

b. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING DIFFERENTIAL PREMIUM.

(1) The policy will be modified through the Basic Policy Endorsements (See Section III.A.2.d, page 48). The policyholder will be required to pay the Self-sustaining Differential Premium.

(2) If the current policies provide benefits above the applicable Guaranty Association limits, the Guaranty Association floor on benefit reductions will be applied to these policyholders as described in Section III.A.2.h, page 50. For those policies with MPV below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that they produce MPVs at least equal to the current MPVs. The adjustments will be made by lengthening the MBP.

(3) Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 49.

(4) The Self-sustaining Premium used for the calculation for this option will be no less than 110% of the Basic Policy If Knew Premium for this policy, reflecting the cost of delay in making this election until Phase Two

(5) If the disabled spouse recovers the active spouse will be required to begin paying the full Self-Sustaining Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements.

c. OPTION THREE - NFO. The policyholders can elect a Non-forfeiture Option. See Section III.A.3.

d. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING DIFFERENTIAL PREMIUM. The policyholder will retain the current policy benefits and pay the Self-sustaining Differential Premium (see Section IV.C.1.e, page 62).

(1) If the disabled spouse recovers the active spouse will be required to begin paying the full Self-sustaining Premium.

(2) The Self-sustaining Differential Premium cannot be less than zero.

D. DISABLED LIVES PAYING PREMIUM (*ON CLAIM - PAYING*)

Policyholders on claim who are paying premiums will have the same options as active lives paying premiums (see Section IV.B, page 59) subject to the following conditions.

1. OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS. Keep the Current Premium rates but accept specified downgrades. The Downgrade process will be as described in Section III.A.1.c, page 43. The Benefit Reductions described in Section III.A.1.f, page 45 will apply, but the benefits will be reduced so that they produce a Self-Sustaining Premium within 2% of the Current Premium.

2. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING PREMIUM. The policy will be endorsed as described in Section III.A.2.d, page 48, at Self-sustaining Premium

    a. The Self-sustaining Premium used for the calculation for this option will be no less than 110% of the Basic Policy If Knew Premium for this policy reflecting the cost of delay in making this election until Phase Two.

    b. Changes in EP and benefit trigger would apply to subsequent periods of care following recovery.

    c. For those policies with MPVs that are currently above their applicable GA limits, the endorsed policy's benefits will be adjusted to produce MPVs at least equal to the applicable GA limits. For those policies with MPVs below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that they produce MPVs at least equal to the current MPVs. The adjustments will be made by lengthening the MBP.

    d. This will be the default for these policyholders.

    e. Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 49.

3. OPTION THREE - NFO. See Section III.A.3.

4. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING PREMIUM. The Self-sustaining Premium will be set as if the policyholder were not on claim. However, in so doing assets will be allocated to the policyholders according to the method previously described for Disabled Lives.

5. In some cases, options like the Downgrade or Basic Policy Endorsements may result in a reduction of the benefits being received by the policyholder on claim at the time of the election.

E. DISABLED LIVES NOT PAYING PREMIUM (*ON CLAIM - WAIVER*)

Policyholders who, as of the Phase Two Policyholder Election Date, are not paying premiums due to a premium waiver provision, and who are disabled or eligible for benefits will have the following options.

1. OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS.

   a. This is the Default Option for policyholders on claim with Premium Waiver in Phase Two. However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, the NFO (Option Three) will be the Default Option.

   b. Policyholders may preserve their Premium Waiver and the policy will be downgraded. The Downgrade Process will be as described in Section III.A.1.c, page 43. The Benefit Reductions described in Section III.A.1.f, page 45, above, will apply but benefits will be reduced so that they produce a Self-sustaining premium that is within 2% of the Current Premium.

   c. If the policyholder resumes paying premiums, the premiums will be at the rate the policyholder would be paying if not on waiver, but the policy will remain downgraded. Note that the Downgrade Process made that premium equal to the Self-sustaining Premium for the downgraded policy at the time of implementation of Phase Two.

   d. If the policyholder regains active status, for future periods of care:

      (1) The EP will be no less than 90 days. If the current EP is more than 90 days, the policy will retain the current EP;

      (2) The EP will apply to each period of care; and

      (3) TQ Triggers will apply. See Section III.A.2.d.(7), page 49.

2. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING DIFFERENTIAL PREMIUM.

   a. The policyholder will have the option to have the current policy endorsed to provide benefits substantially similar to a newly designed Basic Policy. See Section III.A.2.d, page 48.

   b. The policyholder must begin paying the Self-sustaining Differential Premium corresponding to the Self-sustaining premium for the Basic Policy Endorsements set as if the policyholder were not on claim. The Self-sustaining Premium used for the

calculation for this option will be no less than 110% of the Basic Policy If Knew Premium for this policy reflecting the cost of delay in making this election in Phase Two.

c. With the exception of the change from reimbursement to indemnity, no component of the endorsed policy can be richer than the current policy.

d. For those policies with MPVs that are currently above their applicable GA limits, the endorsed policy's benefits will be adjusted to produce MPVs at least equal to the applicable Guaranty Association limits. For those policies with MPVs below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that they produce MPVs at least equal to the current MPVs. The adjustments will be made by lengthening the MBP.

e. Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 49.

f. Changes in EP and benefit trigger would apply to subsequent periods of care following recovery.

g. If the policyholder recovers, he or she will be required to begin paying the full Self-sustaining Premium.

3. OPTION THREE - NFO. Policyholders can elect a Non-forfeiture Option. See Section III.A.3.

4. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING DIFFERENTIAL PREMIUM.

a. A policyholder on claim with Premium Waiver can keep the current policy benefits.

b. The Premium Waiver (including lifetime and dual) will apply only to the Current Premium. The policyholder will be required to begin paying the corresponding Self-sustaining Differential Premium (see Section IV.C.1.e, page 62). If the policyholder recovers he or she will be required to begin paying the full Self-sustaining Premium.

F. SUMMARY OF POLICYHOLDER OPTIONS

The following table summarizes all of the options available to policyholders under the Plan depending on their claim and premium-paying status in both Phase One and Phase Two.

TABLE 6: POLICYHOLDER OPTIONS		
	PHASE ONE	**PHASE TWO**
ACTIVE PAYING	1. KEEP PREMIUM - DOWNGRADE 2. BASIC POLICY - IF KNEW PREMIUM* 3. NFO 4. KEEP BENEFITS - PHASE ONE PREMIUM	1. KEEP PREMIUM - DOWNGRADE 2. BASIC POLICY - SELF SUSTAINING PREMIUM* 3. NFO 4. KEEP BENEFITS - SELF-SUSTAINING PREMIUM
ACTIVE WAIVER	1. DOWNGRADE - RETAIN PREMIUM WAIVER*‡ 2. BASIC POLICY - IF KNEW DIFFERENTIAL PREMIUM 3. NFO 4. KEEP BENEFITS - PHASE ONE DIFFERENTIAL PREMIUM DUAL WAIVER PREMIUM GOVERNED IN PART BY SPOUSE'S STATUS	1. DOWNGRADE - RETAIN PREMIUM WAIVER*‡ 2. BASIC POLICY - SELF SUSTAINING DIFFERENTIAL PREMIUM† 3. NFO 4. KEEP BENEFITS - SELF SUSTAINING DIFFERENTIAL PREMIUM† DUAL WAIVER PREMIUM GOVERNED IN PART BY SPOUSE'S STATUS
ON CLAIM PAYING	1. KEEP PREMIUM - DOWNGRADE 2. BASIC POLICY - IF KNEW PREMIUM* 3. NFO 4. KEEP BENEFITS - PHASE ONE PREMIUM	1. KEEP PREMIUM - DOWNGRADE 2. BASIC POLICY - SELF SUSTAINING PREMIUM*† 3. NFO 4. KEEP BENEFITS - SELF SUSTAINING PREMIUM†
ON CLAIM WAIVER	1. DOWNGRADE - RETAIN PREMIUM WAIVER*‡ 2. BASIC POLICY - IF KNEW DIFFERENTIAL PREMIUM 3. NFO 4. KEEP BENEFITS - PHASE ONE DIFFERENTIAL PREMIUM	1. - DOWNGRADE - RETAIN PREMIUM WAIVER*‡ 2. BASIC POLICY - SELF-SUSTAINING DIFFERENTIAL PREMIUM† 3. NFO 4. KEEP BENEFITS - SELF SUSTAINING DIFFERENTIAL PREMIUM†

***Default Option. †Self-sustaining premium calculated as if policyholder not on claim. ‡If the NFO provides greater benefits, that will be the Default Option. In Phase One, policyholders whose Current Premium is not less than the If Knew Premium need not change premiums or benefits. Option 2 preserves the GA floor for policyholders with benefits above that.**

G. POLICY ILLUSTRATIONS

The following twelve examples illustrate how these options work for some representative policies. The policies selected are actual in-force SHIP policies. They were selected to provide a representative variety of policy features. Reviewing sample policies resembling a particular policy will provide an indication of how the Plan will result in modifications to that policy. Because of the differences among the features in the sample policies, it may be helpful to review several sample policies to see how particular features are affected by the Plan.

ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

This page is provided to assist you in comparing the Plan Options to each other and in selecting the best one for your individual circumstances. The yellow boxes contain the comparative data. The rest of this page provides explanations for that data.

YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$529	ILLUSTR. #	1	YEAR ISSUED	1988
MAXIMUM DAILY BENEFIT	$160			AGE WHEN ISSUED	57
MAXIMUM BENEFIT PERIOD (in years)	2.0			CURRENT AGE	89
MAXIMUM POLICY VALUE	$116,800			GUAR ASSN LIMIT[1]	$300,000
INFLATION PROTECTION	0.0%			STATE OF ISSUE	PA
PREMIUM AND CLAIM STATUS	Premium paying	Active		STATE OF RESIDENCE	PA

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$529	$529	$172	$172	NO PREMIUM	$618
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	-$357	-$357	-$529	+$89
				0.0%	-67.5%	-67.5%	-100.0%	+16.8%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	2.0	2.0	2.5	2.5	2.0	2.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$160	$149	$128	$128	$128	$160
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$116,800	$109,036	$116,800	$116,800	$93,440	$116,800
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$0	$0	$0	$0	$0	$0

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$618**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$2,835**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

The Proposed Rehabilitation Plan (the "Plan") is aimed at reducing or eliminating a very substantial "Funding Gap" or deficit arising from the excess of projected liabilities over the premium and assets projected to be available to fund them, in part by modifying many existing LTC policies while striving to provide policyholders meaningful choices. IF THE REHABILITATION PLAN FAILS TO REDUCE THE FUNDING GAP SUFFICIENTLY, IT IS POSSIBLE THAT SHIP WILL BE PLACED IN LIQUIDATION, POLICYHOLDERS WILL HAVE FEWER OPTIONS, AND SOME MAY LOSE SOME OR ALL OF THEIR COVERAGE IN EXCESS OF GUARANTY ASSOCIATION LIMITS. See discussion beginning at page 92 and especially page 95.

ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$4,116	ILLUSTR. #	2	YEAR ISSUED	1991
MAXIMUM DAILY BENEFIT	$133			AGE WHEN ISSUED	60
MAXIMUM BENEFIT PERIOD (in years)	Unlimited			CURRENT AGE	88
MAXIMUM POLICY VALUE	Unlimited			GUAR ASSN LIMIT[1]	$300,000
INFLATION PROTECTION	0.0%			STATE OF ISSUE	OK
PREMIUM AND CLAIM STATUS	Premium paying	Active		STATE OF RESIDENCE	TX

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$4,116	$4,116	$4,758	$4,758	NO PREMIUM	$7,600
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	+$642	+$642	-$4,116	+$3,484
				0.0%	+15.6%	+15.6%	-100.0%	+84.6%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	Unlimited	2.2	7.7	7.7	2.5	Unlimited
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$133	$106	$106	$106	$106	$133
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	Unlimited	$84,906	$300,000	$300,000	$96,845	Unlimited
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	Unlimited	$0	$0	$0	$0	Unlimited

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$7,197**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$6,039**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

The Proposed Rehabilitation Plan (the "Plan") is aimed at reducing or eliminating a very substantial "Funding Gap" or deficit arising from the excess of projected liabilities over the premium and assets projected to be available to fund them, in part by modifying many existing LTC policies while striving to provide policyholders meaningful choices. IF THE REHABILITATION PLAN FAILS TO REDUCE THE FUNDING GAP SUFFICIENTLY, IT IS POSSIBLE THAT SHIP WILL BE PLACED IN LIQUIDATION, POLICYHOLDERS WILL HAVE FEWER OPTIONS, AND SOME MAY LOSE SOME OR ALL OF THEIR COVERAGE IN EXCESS OF GUARANTY ASSOCIATION LIMITS. See discussion beginning at page 92 and especially page 95.

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	NO PREMIUM	ILLUSTR. #	3	YEAR ISSUED	1995
MAXIMUM DAILY BENEFIT	$159			AGE WHEN ISSUED	64
MAXIMUM BENEFIT PERIOD (in years)	2.0			CURRENT AGE	89
MAXIMUM POLICY VALUE	$290,536			GUAR ASSN LIMIT[1]	$300,000
INFLATION PROTECTION	0.0%			STATE OF ISSUE	GA
PREMIUM AND CLAIM STATUS	Lifetime waiver	Disabled		STATE OF RESIDENCE	GA

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	$0	$0	$0	$0
				NA	NA	NA	NA	NA
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	2.0	2.0	2.5	2.5	2.0	2.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$159	$159	$127	$127	$127	$159
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$290,536	$290,536	$290,536	$290,536	$116,215	$290,536
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$0	$0	$0	$0	$0	$0

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$0**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$867**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

The Proposed Rehabilitation Plan (the "Plan") is aimed at reducing or eliminating a very substantial "Funding Gap" or deficit arising from the excess of projected liabilities over the premium and assets projected to be available to fund them, in part by modifying many existing LTC policies while striving to provide policyholders meaningful choices. IF THE REHABILITATION PLAN FAILS TO REDUCE THE FUNDING GAP SUFFICIENTLY, IT IS POSSIBLE THAT SHIP WILL BE PLACED IN LIQUIDATION, POLICYHOLDERS WILL HAVE FEWER OPTIONS, AND SOME MAY LOSE SOME OR ALL OF THEIR COVERAGE IN EXCESS OF GUARANTY ASSOCIATION LIMITS. See discussion beginning at page 92 and especially page 95.

ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$2,614	ILLUSTR. #	4	YEAR ISSUED	2001
MAXIMUM DAILY BENEFIT	$244			AGE WHEN ISSUED	64
MAXIMUM BENEFIT PERIOD (in years)	4.0			CURRENT AGE	82
MAXIMUM POLICY VALUE	$354,774			GUAR ASSN LIMIT[1]	$300,000
INFLATION PROTECTION	0.0%			STATE OF ISSUE	PA
PREMIUM AND CLAIM STATUS	Premium paying	Active		STATE OF RESIDENCE	FL

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$2,614	$2,614	$3,520	$3,520	NO PREMIUM	$5,344
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	+$906	+$906	-$2,614	+$2,730
				0.0%	+34.6%	+34.6%	-100.0%	+104.4%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	4.0	2.8	4.2	4.2	2.5	4.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$244	$195	$195	$195	$195	$244
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$354,774	$197,227	$300,000	$300,000	$178,365	$354,774
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$54,774	$0	$0	$0	$0	$54,774

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$5,047**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$14,639**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

The Proposed Rehabilitation Plan (the "Plan") is aimed at reducing or eliminating a very substantial "Funding Gap" or deficit arising from the excess of projected liabilities over the premium and assets projected to be available to fund them, in part by modifying many existing LTC policies while striving to provide policyholders meaningful choices. IF THE REHABILITATION PLAN FAILS TO REDUCE THE FUNDING GAP SUFFICIENTLY, IT IS POSSIBLE THAT SHIP WILL BE PLACED IN LIQUIDATION, POLICYHOLDERS WILL HAVE FEWER OPTIONS, AND SOME MAY LOSE SOME OR ALL OF THEIR COVERAGE IN EXCESS OF GUARANTY ASSOCIATION LIMITS. See discussion beginning at page 92 and especially page 95.

ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

This page is provided to assist you in comparing the Plan Options to each other and in selecting the best one for your individual circumstances. The yellow boxes contain the comparative data. The rest of this page provides explanations for that data.

YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$6,306	ILLUSTR. #	5	YEAR ISSUED	1995
MAXIMUM DAILY BENEFIT	$339			AGE WHEN ISSUED	64
MAXIMUM BENEFIT PERIOD (in years)	3.0			CURRENT AGE	89
MAXIMUM POLICY VALUE	$395,961			GUAR ASSN LIMIT[1]	$300,000
INFLATION PROTECTION	5.0%			STATE OF ISSUE	OH
PREMIUM AND CLAIM STATUS	Premium paying	Active		STATE OF RESIDENCE	OH

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$6,306	$6,306	$8,146	$8,169	NO PREMIUM	$10,727
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	+$1,840	+$1,863	-$6,306	+$4,421
				0.0%	+29.2%	+29.5%	-100.0%	+70.1%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	3.0	0.9	3.0	3.0	2.5	3.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$339	$271	$271	$271	$271	$339
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$395,961	$92,110	$302,598	$304,598	$247,207	$395,961
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$95,961	$0	$2,598	$4,598	$0	$95,961

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$10,259**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$18,830**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$2,906	ILLUSTR. #	6	YEAR ISSUED	1996
MAXIMUM DAILY BENEFIT	$307			AGE WHEN ISSUED	62
MAXIMUM BENEFIT PERIOD (in years)	3.0			CURRENT AGE	85
MAXIMUM POLICY VALUE	$365,778			GUAR ASSN LIMIT[1]	$300,000
INFLATION PROTECTION	5.0%			STATE OF ISSUE	PA
PREMIUM AND CLAIM STATUS	Premium paying	Active		STATE OF RESIDENCE	PA

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$2,906	$2,906	$2,532	$2,549	NO PREMIUM	$4,972
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	-$375	-$357	-$2,906	+$2,066
				0.0%	-12.9%	-12.3%	-100.0%	+71.1%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	3.0	3.0	3.3	3.2	2.5	3.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$307	$246	$246	$246	$246	$307
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$365,778	$269,063	$300,000	$300,000	$224,220	$365,778
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$65,778	$0	$0	$0	$0	$65,778

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$4,360**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$21,738**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$2,216	ILLUSTR. #	7	YEAR ISSUED	1997
MAXIMUM DAILY BENEFIT	$246			AGE WHEN ISSUED	63
MAXIMUM BENEFIT PERIOD (in years)	3.0			CURRENT AGE	86
MAXIMUM POLICY VALUE	$286,584			GUAR ASSN LIMIT[1]	$300,000
INFLATION PROTECTION	5.0%			STATE OF ISSUE	IL
PREMIUM AND CLAIM STATUS	Premium paying	Active		STATE OF RESIDENCE	IL

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$2,216	$2,216	$2,814	$2,831	NO PREMIUM	$3,597
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	+$598	+$615	-$2,216	+$1,381
				0.0%	+27.0%	+27.7%	-100.0%	+62.3%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	3.0	3.0	3.9	3.9	2.5	3.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$246	$197	$197	$197	$197	$246
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$286,584	$215,251	$286,584	$286,584	$179,376	$286,584
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$0	$0	$0	$0	$0	$0

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$3,398**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$13,297**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$2,995	ILLUSTR. #	8	YEAR ISSUED	1997
MAXIMUM DAILY BENEFIT	$205			AGE WHEN ISSUED	64
MAXIMUM BENEFIT PERIOD (in years)	5.0			CURRENT AGE	86
MAXIMUM POLICY VALUE	$432,370			GUAR ASSN LIMIT[1]	$300,000
INFLATION PROTECTION	5.0%			STATE OF ISSUE	OK
PREMIUM AND CLAIM STATUS	Premium paying	Active		STATE OF RESIDENCE	OK

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$2,995	$2,995	$1,522	$1,526	NO PREMIUM	$2,995
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	-$1,473	-$1,468	-$2,995	$0
				0.0%	-49.2%	-49.0%	-100.0%	0.0%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	5.0	5.0	4.8	5.0	2.5	5.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$205	$205	$164	$164	$164	$205
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$432,370	$432,370	$300,000	$317,011	$149,483	$432,370
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	5.0%	5.0%	1.5%	2.0%	0.0%	5.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$132,370	$132,370	$0	$17,011	$0	$132,370

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$2,995**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$4,393**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	NO PREMIUM	ILLUSTR. #	9	YEAR ISSUED	1999
MAXIMUM DAILY BENEFIT	$60			AGE WHEN ISSUED	67
MAXIMUM BENEFIT PERIOD (in years)	3.0			CURRENT AGE	88
MAXIMUM POLICY VALUE	$65,700			GUAR ASSN LIMIT[1]	$300,000
INFLATION PROTECTION	0.0%			STATE OF ISSUE	TX
PREMIUM AND CLAIM STATUS	Lifetime waiver	Active		STATE OF RESIDENCE	TX

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	$0	$0	$0	$0
				NA	NA	NA	NA	NA
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	3.0	3.0	3.8	3.8	2.5	3.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$60	$60	$48	$48	$48	$60
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$65,700	$65,700	$65,700	$65,700	$43,800	$65,700
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$0	$0	$0	$0	$0	$0

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$0**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$757**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$6,336	ILLUSTR. #	10	YEAR ISSUED	1995
MAXIMUM DAILY BENEFIT	$174			AGE WHEN ISSUED	67
MAXIMUM BENEFIT PERIOD (in years)	Unlimited			CURRENT AGE	92
MAXIMUM POLICY VALUE	Unlimited			GUAR ASSN LIMIT[1]	$300,000
INFLATION PROTECTION	0.0%			STATE OF ISSUE	NC
PREMIUM AND CLAIM STATUS	Premium paying	Active		STATE OF RESIDENCE	NC

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$6,336	$6,336	$2,886	$2,886	NO PREMIUM	$7,695
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	-$3,450	-$3,450	-$6,336	+$1,359
				0.0%	-54.4%	-54.4%	-100.0%	+21.4%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	Unlimited	Unlimited	5.9	5.9	2.5	Unlimited
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$174	$174	$139	$139	$139	$174
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	Unlimited	Unlimited	$300,000	$300,000	$126,801	Unlimited
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	Unlimited	Unlimited	$0	$0	$0	Unlimited

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$6,336**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$9,296**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

The Proposed Rehabilitation Plan (the "Plan") is aimed at reducing or eliminating a very substantial "Funding Gap" or deficit arising from the excess of projected liabilities over the premium and assets projected to be available to fund them, in part by modifying many existing LTC policies while striving to provide policyholders meaningful choices. IF THE REHABILITATION PLAN FAILS TO REDUCE THE FUNDING GAP SUFFICIENTLY, IT IS POSSIBLE THAT SHIP WILL BE PLACED IN LIQUIDATION, POLICYHOLDERS WILL HAVE FEWER OPTIONS, AND SOME MAY LOSE SOME OR ALL OF THEIR COVERAGE IN EXCESS OF GUARANTY ASSOCIATION LIMITS. See discussion beginning at page 92 and especially page 95.

ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

This page is provided to assist you in comparing the Plan Options to each other and in selecting the best one for your individual circumstances. The yellow boxes contain the comparative data. The rest of this page provides explanations for that data.

YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	NO PREMIUM	ILLUSTR. # 11	YEAR ISSUED	1991	
MAXIMUM DAILY BENEFIT	$206		AGE WHEN ISSUED	55	
MAXIMUM BENEFIT PERIOD (in years)	Unlimited		CURRENT AGE	84	
MAXIMUM POLICY VALUE	Unlimited		GUAR ASSN LIMIT[1]	$300,000	
INFLATION PROTECTION	5.0%		STATE OF ISSUE	TX	
PREMIUM AND CLAIM STATUS	Claim waiver	Disabled	STATE OF RESIDENCE	TX	

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM	$864
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	$0	$0	$0	+$864
				NA	NA	NA	NA	NA
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	Unlimited	Unlimited	4.8	5.0	2.5	Unlimited
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$206	$185	$165	$165	$165	$206
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	Unlimited	Unlimited	$300,000	$314,012	$150,238	Unlimited
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	Unlimited	Unlimited	$0	$14,012	$0	Unlimited

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$0**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$14,325**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

This page is provided to assist you in comparing the Plan Options to each other and in selecting the best one for your individual circumstances. The yellow boxes contain the comparative data. The rest of this page provides explanations for that data.

YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$1,198	ILLUSTR. #	12	YEAR ISSUED	1988
MAXIMUM DAILY BENEFIT	$80			AGE WHEN ISSUED	56
MAXIMUM BENEFIT PERIOD (in years)	4.0			CURRENT AGE	88
MAXIMUM POLICY VALUE	$116,800			GUAR ASSN LIMIT[1]	$300,000
INFLATION PROTECTION	0.0%			STATE OF ISSUE	TX
PREMIUM AND CLAIM STATUS	Premium paying	Active		STATE OF RESIDENCE	TX

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$1,198	$1,198	$529	$529	NO PREMIUM	$1,198
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	-$669	-$669	-$1,198	$0
				0.0%	-55.8%	-55.8%	-100.0%	0.0%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	4.0	4.0	5.0	5.0	2.5	4.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$80	$80	$64	$64	$64	$80
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$116,800	$116,800	$116,800	$116,800	$58,400	$116,800
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$0	$0	$0	$0	$0	$0

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$1,198**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$1,757**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

The Proposed Rehabilitation Plan (the "Plan") is aimed at reducing or eliminating a very substantial "Funding Gap" or deficit arising from the excess of projected liabilities over the premium and assets projected to be available to fund them, in part by modifying many existing LTC policies while striving to provide policyholders meaningful choices. IF THE REHABILITATION PLAN FAILS TO REDUCE THE FUNDING GAP SUFFICIENTLY, IT IS POSSIBLE THAT SHIP WILL BE PLACED IN LIQUIDATION, POLICYHOLDERS WILL HAVE FEWER OPTIONS, AND SOME MAY LOSE SOME OR ALL OF THEIR COVERAGE IN EXCESS OF GUARANTY ASSOCIATION LIMITS. See discussion beginning at page 92 and especially page 95.

V. PHASE THREE

Following implementation of Phase One and Phase Two, SHIP will continue managing its LTCI in a run-off mode. While some aspects of Phase Three will be developed in the future, if the Company has improved to the point of having assets available, payments will be made to policyholders, agents, and other creditors on account of amounts owed to them. Certain amounts may be owed to policyholders on account of the ***Unfunded Benefit Liability*** created as part of the policy restructuring. See Section VI.H, page 91. By virtue of the restructuring, this Unfunded Benefit Liability (UBL) will be a non-insurance obligation payable only if SHIP has assets available for payments to general creditors in Phase Three. To the extent such assets are available, they will be applied proportionately to the UBL along with other unpaid general creditors liabilities, such as agent commissions and amounts owed to companies previously reinsured by SHIP. The UBL payments to policyholders will actually take the form of extended Maximum Benefit Periods.

It is possible that in Phase Three SHIP will not be able to pay off all remaining liabilities in full. In that event, it is likely that it will then be placed in Liquidation in accordance with Article V. To the extent that at that time there remain unsatisfied insurance policy obligations, the Guaranty Associations may be triggered to protect the remaining policy obligations, subject to applicable statutory conditions and limits. See Section VI.J, page 92.

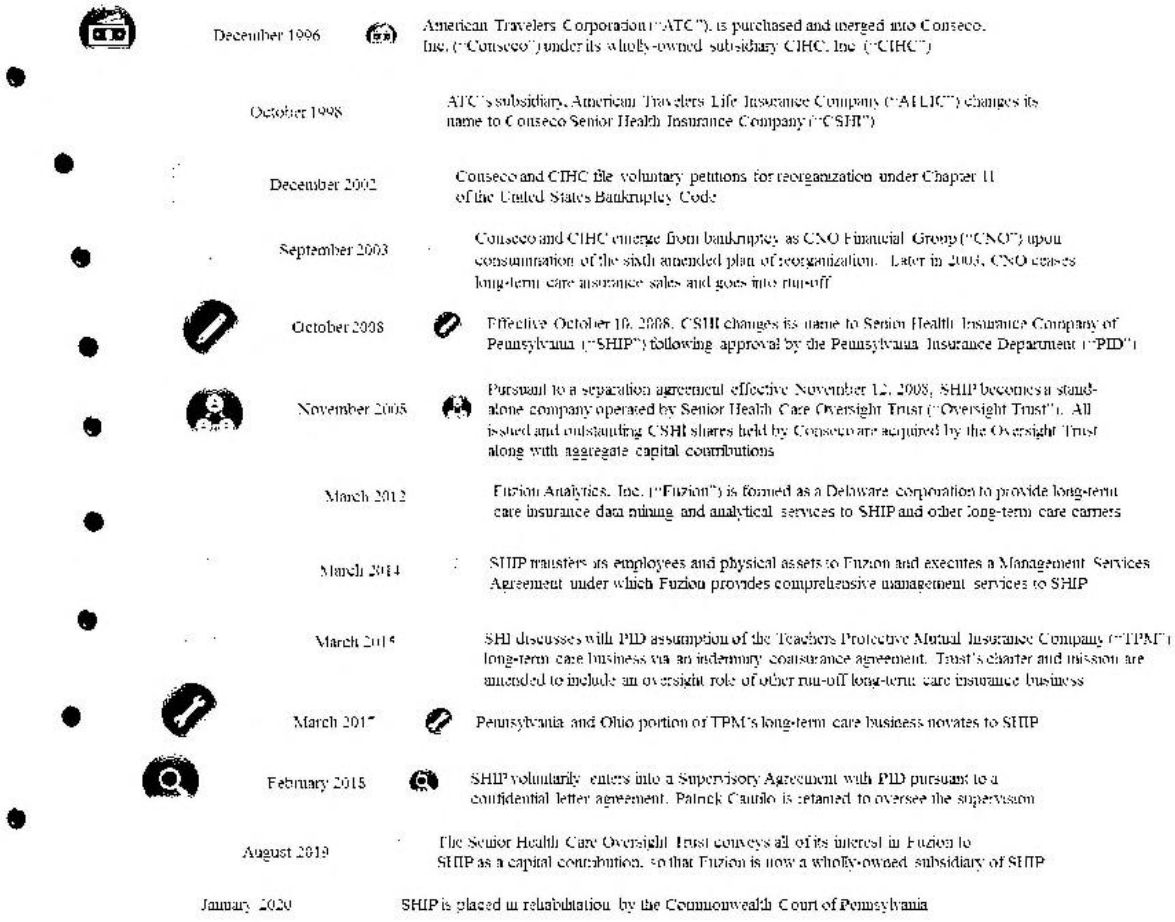
VI. OTHER MATTERS

A. ABOUT SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

SHIP commenced business on July 5, 1887, as the Home Beneficial Society. It underwent many transactions and transformations in the ensuing century, culminating in the adoption of the current name in October 2008, when it was transferred by its then owner, Conseco, to the newly formed, nonprofit, *Senior Health Care Oversight Trust* (the "Trust" - see page 90) so it could continue running off its long-term care insurance ("LTCI") business independently. At the time, SHIP had 152,000 LTC policies in force. As of year-end 2019 that number was down to close to 45,000 and as of this filing it is at around 35,000. It is a Pennsylvania life and health insurance company. Prior to Rehabilitation, SHIP was licensed in 46 states (excluding Connecticut, New York, Rhode Island, and Vermont), the District of Columbia, and the U.S. Virgin Islands. Since SHIP's creation in 2008, it has utilized an outsourcing model for select functions, specifically: Long Term Care Group, Inc. ("LTCG") for lower-level claims administration functions; Milliman for rate increase analyses and valuations; Conning, Inc., and New England Asset Management, Inc., for investment services; KPMG for tax services; and external law firms for specific legal issues. Beginning in 2018, the Company engaged Ernst & Young for internal audit services. After SHIP was placed in rehabilitation, the Rehabilitator has retained some and replaced others of these service providers.

Table 7 summarizes the Company's corporate history.

TABLE 7 - CORPORATE HISTORY



B. LONG-TERM CARE INSURANCE

At the time this Approved Rehabilitation Plan is filed, the insurance business of SHIP consists entirely of long-term care insurance (LTCI), much of it issued many decades ago, and none issued any later than 2003, when the Company ceased writing new business. Of approximately 646,000 LTCI policies sold by SHIP and its predecessors since the late 1970s, fewer than 36,000 remain in force. More precisely,

1. As of year-end 2018, SHIP had 51,635 LTC policies in force, of which 6,151 policyholders were on claim. As of that date, it also reinsured 2,620 policies of which 401 were on claim. See Section VI.M , page 96. Thus at that time it administered a total of 54,255 policies of which 6,552 were on claim.

2. By year end 2019, SHIP's direct LTCI business was down to 45,518 policies, with 5,776 on claim. Its assumed business was down to 2,267 policies, 376 on claim. At the end of that year, therefore, SHIP was administering 47,785 policies of which 6,152 were on claim.

3. By mid-year (June 30, 2020) these numbers had declined further. The total of direct LTC policies was down to 42,559, of which 5,402 were on claim. Assumed policies numbered 2,114, with 352 on claim. Total of administered LTC policies was therefore 44,673, of which 5,753 were on claim. As noted, by the time of this filing, direct LTC policies number around 39,000.

4. A key characteristic of this remaining "legacy" block of LTCI policies as a group is that the premiums being paid, when added to the Company's assets, are projected to be grossly insufficient to pay the benefits expected to be due under those policies. This anticipated "Funding Gap" led to the Company being placed in Rehabilitation on January 29, 2020, and is the key challenge sought to be addressed by the Plan.

5. SHIP's long-term care insurance policies cover long-term care services, including confinement to nursing facilities and assisted living facilities, as well as home health care and adult day care for individuals who meet specified requirements. These requirements vary among the Company's policies but typically include things like the policyholder requiring care for at least 90 days, and being unable to perform 2 or more Activities of Daily Living (eating, dressing, bathing, transferring, toileting, and continence) without substantial assistance (hands on or standby).

6. The Company's business is comprised of LTCI and health policies written by the Company and assumed reinsurance. The non-LTC health policies written by SHIP and its predecessors were assumed by reinsurance by Conseco when SHIP was spun off in 2008. SHIP, therefore, is not administering those policies, which, as of the time SHIP was placed in rehabilitation numbered around 45,500. For the LTCI policies written by the Company and its predecessors, average policyholder age is 86 and the average claimant is 89 years old. SHIP's policies are approximately 13% Home Health Care coverage, 17% Facility Care coverage (nursing home and/or assisted living facility), and 70% Comprehensive coverage covering multiple levels of care. The following paragraphs provide a general description of certain terms and features that are included in many of the Company's LTC Policies.

7. Tax Qualified v. Non-Tax Qualified - In order to trigger coverage under a policy, the policyholder generally must satisfy certain needs-based tests that vary depending on whether the policy is Tax Qualified or Non-Tax Qualified. Under Section 213 of the Internal Revenue Code ("IRC"), premiums paid for a Tax Qualified LTC policy are deductible medical expenses. According to Section 7702B of the IRC, a Tax Qualified policy is one that:

   a. provides insurance coverage only for qualified LTC services;

b. does not pay or reimburse expenses that are reimbursable under Medicare;

c. is guaranteed renewable;

d. does not provide for a cash surrender value or other money that can be paid, assigned or pledged as collateral for a loan, or borrowed;

e. provides that all refunds of premiums (other than refunds on the death of the insured or on a complete surrender or cancellation of the policy, which cannot exceed the aggregate premiums paid under the policy) and the policyholder dividends, or similar amounts, are applied as a reduction of future premiums or to increase future benefits; and

f. satisfies certain consumer protection requirements as well as disclosure and nonforfeitability requirements.

8. "Qualified long-term care services" are defined as necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and other rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual and are provided pursuant to a plan of care prescribed by a licensed health care practitioner. A "chronically ill individual" is defined as one who has been certified within the previous twelve (12) months by a licensed health care provider as:

a. being unable to perform (without substantial assistance from another individual) at least two (2) Activities of Daily Living (eating, toileting, transferring, bathing, dressing and continence) for a period of at least 90 days due to a loss of functional capacity;

b. having a level of disability similar to the level of disability described in the clause above, as determined by the Internal Revenue Service in consultation with the Department of Health and Human Services; or

c. requiring substantial supervision to protect such an individual from threats to health and safety due to severe cognitive impairment.

9. A Non-Tax Qualified Policy generally contains eligibility standards, such a Medical Necessity, which is a lower threshold to trigger coverage. For example, some policy forms contain the following conditions for eligibility:

a. *Your Physician certifies Your care to be Medically Necessary; or*

b. *You are unable to perform two (2) or more Activities of Daily Living without assistance or supervision; or*

c. *You are afflicted with Cognitive Impairment.*

Approximately 85% of the Company's policies are Non-Tax Qualified policies, and approximately 66% of the in-force policies are eligible to qualify for care through the Medical Necessity provision.

10. Daily Benefit Amount - The Company's LTC policies are subject to a Maximum Daily Benefit that was selected by the policyholder when he or she purchased the coverage. The Maximum Daily Benefit available ranged from $10 to $300 per day, with many policies subject to annual percentage increases. Some policies, known as "indemnity," pay the full Maximum Daily Benefit, regardless of actual expenses incurred. With the annual percentage increases, in some cases the Maximum Daily Benefit has accumulated to over $700 and can be envisioned to continue increasing to over $1,000, far in excess of the cost of care. The Company's average Maximum Daily Benefit for in-force policyholders is $173.

11. Inflation Benefit - Some of the Company's LTC policies were issued with an inflation benefit (referred to as "Inflation Protection"). Inflation Protection may increase a policy's Maximum Daily Benefit by a fixed percentage, often 3% or 5% each year, and inflate the Maximum Lifetime Benefit or Benefit Account Value proportionately. The inflation may be simple (increase by the fixed percentage of the original benefit each year) or compound (increase by the fixed percentage of the current benefit each year). The duration of the inflation benefit may be limited to 20 years, or until a policyholder attains the age of 85, but many policies have Inflation Protection for the life of the policy. Approximately 32% of the in-force policyholders have lifetime 5% compound inflation.

12. Indemnification - Indemnity and reimbursement denote the method by which the Maximum Daily Benefit will be paid out. Some policies provide coverage for the actual expenses of care (reimbursement), while others pay the full daily benefit amount regardless of actual expenses incurred (indemnity) much like disability insurance policies. The payment method can vary on comprehensive policies, between Assisted Living Facility Care or Home Health Services. Approximately 63% of in-force policyholders have the indemnity benefit for their main coverage.

13. Benefit Period - Most of the Company's LTC policies are subject to a Maximum Benefit Period. The Maximum Benefit Periods range from one year to six years. Some policies, however, have an unlimited benefit period ("lifetime policies") while others are subject to a maximum dollar amount. Approximately 72% of the in-force policyholders have a limited benefit period while approximately 28% of policyholders have lifetime policies.

14. Elimination Period - Some of the Company's LTC policies have an Elimination Period, which is a period of time during which the Company is not required to pay benefits to an otherwise eligible policyholder receiving covered care or services. Some policies were issued with a zero-day Elimination Period. Approximately 66% of the in-force policyholders have a zero-day Elimination Period.

15. Waiver of Premium - Approximately 99% of the Company's LTC policies provide that a policyholder who receives benefits under his or her policy for a specified period of time (such as 90 days) is no longer required to pay premiums for coverage after that time period as long as the policyholder remains eligible for benefits and/or receives a specified level of care. Once the policyholder's eligibility for benefits ends, the policyholder is required to resume paying premiums. Approximately 14% of policyholders who otherwise would pay premiums are currently eligible for the Waiver of Premium benefit.

16. Restoration of Benefits - The Restoration of Benefits ("ROB") provision restores the policy's Benefit Period to the original Maximum Benefit Period after receiving some or all claim benefits if the policyholder does not need or receive care during a specified period of time such as 180 days. In most instances, partial benefits were utilized prior to the restoration period. Some policies may restore an unlimited number of times, while others are restricted in the number of times the policy can be restored. Approximately 76% of the in-force policyholders have a ROB benefit.

17. Return of Premium - Approximately 5% of the Company's LTC policies were issued with a Return of Premium ("ROP") benefit. This benefit provides for the return of a percentage of premium paid by the policyholder if the policyholder does not have a claim or has a limited amount of benefits paid under the policy. The ROP typically occurs upon termination or upon ten-year incremental anniversaries. Since 2011, over $53 million has been returned through the ROP benefit.

C. FINANCIAL CONDITION

The Company has been in a declining financial condition for many years. Its reported surplus is reflected in the following table:

TABLE 8: FINANCIAL CONDITION (IN DOLLARS)

YEAR	ASSETS	LIABILITIES	CAPITAL & SURPLUS/ (DEFICIT)
2009	3,251,994,962	3,058,545,856	193,449,106
2010	3,317,023,144	3,139,706,226	177,314,918
2011	3,161,093,979	3,046,696,672	114,397,307
2012	3,080,745,346	2,975,278,318	105,467,028
2013	2,985,938,782	2,887,736,889	98,201,892
2014	2,906,965,242	2,826,959,318	80,005,924

2015	2,879,794,716	2,824,037,145	55,757,570
2016	2,744,535,287	2,716,512,099	28,023,187
2017	2,688,468,510	2,675,819,343	12,649,166
2018	2,186,058,273	2,652,931,248	(466,814,972)
2019	1,907,181,137	2,823,279,366	(916,098,229)
2020	1,369,908,000	2,592,415,000	(1,222,507,000)

More complete financial information as of December 31, 2019, is included at Appendix B, along with summary updated information through December 31, 2020. It is estimated that SHIP's Funding Gap is more than $1.2 billion. That is to say, based on Current Premium payments and the current value of SHIP's assets, in the absence of rehabilitation, by the time all of SHIP's policies terminate about twenty to twenty-five years from now, it will have incurred liability for covered benefits costing at least $1.2 billion more than the money that will be available to pay for those benefits. It is important to note that these are estimates or projections for events that will occur over a long period of time. Any of a multitude of factors can change during that time affecting materially the accuracy of those projections.

There are many reasons that SHIP finds itself in this dilemma, some understood better than others. The Rehabilitator has been conducting and will continue thorough and exhaustive investigations and analyses of the reasons for SHIP's current financial condition. The areas of investigation and analysis will include, but not be limited to, industry wide challenges, common industry practices, volatility in the financial markets, and the conduct of SHIP's management, business partners, consultants and other service providers. The Rehabilitator, in consultation with her advisors and experts, will determine how these forces may have contributed to SHIP's current financial condition. Actions will be taken as appropriate.

Industry wide challenges may have played a role. The LTCI industry or line of insurance business is relatively young, significant numbers of such policies being sold for the first time in the late 1970s and early 1980s. When these insurance products were first designed, there did not exist a robust data base of historical LTCI experience of the type on which actuaries typically rely to calculate what benefits will cost, how the policies will "behave" over time, and what level of premium will be required to make them financially safe. There was insufficient historical data on which to base expectations about benefit costs and required premiums. The industry therefore referred to experience in other lines of insurance, such as life and disability, to make such projections. Soon, the industry came to understand that the characteristics of LTCI policies are materially different in key respects from those in other lines of insurance. For example, many fewer policyholders voluntarily surrender their LTCI policies before expiration than is true of other types of insurance. Similarly, the length of time during which LTCI policyholders will require benefits is materially longer than had been projected. In short, many factors affecting projected liabilities

turned out materially different from what had been assumed when the policies were first issued, and when premium rates were set for them.

This problem was compounded by a decision by the industry to structure these policies as level-premium guaranteed-renewable contracts. In summary, this meant that, as long as the policyholders paid their premiums, the policies could not be cancelled despite changes in age, health condition, and other circumstances. Moreover, the premiums could only be increased if they were increased by the same percentage for all policyholders who had the same type of policy, and then only if the state insurance regulator approved the increase. Over time, a large percentage of these policies were found to be substantially underpriced in that the premiums paid for a given group of such policies could be projected to fall far short of what the company would need for the benefits due under the policies for that group. Obtaining the required approval for rate increases from state regulators proved difficult over time, resulting in two key problems. First, for many LTCI companies, the entire block of such policies was projected to create liabilities far in excess of what the companies would be able to pay. In fact, for many companies like SHIP, this became a serious threat of, or contributing cause to, insolvency. Second, because of differences in the responses by different states to requests for authorization to increase premium rates, over time there emerged wide divergence in the premiums policyholders holding similar policies would pay in different states. Some critics characterized this phenomenon as resulting in policyholders in rate-increase-approving states subsidizing those in states that rejected such requests. All of this can be contrasted with typical health insurance policies that generally last only a year or less, and the premiums for which are adjusted at least annually.

Adding to these challenges were material changes in the economic environment in which these policies were required to perform. For example, when early LTCI policies were sold, there did not exist a robust assisted living facility ("ALF") or continuing care retirement center ("CCRC") industry. When one became incapable of caring for oneself, the principal choices were internment in a nursing home, widely viewed as undesirable unless absolutely necessary, or (at much lower cost) having family or hired help care for one at home. However, as LTCI policies began becoming more popular and provided a funding source for other alternatives, there emerged a vibrant industry of desirable retirement homes providing varying levels of care, but typically in much more enticing surroundings and with attractive amenities. These ALFs and CCRCs increased the cost of caring for those who qualified for long-term care benefits but preferred not to remain at home to be cared for by their families or hired care-givers. In many other ways, the cost of caring for those who could not fend for themselves also increased beyond what had been projected by some companies and their consultants when early LTCI policies were priced.

Another major development affected a different key source of funding for future benefits. LTCI policies are designed to generate far more premium than needed to pay benefits in their early years, with those amounts to be invested and generate a material investment income that will be added to the premium and be used in later years when benefit costs are expected to exceed premiums being collected at that later time. In short, the notion is that the company will build-up a fund of premium and investment income that will suffice to pay the large claims expected in the future. In addition to premium being inadequately low when first set, and claims costing more than expected,

income earned on the invested premium has also turned out to be much less than anticipated. Changes in the capital market and the broader economy, especially the "great recession" of 2008, dramatically suppressed investment returns below expectations. Current economic circumstances are exacerbating this problem. Many LTCI insurers have amassed billions of dollars in invested premiums. A decline of 1% in yield on each $1 billion of invested premium amounts to a loss every year of $10 million in funds to be reinvested and be available for future claims. It is not hard to see how a decline in market yields of even just 3% for five years for a company with $2 billion in invested assets could be a major event. That would entail a loss of at least $300 million! This is the nature of lost investment income experienced by SHIP and the rest of the LTCI industry, but on more invested assets for many more years. As a point of reference, the Wall Street Journal Prime Rate was at: 8.25% on March 5, 1975; **17.25%** on March 4, 1980; 10% on January 8, 1990; 9% on March 22, 2000; 5.75% on March 22, 2005; 3.25% on December 16, 2008; 5.50% on December 20, 2018; back down to 3.25% on April 10, 2020, and staying at that level since.

These and other challenges faced by SHIP over the eleven years since it was separated from Conseco have combined to create the Funding Gap described above. The purpose of the Plan is to narrow or eliminate that Funding Gap by a combination of an increase in revenue through rate increases and a reduction in liabilities through benefit modifications.

D. REHABILITATION PROCEEDING

Since the fall of 2008, SHIP has been owned and overseen by the Senior Health Care Oversight Trust ("Trust" - see paragraph VI.E, page 90) and its Trustees. As SHIP's domiciliary regulator, the Pennsylvania Insurance Department ("PID") regulates SHIP's affairs and monitors its financial condition. On May 7, 2015, the PID concluded a financial examination of SHIP for the five-year period ending on December 31, 2013. The results were detailed in the Report of Examination dated as of that date, which concluded that, as of December 31, 2013, SHIP had capital & surplus of $98,201,892 and made no recommendations.

As surplus continued to decline (see Table 7, at page 86, above), the PID became substantially concerned about SHIP's financial situation. The Department engaged in an intense regulatory focus aimed in part at encouraging management and the Trustees to review and revise the actuarial and other assumptions on which they were basing their financial projections and reports of SHIP's financial condition. In 2017 the PID commenced a limited examination of SHIP's affairs and engaged an independent consulting actuary to assist, especially, in evaluation of the adequacy of the Company's reserves. This work revealed a number of areas of concern and the PID appointed a Special Representative to work with SHIP management, the Trustees, and consultants for both the Company and the PID, to ascertain SHIP's financial condition and to determine whether it would be able to fulfill the contractual promises inherent in the LTCI block the Company was running off. As this work progressed it became evident that SHIP was in a more hazardous financial condition even than suggested by the 2017 statutory annual statement filed in March 2018, which reported a decline in surplus to just over $12.6 million from over $28 million a year earlier and almost twice that the year before.

SHIP and its consultants, in communication with the PID and its representatives and advisors, re-evaluated their underlying assumptions, and, in early 2019, SHIP completed an annual statement for 2018 that reported a $467 million deficit. Management was provided an opportunity to develop a corrective action plan to eliminate this deficit and restore the Company's surplus to acceptable levels but failed to do so. On January 29, 2020, at the request of Pennsylvania Insurance Commissioner Jessica K. Altman, and with the consent of a majority of the Trustees and SHIP's directors, the Commonwealth Court of Pennsylvania entered the Rehabilitation Order placing SHIP in rehabilitation and appointing Commissioner Altman as Rehabilitator. The order directed the Rehabilitator to file a preliminary plan for SHIP's rehabilitation on or before April 22, 2020. Commissioner Altman appointed Patrick H. Cantilo as Special Deputy Rehabilitator (SDR) to comply with the Court's requirement. A Proposed Rehabilitation Plan was filed on that date, an Amended Rehabilitation Plan was filed on October 21, 2020, the Second Amended Rehabilitation Plan was filed on May 3. 2021, and this version was prepared following the Court's August 25, 2021, Memorandum Opinion and Order approving the rehabilitation plan. This Approved Rehabilitation Plan reflects updates made necessary by the Court's approval, including those affecting the payment of agent's commissions addressed in Section VI.N, page 100.

E. SENIOR HEALTH CARE OVERSIGHT TRUST

As mentioned above, SHIP had been a subsidiary of Conseco, Inc. ("Conseco") until 2008 when it agreed with PID's approval to transfer the Company to a newly created independent nonprofit trust. For that purpose, the Senior Health Care Oversight Trust (the Trust) was formed as a Pennsylvania business trust and the following served as its trustees (the "Trustees") as of the date the Company was placed in Rehabilitation and for at least seven years before that date:

1. Julianne Marie Bowler (Chair), since 2009 the Chief Underwriting Officer, and also the Chief Compliance and Administrative Officer, of Narragansett Bay Insurance Company. Ms. Bowler had served as the Massachusetts Insurance Commissioner from 2002 to 2007;

2. Cecil Dale Bykerk, President of CDBykerk Consulting, LLC, a life and health insurance consulting actuary;

3. Thomas Edward Hampton, Senior Advisor to Dentons US LLP, a Certified Public Accountant and former commissioner of the District of Columbia Department of Insurance, Securities, and Banking;

4. John Martin Morrison, senior Partner at Morrison, Sherwood, Wilson, Deola, PLLP, and former Montana State Auditor and Insurance Commissioner; and

5. Gregory Vincent Serio, Partner and Managing Director of New York lobbying firm Park Strategies, and former New York Superintendent of Insurance.

The transaction transferring SHIP to the Trust was memorialized in an August 1, 2008, Transfer Agreement between Conseco and the Trust. The Trust has been (and continues to be)

governed by the board of trustees identified above, who have also served as directors of SHIP and Fuzion, along with certain senior officers of the companies. Their authority to oversee the Company has been effectively suspended by the rehabilitation proceedings.

F. FUZION ANALYTICS

Fuzion Analytics, Inc. ("Fuzion"), is a Delaware corporation formed in 2012 as a subsidiary of the Senior Health Care Oversight Trust ostensibly to provide LTCI data mining, analytical and other services to long-term care insurers, including SHIP. Beginning in 2012, SHIP entered into several agreements with Fuzion under which, over time, it paid Fuzion millions of dollars. In 2014, SHIP conveyed essentially all of its infrastructure to Fuzion in exchange for agreed-upon cash consideration consisting initially of a payment of $367,806. In due course, Fuzion began providing SHIP all of the services necessary to administer SHIP's affairs, other than those being performed by other vendors. Since that conveyance, SHIP has had no facilities or employees, relying instead on Fuzion and other vendors to perform all of the functions necessary to run-off SHIP's LTCI business. On August 20, 2019, the Senior Health Care Oversight Trust conveyed all of its interest in Fuzion to SHIP as a capital contribution, so that Fuzion is now a wholly owned subsidiary of SHIP. In addition to the services provided to SHIP, Fuzion continues to provide Fraud Waste and Abuse and other services to customers in the long-term care industry.

G. LTCG, INC.

In 2008 SHIP entered into a Master Services Agreement with Univita for a broad array of claims and administrative services, excluding complaints. Univita has since become the Long-Term Group, Inc., ("LTCG") and continues providing these services to SHIP.

H. POLICY RESTRUCTURING

Before the Effective Date and before policyholders have made their elections, the Rehabilitator will determine which of SHIP's policies are Impaired Policies in that the assets and premiums projected to be available will not suffice to pay the liabilities projected to arise under such policies. For purposes of implementing the Plan and to facilitate identification and implementation of key economic and tax components of the Rehabilitator's strategy, SHIP's LTC policy liabilities will be restructured to incorporate the terms of the Plan and permit Policyholder Elections. The restructuring must be approved by the Court. Now that the Plan has been approved, the Rehabilitator expects to file an application with the Court for approval of the Restructuring Statement within the next few weeks. The Rehabilitator will request that the Court deem SHIP's liabilities for Impaired Policies to have been restructured as of a specified date, and before giving effect to Policyholder Elections or modifications under the Plan. However, this restructuring will not affect the elections made by or available to the policyholders.

The restructuring will be for the purpose of separating the liabilities arising under SHIP's LTC policies that it is projected to have sufficient assets to fund (the ***Initial Funded Restructured Policy Value*** - "**IFRPV**"), from those that it is projected to be unable to fund (the Unfunded Benefit Liability - UBL). This restructuring will consist of notionally allocating the liability arising under each such policy (equal to its gross premium reserve - GPR) to its IFRPV and its UBL, with the UBL for each policy being the difference between its original GPR and its IFRPV. Premiums paid as to each policy and Allocated Assets determined under the Plan as described in Section II.E.4.e, page 28, are projected to suffice to enable the Company to fund its IFRPV. As a result, after the Effective Date, SHIP will have assets and expected premiums at least equal to the aggregate funded liabilities (IFRPV) remaining under the Restructured Policies. It is important to note that the Policyholder Elections are not intended to, and will not, eliminate the Unfunded Benefit Liability. To the extent that it cannot be paid, that liability is expected to be discharged in due course by the Commonwealth Court upon the Rehabilitator's application.

The Company will retain non-insurance indebtedness to the policyholders on account of the amount by which the liabilities have been reduced, *i.e.*, the UBL. However, this liability will not be an insurance obligation arising under SHIP's policies and would not constitute a contractual obligation covered by the Guaranty Associations if SHIP were liquidated. Under the Plan, this liability will be converted to non-insurance general creditor indebtedness. It is possible that realization by SHIP of additional assets will enable it to make at least partial payments of the UBL in Phase Three. If made, those payments will take the form of extensions of the benefit periods in the affected policies. In any case, as explained below, the Rehabilitator will request that the portion of SHIP's UBL that it will not be able to fund be discharged by the Commonwealth Court as part of the Plan. As noted, a complete Restructuring Statement will soon be filed with the Court for approval.

I. GAUGING PLAN PERFORMANCE

During the pendency of the Plan, the Company's financial condition will be monitored closely with emphasis on changes in the projected deficit. Elections by policyholders to increase premiums and reduce benefits in the aggregate are expected to have a material effect on that projected deficit. Various aspects of the Plan are also expected to have material effects on key trends such as average claim cost, claim incidence, claim duration and policy terminations. Most of these are heavily dependent on policyholder behavior that is difficult to predict with certainty. As time passes following implementation of each phase of the Plan, however, changes in these key trends will become more evident and the effects of the Plan as a whole will be more susceptible of quantification.

J. GUARANTY ASSOCIATIONS

This is a general summary of the state Insurance Guaranty Association system. Readers should review the individual state laws to understand how individual Guaranty Associations operate in each jurisdiction and the protections they afford. The Plan does not contemplate involvement by

Guaranty Associations in the Plan's operations. This information is provided solely in the interest of addressing anticipated questions.

All U.S. states and the District of Columbia have legislatively established entities, commonly referred to as "Insurance Guaranty Associations," which protect the policyholders of a licensed insurance company in the event their insurance company fails. These Guaranty Associations generally are required to provide for the continuation of the life and health insurance coverage provided by the failed insurer, in most cases up to statutory maximum coverage amounts and subject to specified conditions.

Virtually all of SHIP's LTC insurance policies would be covered under the state Guaranty Association system, subject to individual state statutory maxima and conditions, if SHIP were placed into liquidation with a finding that it is insolvent. Policies held by residents of other countries may not be covered by Guaranty Associations.

In most states, Guaranty Association benefits can be "triggered" in one of several ways. Some "triggers" are permissive, authorizing the Guaranty Association to guarantee, assume or reinsure, or cause to be guaranteed, assumed, or reinsured, the covered contractual obligations arising under the insurer's policies or contracts (or to provide loans or other assistance). Other "triggers" are mandatory, requiring the Guaranty Association to take such measures. When triggered, the Guaranty Associations generally provide such protections to the residents of their states, though the contracts may have been issued in other states. In most states, the permissive trigger can be used when an insurer is deemed "impaired" but has not been found insolvent or ordered liquidated. As the term implies permissive triggers are optional with the Guaranty Associations and very rarely used.

Mandatory triggers generally include an insurer not paying claims on time and being placed in liquidation with a finding of insolvency. These provisions vary somewhat among the several states. The Rehabilitator has concluded that SHIP does not now qualify for mandatory triggers largely because there has not been an order of liquidation with a finding of insolvency and it is currently paying claims on time. However, though SHIP is currently paying claims on time as required by the Rehabilitation Order, its financial condition is so dire that it is a virtual certainty that it cannot continue paying claims in full and on time for as long as required by its LTC insurance contracts without remedial measures. In the absence of a rehabilitation plan, the continuation of full benefit payments to current claimants virtually assures that policyholders who go on claim in the future will not be able to receive full, or in some cases any, benefits from SHIP.

Generally, if a policyholder is entitled to receive benefits from the Guaranty Association of his or her state of residence no further inquiry is necessary to determine which Guaranty Association is responsible for his or her policy. However, when that is not the case, it may be necessary to determine whether the Pennsylvania Life and Health Insurance Guaranty Association (PLHIGA) may be required to provide such benefits because SHIP is domiciled in Pennsylvania. It is important to note that the conditions and limits of Guaranty Association protection typically apply to each policyholder, not to each policy. Thus, in a state in which such benefits are limited to $300,000 (the

majority of states), that limit will apply to all of a policyholder's policies issued by the same company combined. Thus, since many SHIP policyholders have more than one SHIP LTC policy, this limit will apply to all of them combined. If one policy is expected to receive benefits up to the applicable cap, all of the benefits of the other policy or policies will potentially be lost. The laws of each specific jurisdiction should be reviewed carefully to determine how these conditions and limits apply in particular cases.

It is important to note also that the amount of statutorily promulgated Guaranty Association coverage limits is not directly comparable to a policy's GPR. GPR is the present value as of the valuation date of expected benefits unpaid, expected expenses unpaid, and unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect. It measures the present value of benefits and expenses less the present value of premiums. The Guaranty Association coverage limits are stated nominally (that is the total to be paid over time, no matter how long that time) and not at present value. The GPR equivalent of stated Guaranty Association Limit depends on factors individual to each policyholder, mostly related to the expected timing and amount of benefit and premium payments. Thus, a $300,000 Guaranty Association limit may equate to a GPR of $270,000 or some other amount less than $300,000 for a given policyholder.

Neither the Rehabilitator nor SHIP would be responsible for coverage decisions of the Guaranty Associations. Each Guaranty Association evaluates its own liability and makes its own coverage determinations in accordance with applicable law. Those laws vary to some degree among the states and benefits available in some states may differ from those available in others. For example, in some states the Guaranty Associations do not provide coverage for any portion of a policy or contract to the extent that the rate of interest on which it is based exceeds a specified rate, typically set by reference to Moody's Corporate Bond Yield Average over a specified time. These interest rate limitations often apply retrospectively (to interest earned pre-liquidation) and prospectively (to interest earned after liquidation), though perhaps in different ways. Other states have adopted legislation making such provisions inapplicable to LTCI.

As noted above, Guaranty Association benefits are subject to statutory conditions and limits. For example, PLHIGA is not obligated to provide more than $300,000 in benefits to a covered individual. In some states that limit can be significantly higher. However, the fact that applicable limits may be higher in another state does not entitle Pennsylvania residents to the higher protection afforded by the Guaranty Association of another state. In addition, the Guaranty Association statutes contain certain residency and other requirements that must be met in order to receive benefits. Some of SHIP's policyholders may have aggregate claims in excess of these limits or which do not qualify for Guaranty Association benefits for other reasons (Uncovered Benefits).

The methods by which Guaranty Associations discharge their statutory responsibilities vary from case to case but normally involve assumption by a Guaranty Association or an insurer of the contractual obligations created by the policies issued by the failed insurer, up to statutorily prescribed limits and subject to statutory conditions. Policyholders are required to continue paying their premiums without interruption in order to preserve their insurance coverage, unless those premiums have been suspended by Premium Waiver provisions in their policies. However, once benefits paid

by the Guaranty Association reach the applicable statutory limit (and those benefits are therefore discontinued), typically the policyholder will no longer be required by the Guaranty Association to continue making premium payments.

As noted, SHIP has not been placed in liquidation and Guaranty Association coverage and associated limits are therefore not applicable to SHIP policies. While it is hoped that it will not be necessary to place SHIP in liquidation, and no specific plans exist to do so, past experience provides guidance about some likely aspects of such an eventuality. Specifically, it is probable that if the Guaranty Associations are "triggered" for a SHIP liquidation they would seek to raise premium rates using a methodology similar to the Plan's If Knew Premium. Thus, the resulting premium rate increases can be expected to resemble those contemplated by the Plan. To the extent that the Plan does so now, it should reduce or eliminate the need for the Guaranty Associations to do so if that were to occur.

As explained on page 12, the Plan is designed to provide policyholders at least the benefits they would receive from Guaranty Associations in liquidation. Every policyholder will be offered at least one option in Phase One that will provide him or her potential benefits equal to those that would be available from the applicable Guaranty Association in the event of liquidation, but no more than the current policy benefits. Option Two will do that for all policyholders, and for many policyholders other options will do that as well. In that respect, the Plan is expected to place policyholders in no worse a position than they would face in a liquidation of SHIP.

K. LIQUIDATION CLAIMS IN EXCESS OF GUARANTY ASSOCIATION LIMITS

It is estimated that more that 20% of the benefits to which SHIP policyholders are expected to be entitled under current LTC policies would exceed the statutory limits of guaranty association coverage as described in the preceding Section. While the Rehabilitator believed that applicable law would authorize her to use SHIP assets to pay at least part of those "uncovered benefits," some members of the insurance industry hold the opposite view. This issue has so far prevented the liquidator of Penn Treaty Network America Insurance Company and American Network Insurance Company from making such payments. The matter is the subject of litigation pending in the Commonwealth Court. In that proceeding the Court has ruled that policyholders are not entitled to benefits in excess of guaranty association limits. The litigation continues and it is possible that this decision will be reversed on appeal. However, for now at least, that is the law in Pennsylvania, which would also govern a liquidation of SHIP. These two insurers are also Pennsylvania-domiciled long-term care insurers and if that decision remains in place, the Rehabilitator, who is also the Liquidator in those cases, believes that she might be prevented from paying uncovered benefits to SHIP's policyholders if it also has to be placed in liquidation. Thus, it is possible that placing SHIP in liquidation might result in "truncating" the contractual benefits for which policyholders have been paying premiums to the limits of guaranty association coverage.

L. JURISDICTION OF COMMONWEALTH COURT

In composing this Plan, the Rehabilitator makes the assumption that the Commonwealth Court has exclusive *in rem* jurisdiction over SHIP and all of its assets. The Rehabilitator believes that this principle is both established law and indispensable to the success of a rehabilitation plan of this breadth and complexity. That means that it is the only court with jurisdiction over SHIP's assets and business. Note by way of distinction that other courts may have *in personam* jurisdiction over SHIP, its policyholders and claimants. The Commonwealth Court has authority to approve a rehabilitation plan for the company. The governing Pennsylvania statute, 40 P.S. § 221.16, expressly authorizes the rehabilitator to "prepare a plan for the reorganization, consolidation, conversion, reinsurance, merger, or other transformation of" SHIP. Without going into detail, that statute gives the rehabilitator broad discretion to develop a plan to correct the conditions that led to the need to place SHIP in rehabilitation, including changing the Company's policies (and rates) as part of the Plan. So long as all affected parties (including other state insurance departments) are provided an opportunity to object, the Rehabilitator believes they will be bound by the Court's approval of the Plan, and its modification of policies and premium rates as part of the Plan.

Some concern has been expressed by certain state regulators about the notion that premium rate modifications under the Plan will not require approval of the states in which the policies were issued. The concern is not surprising given that there have not been many troubled companies for which the issue of rate increases in rehabilitation has arisen. Moreover, insurance rate regulation tends to be an area of intense public and political focus. In some states, Commissioners are constrained by statute in the magnitude of premium rate increases they can authorize for long-term care insurance policies. Regulations have the same effect in other jurisdictions. The Rehabilitator believes strongly that there is fundamental distinction between rate increases for companies in the market place and the extraordinary case of rate increases as part of a court supervised rehabilitation plan for a troubled company. While the matter is without an abundance of clear specific legal precedent, the Rehabilitator believes that the applicable legal authorities support the conclusion that it is properly within the purview of the Rehabilitator and the Commonwealth Court in an Article V rehabilitation proceeding. More importantly, the Plan would not be feasible, and would fail in a key goal, if rate modifications required approval from each of the states in which SHIP policies have been issued. First, that would prevent the plan from accomplishing its key goal of placing policyholders on "a level playing field" by having them pay substantially the same premium for the same coverage, thereby reducing or eliminating the much-criticized historical subsidies. Second, the need to obtain such approvals would insert a lengthy delay in the time-line that would be costly, if not fatal, to the Plan. Nonetheless, the Rehabilitator has added Section VI.V (page 108) as a means of addressing these concerns. That Section strives to reconcile the desire of certain states to make their own rate increases determinations with the fundamental goals of the Plan.

M. REINSURANCE

SHIP has assumed a number of LTC policies through co-insurance or reinsurance and ceded other policies under other reinsurance agreements. This Section describes those arrangements.

1. TRANSAMERICA

On October 11, 1994, JC Penney Insurance Company and JC Penney Life Insurance Company (collectively "JCP") entered into a Reinsurance and Purchase Agreement and Administrative Services Agreement with American Travellers Life Insurance Company ("American Travellers"). The Reinsurance and Purchase Agreement was structured on an Indemnity Reinsurance basis and a trust account was later established pursuant to a Trust Agreement executed on December 31, 2002. American Travellers was purchased by Conseco in 1996 and subsequently changed its name to Conseco Senior Health Insurance Company and then to Senior Health Insurance Company of Pennsylvania ("SHIP"). JCP changed its name to Stonebridge Life Insurance Company in 2002 and, as a result of corporate transactions, is now Transamerica Life Insurance Company.

2. PRIMERICA

On December 20, 1995 Primerica Life Insurance Company ("Primerica") and Transport Life Insurance Company ("Transport Life") entered into a Reinsurance and Administration Agreement whereby Transport Life, on an indemnity basis, accepted 100% of the policy liabilities of Primerica's individual and group accident and health insurance policies. Transport Life merged with Conseco Senior Health Insurance Company in November 1997 and, with the separation from Conseco, Senior Health Insurance Company of Pennsylvania ("SHIP") became the successor under the Reinsurance and Administration Agreement. Amendment #2 to the Reinsurance and Administration Agreement, dated November 11, 2008, limits the scope of SHIP's reinsurance and administration to long-term care policies only.

3. AMERICAN HEALTH AND LIFE

Pursuant to a Reinsurance Agreement dated November 1, 1996, Transport Life entered into a Reinsurance Agreement whereby Transport Life agreed to administer and reinsure, on a coinsurance basis, 100% of the liability of American Health and Life Insurance Company's long-term care policies. As a result of certain corporate transactions, and later the separation of SHIP from Conseco, SHIP became the successor to Transport Life's interests under the Reinsurance Agreement and continues to administer the policies.

4. WASHINGTON NATIONAL INSURANCE COMPANY

On June 30, 1998, American Travellers entered into a Coinsurance Agreement with Conseco Life whereby American Travellers ceded 100% of its net liability for certain Connecticut resident state policies to SHIP, including servicing and administration of these policies. On April 1, 2013, CNO assumed, through novation, all of the policies with the exception of certain Connecticut policies which opted out of the assumption. Washington National Insurance Company reinsured those Connecticut policies that opted out.

5. CONSECO LIFE INSURANCE COMPANY

Under an Assignment Agreement effective October 1, 2008 with Conseco Life Insurance Company ("CLIC"), all the assets and liabilities pertaining to SHIP's non-long-term care business were assigned to, and assumed by, CLIC, which, together with DXC Technology, administers all of the business. SHIP remains contingently liable for the assigned business in the event CLIC fails to perform its obligations under the Assignment Agreement. In recognition of this liability, CLIC is required to and does maintain assets in a trust account of which SHIP is beneficiary. That account is required, and appears, to be adequately funded. The business they manage consists of:

1. 5,781 Traditional Life,
2. 175 Universal Life,
3. 71 Deferred Annuities,
4. 273 Medicare Supplement,
5. 37,682 Specified Disease,
6. 689 Accident Only,
7. 603 Hospital Indemnity,
8. 435 Long term disability, and
9. 38 Other.

6. TEACHER'S PROTECTIVE MUTUAL LIFE INSURANCE COMPANY

Teacher's Protective Mutual Life Insurance Company ("Teachers'") and Senior Health Insurance Company of Pennsylvania ("SHIP") entered into an Indemnity and Assumption Reinsurance and Administrative Services Agreement on December 28, 2015, pursuant to which Teachers ceded to SHIP, on an indemnity reinsurance basis, 100% of liabilities and obligations paid or payable by Teacher's. These policies have been novated by SHIP so that they are treated as if they had been issued by SHIP in the first place.

7. TREATMENT OF REINSURANCE ASSUMED

The LTC insurance policies for which SHIP became responsible from Transamerica, Primerica and American Health and Life or their predecessors (the "ceding companies") are what is generally referred to in the industry as "reinsurance assumed." All of these assumed LTCI policies have historically been treated by SHIP for administrative purposes in a manner very similar to those issued directly by SHIP. However, communications with policyholders and regulators properly identified them as policies of the ceding companies.

It is important to note that while these policies have been reinsured by SHIP, they were never "novated" as part of the transaction. Novation occurs when the assuming company substitutes for the ceding company so that all of the policyholders' contractual rights are against the assuming company and the ceding company is relieved of further obligation for the policies at issue. That did not happen in these cases. That means that the policyholders retained, and continue to retain, their contractual rights against the ceding companies (the companies that transferred the policies to SHIP

through reinsurance) or their successors. In turn, the ceding companies retain contractual rights against SHIP. However, under the Plan, payments owed by SHIP to the ceding companies on account of these rights are subordinated to amounts owed by SHIP to policyholders under SHIP policies. These assumed policies would not be treated as if they had been issued by SHIP if it were placed in liquidation. In liquidation these policies also would not be subject to the statutory Guaranty Association limits. In the event that SHIP is placed in liquidation, these policies reinsured and administered by SHIP, but not novated, will be administered as the responsibility of the ceding companies.

For purposes of the Plan, it is also important to note that the law governing financially troubled insurers generally requires that liabilities arising under insurance policies issued by the troubled company ("Direct Business") be paid in full before those arising under reinsurance assumed can receive any payment. The companies (or their successors) from which SHIP assumed the Reinsurance Assumed remain responsible to the policyholders if SHIP fails to fulfill the contractual obligations arising under those policies.

The preliminary plan of rehabilitation filed on April 22, 2020, proposed to treat Direct Business and Reinsurance Assumed in the same way under the Plan. The Rehabilitator believed that this would be most advantageous to the affected policyholders. However, this proposal resulted in a number of objections from insurance regulators around the country, asserting that it departs from established custom and practice and is unsupported by applicable law. In response to these objections, the Rehabilitator changed that provision of the preliminary plan of rehabilitation. The Plan now treats the reinsurance assumed differently from the policies issued directly by SHIP and its predecessors. As a result of this change:

a. The reinsurance assumed policies will not be modified under the Plan and the policyholders will not be asked (or have the ability) to make elections under the Plan;

b. SHIP will not be financially responsible for claims and commissions owed under these policies and will not have the right to treat premiums paid by these policyholders as assets of SHIP; and

c. If SHIP is placed in liquidation, the terms of these policies will remain unchanged and the policyholders will not receive benefits from any life and health insurance Guaranty Association. Instead, in that case, the ceding company (or its successor) will remain fully responsible for these policies and any claims and commissions owed under these policies.

Whether, and to what extent, premium rate increases will be sought for these policies in the future will be decided by the ceding companies, not the Rehabilitator. It is possible that SHIP will enter into agreements to administer some or all of these policies in exchange for appropriate fees.

Consistent with this change in the Plan, on October 1, 2020, Transamerica and SHIP entered into a Recapture Agreement though which Transamerica assumed complete responsibility for the

LTC insurance policies its predecessors had ceded to SHIP's predecessors. This Agreement was approved by the Commonwealth Court on December 29, 2020.

N. COMMISSIONS

The payment of commissions owed to Agents under agreements made prior to the inception of rehabilitation proceedings will be suspended under the Plan until policyholders' LTC claims have been paid in full and adequate provision made for reasonably anticipated future claims. Further, the Plan will suspend the accrual of commissions as of the Initial Plan Effective Date. Agents and brokers may assert claims for commissions earned prior to the Initial Plan Effective Date but, under the Plan, those claims will be subordinated to amounts owed to policyholders under SHIP's insurance policies.

The Rehabilitator notes that Agents are not currently providing services at the request of and in support of the Rehabilitator. Since entering rehabilitation, SHIP has evaluated the ongoing role of Agents. It is the belief of the Rehabilitator that most policyholders do not have a close relationship with their Agents, often have not spoken with their Agents since their policies were purchased, and do not contact their Agents for questions about their policies or benefits. Most policyholders contact SHIP directly for policy information or questions, or a financial advisor or trusted professional (lawyer, banker, trustee or family member). The Rehabilitator believes that the payment of commissions should be subordinated to the payment of policyholder obligations consistent with the treatment described in 40 P.S. § 221.44. Certain Agents and Brokers formally objected to this Section VI.N, but per settlement with the Rehabilitator, withdrew their objections as moot.

O. CERTAIN RETIREE BENEFITS

Transport Life Insurance Company, SHIP's predecessor, had entered into employment agreements with several of its former executives that provided for the post-retirement payment of health care benefits for them and their spouses. Through the series of transactions as a result of which Transport Life became SHIP (see page 97), SHIP became responsible for these payments and has continued to make them without interruption. The Rehabilitator believes that these payments are pre-rehabilitation contractual obligations to general creditors. Like agent commissions, they should be subordinated to the payment of policyholder obligations consistent with the treatment described in 40 P.S. § 221.44. As part of the Plan, these payments will be suspended until all policyholder obligations have been satisfied or reasonable provision has been made for them.

P. OPT OUT

The Company's LTC policies do not provide for any cash or surrender value and policyholders are not entitled to any cash payment upon cancellation either in the ordinary course of business or in liquidation. In short, upon liquidation, policyholders would not receive cash payments.

While the Plan does not propose a separately-identified cash opt-out option, certain features of the Plan would satisfy an opt-out requirement if one were found to be applicable. First, many policyholders will not be required by the Plan to make any changes in their policies. Second, every policyholder will have an option in every scenario to select a Non-forfeiture Option under which no more premium will be due. In fact, elements of the Plan make the NFO option materially more valuable than traditional NFOs. See section II.J, page 34. Finally, every policyholder will have at least one option under which he or she would receive at least as much in benefits as would be provided by his or her Guaranty Association coverage.

Q. STATE DEPOSITS

SHIP has been required to place deposits with various states as a condition of its licensing in those states. These state deposits total approximately $19.3 million. The Rehabilitator believes that, as the Plan is implemented, she should pursue recovery of those deposits so that the funds can be used to support the Plan.

R. TAX MATTERS

The Plan is not intended to create net adverse tax consequences for policyholders or SHIP, and the Rehabilitator does not believe that it will do so if it is implemented as proposed. However, the tax effects of the Plan depend in part on events, circumstances and the conduct of other parties that are not within the control of, nor can be predicted by, the Rehabilitator.

While a number of federal income tax issues may arise under the Plan, two areas are of particular importance. First, will any modification of LTC policies under the Plan create adverse tax consequences for policyholders? Second, will the inability to fund fully policy obligations or provisions of the Plan create adverse tax consequences for SHIP?

1. POLICY MODIFICATIONS.

It does not appear that the Plan is likely to create adverse tax consequences for policyholders. However, because Policy Modifications and other provisions of the Plan, may raise such issues, it is likely that the Rehabilitator will seek from the Internal Revenue Service of the Department of the Treasury (the "IRS") a favorable private letter ruling ("PLR") to the effect that Policy Modifications under the Plan would not produce taxable deemed exchanges or other adverse tax consequences for policyholders.

2. TAX ISSUES FOR SHIP

It is possible that reductions in insurance reserves resulting from Policy Modifications or other elements of the Plan would create significant taxable income. However, the Plan contemplates offsets to taxable income arising from the restructuring of SHIP's policies, bifurcating the liabilities arising under them as between their Initial Funded Restructured Policy Value (IFRPV) and their

Unfunded Benefit Liability (UBL), constituting general creditors obligations and not insurance policy liabilities. The Plan also contemplates the eventual discharge by the Commonwealth Court of the portion of the UBL that cannot be paid, which will minimize this tax exposure. The IFRPV is the portion of a policy's liability that SHIP is expected to be able to fund. The UBL is the portion of that liability that SHIP is not expected to be able to fund.

SHIP is part of a consolidated group for federal income tax compliance purposes, which also includes its affiliates, the Trust and Fuzion. The group files a consolidated federal income tax return. SHIP and its affiliates currently possess substantial Deferred Tax Assets ("DTAs") such as net operating loss carry-forwards. These DTAs may serve to offset taxable income generated by operation of the Plan. It is possible that implementation of the Plan may give rise to tax liability, however, because of certain limitations in the Internal Revenue Code on the use of such carry-forwards. The ability of SHIP to realize the benefit of these DTAs may also depend in part on decisions made by other members of the consolidated group. While Fuzion is SHIP's wholly owned subsidiary, and under its control, the Trust is governed independently. Current tax law may affect the degree to which other parties may make decisions adverse to SHIP's interest and rehabilitation. Moreover, the discharge of indebtedness under the Plan may also result in reducing or eliminating SHIP's ability to take advantage of these DTAs.

As indicated above, to the extent that the Plan results in the reduction of policy obligations through the modification of policies to make them properly priced or Self-sustaining, it is possible that such reduction would result in federal income tax liability. It is possible that not all of such income may be excludable under an insolvency exception or be offset against net operating loss carry-forwards and other DTAs. It is also possible, as noted, that implementation of the Plan may give rise to tax liability. The Plan is designed, and the Rehabilitator intends to implement it, in a manner that will minimize or eliminate such potential adverse tax consequences. However, there can be no assurances that these measures will be effective.

Nothing in the Plan Document is intended to provide, nor shall be interpreted as providing tax or legal advice. Policyholders and other persons affected by the Plan should consult their own tax, legal, and other advisors regarding the possible tax and other effects of the Plan. The Rehabilitator may seek guidance (such as a private letter ruling) from the U.S. Secretary of the Treasury regarding certain potential tax aspects or consequences of the Plan.

S. PRINCIPLES AND FAIRNESS OF THE PLAN

The Plan is designed to comply with applicable statutory provisions. In addition, by reference to Pennsylvania statutes and judicial opinions governing other insurance rehabilitation and insolvency proceedings in this and other states, the Rehabilitator has adopted the following core principles that should guide implementation of the Plan:

1. To the extent reasonably possible under the circumstances, the Plan should correct the conditions which constituted the grounds for the order to rehabilitate the Company;

2. The paramount goal of the Plan should be protection of policyholders;

3. The Plan should be fair and equitable;

4. The Plan should put policyholders and creditors as a group in a position not materially inferior to what liquidation of SHIP as of the Effective Date would produce; and

5. The Plan should include metrics to gauge progress.

The Rehabilitator believes that the Plan reasonably embodies these principles and that it is fair and equitable to policyholders, creditors and affected parties. It addresses historically discriminatory premium rates through asset allocations in determining Self-sustaining Policies and through the premium rate increase structure governing Policy Modifications. Within the means available, as regards policyholders the Plan is designed to reduce the Funding Gap which principally led to the inception of the rehabilitation proceeding. It does so through premium rate increases and benefit reductions to reduce or eliminate on a policy-by-policy basis the shortfall between assets and liabilities. The principal goal of the Plan is to protect the interests of policyholders by maximizing preservation of their insurance coverage. It treats similarly situated policyholders in the same way and devotes SHIP's assets to the fulfillment of its purposes in a non-discriminatory and non-arbitrary manner.

T. RISK FACTORS

There are substantial risks and uncertainties associated with the Plan and its implementation. Those described herein are not the only ones that could materially impact SHIP, the Plan, its implementation, and its impact on policyholders, creditors and the public.

1. The actuarial assumptions and projections used to develop the Plan, including investment income, default rates, lapse rates, expenses and claims may be materially different from actual results. Therefore, the benefits and claims that SHIP will be able to pay may be materially higher or lower than the amounts assumed in the Plan.

2. Although the Plan does not contemplate that SHIP will, as a result of the Plan, implement future premium rate increases not described in the Plan, there can be no assurances that such rate increases will not be sought by Guaranty Associations if SHIP is placed in liquidation.

3. Objections may be lodged against the Plan or its implementation which may not be able to be overcome without material changes in the Plan.

4. The Rehabilitator believes that the provisions of the Plan can be implemented with approval of the Commonwealth Court and without the need that insurance regulators in every state approve the Plan, including premium rate increases implemented under the Plan. However, regulators in other states may conclude that their approval is required. The Rehabilitator cannot provide any assurance that approval from other regulators will not ultimately be

deemed necessary. Neither can the Rehabilitator provide assurances that if such other state approvals are necessary they can be obtained consistent with the timing and substance of the Plan.

5. Governmental authorities may change the laws and regulations that apply to SHIP, its business and state insurance receiverships in ways that impact policyholders, SHIP, the Plan, or its implementation negatively.

6. Adverse developments in the broader economy may affect adversely the performance of SHIP's invested assets, the costs of its operations or the development of its liabilities. As a result, financial assumptions made in the Plan may differ materially from actual events.

7. Certain changes in the general health of SHIP's insured population (such as developments prolonging the period that such persons remain on claim, the severity of such claims, or the frequency with which policyholders go on claim) may affect materially the development of SHIP's insurance liabilities. As a result, loss assumptions made in the Plan may differ materially from actual events.

8. The emergence of the Coronavirus disease known as "COVID-19" has created unprecedented and wide-ranging disruptions in virtually every facet of American society. Its economic implications, and the changes that will result in American healthcare and insurance are only now beginning to surface and will take a prolonged time to develop completely and be fully understood. The Rehabilitator cannot predict what effect COVID-19 will have on the Plan and its implementation. The Special Deputy Rehabilitator and rehabilitation team have made efforts to incorporate in the Plan expanded timelines and elements of flexibility that will facilitate responding to these recent and continuing developments.

9. The Plan depends on implementation of a complex restructure of SHIP's insurance business for which there is no close precedent, and which depends in part on legal provisions that may be difficult to implement. Failure to implement these provisions may have a material adverse effect on the success of the Plan.

10. The success of the Plan will depend in part on policyholder elections which are difficult to predict. The actual results of those elections may have a material adverse effect on the Plan.

U. ALTERNATIVES TO THE PLAN

Before determining that the Rehabilitation Plan is the best option for SHIP's policyholders, the Rehabilitator and the rehabilitation team considered a number of alternatives. Each of these is described briefly below, although a complete explanation of what their terms would include would be too lengthy to be included here and would require further development not justified under the circumstances.

1. SALE OR RECAPITALIZATION

Before SHIP was placed in rehabilitation, its management and the Trustees explored many alternatives to avoid delinquency proceedings. These included sale of the company, reinsurance transactions, recapitalization transactions, and restructuring of the investment portfolio. All of these options were deemed impractical or insufficient. SHIP has a closed block of highly unprofitable LTC insurance business making it very unattractive to buyers and investors. Its financial composition is such that legitimate reinsurance transactions would not offer the prospect of material economic improvement. There is no sufficiently profitable block of insurance within the company to absorb the excess risk of the LTC block. The broad capital markets comprise a low-yield environment that also does not offer a reasonable prospect of material economic improvement from restructuring of SHIP's invested assets. Working with Pennsylvania Insurance Department representatives, management did implement a number of cost saving measures, but the net result is too small to avoid the need for rehabilitation.

2. LIQUIDATION

Before embarking on designing the details of the Approved Rehabilitation Plan the team evaluated whether policyholders would be better served by placing the Company in liquidation. After extensive analysis and discussion it was determined that policyholders would fare better under the Approved Rehabilitation Plan. The principal reasons that the Plan was deemed preferable to liquidation were:

a. It would offer policyholders additional choices to address their individual needs under these difficult circumstances.

b. It would provide policyholders the ability to preserve their current coverage if they were willing and able to pay the required premium rate increase.

c. It would eliminate the historical premium rate inequities and subsidies prospectively so that all policyholders would pay comparable premiums for comparable coverages. This is viewed as particularly important since widely different responses to requests for approval of premium rate increases among the states over time have resulted in holders of policies issued in certain states paying substantially higher premiums than holders of similar policies issued in other states. This has created a much-criticized subsidy problem in which the higher premiums paid by the former theoretically have been used in part to pay the claims of the latter.

d. It would avoid the truncation of policy benefits to the applicable Guaranty Association limit ($300,000 in most states). This would be particularly important to the policyholders who have more than one SHIP LTC policy since the Guaranty Association limits apply to each insured for all policies combined. See Section VI.K, page 95.

e. Unlike what would occur under the Plan, premium rate increases sought by Guaranty Associations in liquidation would inure to the benefit of insurers assessed to fund the Guaranty Associations, not for policyholder claims.

3. "GOOD BANK - BAD BANK"

Consideration was also given to a rehabilitation plan along the lines that had been proposed for Penn Treaty Network America Insurance Company and its subsidiary, American Network Insurance Company. Under such a "business division" plan, SHIP's LTC business would be divided between a "Good Bank" and a "Bad Bank." Separate legal entities would hold each group of policies, liquidating one with Guaranty Association benefits, and placing the self-sustaining policies, in the other for continued coverage. Many aspects of this plan would be unprecedented and potentially controversial.

It is doubtful that both companies could retain insurance licenses in all the states in which SHIP has been licensed. Many of those licenses have already been suspended or revoked and may be hard to recover in SHIP's current condition. This is problematic because Good Bank needs the licenses to continue the self-sustaining policies in business and Bad Bank may need them in order to remain a "member insurer" so as to retain Guaranty Association protection.

In order to afford policyholders the option to make non-self-sustaining policies self-sustaining and eligible to be in "Good Bank," a complicated elective modification process would have to be implemented. That process would be vulnerable to the same criticism as the Rehabilitation Plan in that the required modifications would have to be approved by the Rehabilitator and the Rehabilitation Court, not the issuing state.

The Plan would be even more complex than the Proposed Rehabilitation Plan and would likely draw even more objections.

4. PROPOSED REHABILITATION PLAN

The Approved Rehabilitation Plan is the Rehabilitator's recommended approach for SHIP's rehabilitation. However, there are a number of states that have objected with varying degrees of formality to the aspect of the Plan under which the premium rates and benefits of SHIP's policies issued in their states would be modified with the approval of the Commonwealth Court but not of the insurance regulator of the issuing state ("Objecting States"). The Rehabilitator has considered the alternatives described in the following three Sections to address these concerns.

5. ANCILLARY APPROVAL OF MODIFICATIONS

One such alternative would have been to submit benefit and premium rate modifications for approval by each issuing state. The Rehabilitator has concluded that this would even be inferior to liquidation. First, past experience indicates that the process of obtaining approval for rate and benefit modifications would take a prolonged period of time. Second, the same experience indicates

that the outcome can be expected to be widely divergent rates for similar policies, perpetuating the premium subsidies, inadequate premium rates, and hodgepodge of reduced-benefit options. In addition, implementation of such an approach would be immensely more complicated than the normal multi-state insurance rehabilitation in which the domiciliary regulator and court manage the entire proceeding.

6. EXCLUDE OBJECTING POLICIES

Another possible approach would have been to avoid rate increases for policies issued in Objecting States ("Objecting Policies"). That would have required that those policyholders not be able to select Option One (Downgrade), Option Two (Basic Policy Endorsements), or Option Four (If Knew Premium rate increases for current benefits). Those three options entail modification of rates or benefits in the existing policies. That would have left only the Non-forfeiture Option ("NFO") for these policyholders. Although the NFO eliminates premiums permanently, it reduces benefits substantially, though not as much as the NFO or reduced paid-up policy ("RPU") currently offered to lapsing policyholders. This very limiting outcome would have been highly undesirable.

As a variation of this alternative, the Objecting States could have been asked to permit SHIP to offer Objecting Policies Option 1 under the Plan as well, allowing them to retain reduced benefits without premium changes. For some policyholders that could have been preferable to the NFO, although for others the NFO might be the better deal. Objecting States might also have allowed SHIP to offer Option Two, which entails more moderate rate increases, and even no rate increases in some cases.

This approach might have allowed the Plan to proceed without making the objectionable modifications to the Objecting Policies while retaining all the Plan benefits for other policyholders. The net effect could have been beneficial for the outcome of the Plan if more policyholders elected to give up their current rich policies which collectively account for the bulk of SHIP's problem.

However, for the affected policyholders this would have been materially inferior to the *status quo* and the Plan because policyholders would have had much more limited options and would not have had the possibility of retaining their current benefits even by paying the required premiums. Accordingly, the Rehabilitator did not favor this approach that effectively would have put the Objecting Policies at a disadvantage when compared to the treatment of other policyholders under the Plan.

7. ISSUE-STATE RATE APPROVALS

The Rehabilitator has concluded that a better alternative is to let the Commissioner (or equivalent officer) in a particular state withdraw all of the policies issued in that state from the rate increase determination provisions of the Plan and instead have that Commissioner make the rate increase determination for those policies independent of the Plan. Under this approach, if a commissioner advises the Rehabilitator to that effect, the rate increases resulting from Options under the Plan will not apply to the policies issued in that state (the "opt-out state"). Instead, the insurance

department of the opt-out state will make the rate increase determinations for those policies and the benefits under Plan provisions will be adjusted to correspond to the premium rates approved by the opt-out state. The Rehabilitator proposed this approach and it is now part of the Approved Rehabilitation Plan. Section VI.V, below at page 108, describes the basic elements of the mechanism for enabling states to make their own rate increases decisions within the context of the Plan. Note that, apart from the rate increase determinations, under this approach the policies issued in the opt-out state will still be administered by the Rehabilitator under the Plan so that the opt-out state will not have to provide that administration.

8. CONCLUSION

On balance, the Rehabilitator concluded that the best approach is the Plan as approved by the Court, with the component as described in alternative seven, above. Accordingly, the Approved Plan now includes the additional following section.

V. ISSUE-STATE RATE APPROVALS

This Section describes the issue-state rate approval alternative for states that object to the Rehabilitator and the Commonwealth Court modifying rates as part of the Plan for SHIP LTC policies issued in those states, and which elect to make their own determinations as to such rate increases themselves (***Opt-out States***).

While this Section was added to the Plan to accommodate that objection, the Rehabilitator makes an important observation. In order to reduce policyholder subsidization and overall burden, and in an effort to achieve the best result possible under the circumstances, the Rehabilitator has undertaken the development of a model that allows her to address each policy individually in a seriatim fashion. Most, if not all, material policyholder calculations under the Plan (including premium rate adjustments) are performed individually for each long-term care policy. As noted more fully below, if a state elects to make its own determination for the rates charged for the policies issued in that state in groups rather than individually, the result may be disadvantageous to many policyholders. In determining whether or not to "opt out" a state should consider carefully its ability to address the circumstances of each policy individually, as does the Rehabilitator. If a state is unable or unwilling to do this, it may want to evaluate whether the results of its premium rate increase decisions may prove to be inferior to those proposed by the Rehabilitator, all things considered.

1. SUMMARY

If the chief insurance regulator ("Commissioner") of an issue-state formally advises the Rehabilitator that his or her state elects to "opt-out" of the rate increase component of the Approved Rehabilitation Plan, the Plan will not apply in the same way to the policies issued in that state (the ***Opt-out Policies***). In that case, the Rehabilitator will file in the Opt-out State a premium rate increase request for the Opt-out Policies the Current Premiums of which are below If Knew

premiums. **Holders of Opt-out Policies with Current Premiums equal to or greater than If Knew Premium will be unaffected and will retain their current policies without modification.** The holders of the Opt-out Policies with Current Premium below If Knew Premium will not be able to elect from among the Plan options and will instead have the choices described below, determined by how the Opt-out State responds to the Rehabilitator's premium rate increase request.

THE INTENT OF THIS SECTION IS TO ENABLE STATES THAT OBJECT TO THE REHABILITATOR OR COMMONWEALTH COURT SETTING PREMIUM RATES UNDER THE PLAN WITHOUT THEIR APPROVAL TO REVIEW AND APPROVE (ENTIRELY OR PARTIALLY) OR DISAPPROVE THE PLAN'S PREMIUM RATES THEMSELVES. HOWEVER, THE EFFECTS OF A STATE "OPTING OUT" UNDER THIS SECTION MAY INCLUDE A REDUCED NUMBER OF MEANINGFUL OPTIONS FOR AFFECTED POLICYHOLDERS AND SOME OF THOSE POLICYHOLDERS PAYING HIGHER PREMIUMS THAN THEY WOULD UNDER THE PLAN. IN ADDITION, SOME POLICYHOLDERS WHO DO NOT MAKE AN ELECTION MAY FACE INVOLUNTARY BENEFIT REDUCTIONS.

IT SHOULD ALSO BE NOTED THAT THE DECISIONS OF OPT-OUT STATES WILL AFFECT POLICYHOLDERS RESIDING IN OTHER STATES WHOSE POLICIES HAD BEEN ISSUED IN THE OPT-OUT STATE. CONVERSELY, THOSE DECISIONS WILL NOT AFFECT POLICIES HELD BY RESIDENTS OF THE OPT-OUT STATES BUT ISSUED IN OTHER STATES.

2. OPT-OUT ELECTIONS

a. In the next few weeks, the Rehabilitator will provide every state in which SHIP policies in force (and not in NFO status) have been issued the opportunity to opt out of the rate approval provisions of the Plan. Every state that has not by the specified deadline (the ***Opt-out Deadline***) communicated to the Rehabilitator an election to opt out will be deemed to have opted into the Plan and the rest of this Section will not apply to the policies issued in that state. The Rehabilitator will endeavor to provide states at least thirty (30) days to make the Opt-out Election. States may, but are not required to, affirmatively opt into the Plan. States that do not timely communicate an appropriate Opt-out Election to the Rehabilitator will be deemed to have opted into the Plan.

b. The communication necessary to Opt Out (the ***Opt-out Election***) must be signed and sworn by the Commissioner, Director, Superintendent or other senior insurance regulatory official of the state. The communication need not take any particular form but must contain the following statement:

> *On behalf of the State [or Commonwealth] of [X], and in the exercise of my authority as [X]'s senior insurance regulatory official I hereby elect to withdraw from the premium rate increase approval provisions of the Rehabilitation Plan for Senior Health Insurance*

Company of Pennsylvania (SHIP) all of the in force long-term care insurance policies currently held by SHIP and first issued by SHIP or its predecessors in [X]. I have read the Plan and understand the consequences of this election.

c. The original signed and sworn Opt-out Election must be received by the Rehabilitator at the address specified no later than the Opt-out Deadline, but the Opt-out Election will be effective if an electronic form (including a facsimile) of the Opt-out Election is received by the Rehabilitator on or before the Opt-out Deadline and the original signed and sworn Opt-out Election is received by the Rehabilitator no later than ten days after the Opt-out Deadline. **It is recommended that states commence the evaluation of whether they want to opt out of the Plan as soon as possible so that they will have ample time to finalize and communicate their decision once they receive the opt-out election notice. The Rehabilitator will be pleased to answer any question that may assist a state in evaluating this matter. States have not been required to take any action under this Section before the Plan was approved.**

d. The Rehabilitator will acknowledge every Opt-out Election in writing. An Opt-out Election sent in advance of the Opt-out Deadline may be canceled by the Opt-out State in a communication sent in the same manner and received by the Rehabilitator no later than the Opt-out Deadline so long as it contains the following language:

*On behalf of State [or Commonwealth] of [X], and in the exercise of my authority as [X]'s senior insurance regulatory official, having first elected by communication dated [*Opt-out Election date*] to withdraw from the premium rate increase approval provisions of the Rehabilitation Plan for Senior Health Insurance Company of Pennsylvania (SHIP) as to all of the in force long-term care insurance policies currently held by SHIP and first issued by SHIP or its predecessors in [X], I hereby revoke the Opt-out Election. Accordingly, I request that all of the SHIP long-term care insurance policies issued in [X] be included in the premium rate increase approval provisions of SHIP's Rehabilitation Plan. I have read the Plan and understand the consequences of this revocation.*

e. Opt-out Elections may only be revoked after the Opt-out Deadline with the Rehabilitator's written consent. Generally, such consent will be provided unless the revocation will have an adverse effect on the Plan or opt-in policyholders.

f. An Opt-out Election will be effective as to all Opt-out Policies the Current Premium of which is below If Knew Premium, even if the Opt-out State determines to approve

some (but not all) of the premium rate increases sought by the Rehabilitator from the Opt-out State. A STATE MAY NOT OPT OUT AS TO ONLY SOME OF SHIP'S POLICIES ISSUED IN THAT STATE.

PHASE ONE

3. PREMIUM RATE INCREASE APPLICATION

a. Following receipt of a valid Opt-out Election, the Rehabilitator will file in each Opt-out State a request for approval of the full amount of actuarially justified rate increases (on an If Knew Premium basis) for the SHIP LTC policies issued in that state the Current Premium of which is below If Knew Premium. The rate increase application will be submitted on a seriatim basis (that is, policy-by-policy, not in the aggregate or by policy form), seeking a specific rate increase for each policy. No rate increases will be sought for Opt-out Policies the premiums of which are already equal to or above the If Knew Premium or which are on premium waiver (including those in NFO status). If an Opt-out State does not respond to the application for rate increases as to any policy within 60 days, the request as to that policy will be deemed denied. If an Opt-out State does not respond to the Rehabilitator's rate increase application within 60 days, the request will be deemed denied in its entirety. An Opt-out State may approve premium rate increases for Opt-out Policies in whatever amount it deems appropriate and the approved percentages may vary among the Opt-out Policies the Current Premium of which is below If Knew Premium. The Opt-out State's decision as to the requested rate increases will govern the choices available to the holders of Opt-out Policies the Current Premium of which is below If Knew Premium.

b. If the Opt-out State timely approves the requested rate increases in full for all Opt-out Policies, it will be treated as if it had not opted out of the Plan, it will be deemed to be an ***Opt-in State***, and its policyholders will be included in the Plan just as those whose policies were issued in states that did not opt out (Opt-in States). If the Opt-out State does not timely approve the full rate increase sought by the Rehabilitator for all Opt-out Policies, all of the policies (including those on premium waiver) issued in that state the Current Premium (whether or not waived) of which is below If Knew Premium will be deemed Opt-out Policies subject to the following provisions.

c. If the Opt-out State responds to the rate increase application in the aggregate or by group (such as by policy form) rather than seriatim (policy-by-policy), the Rehabilitator will apply the resulting increases on a policy-by-policy basis. Note that, for some policyholders, the state's approved rate might exceed the requested rate increase.

d. APPROVAL OF THE RATE INCREASES IN THE AGGREGATE RATHER THAN SERIATIM (POLICY-BY-POLICY) COULD RESULT IN SOME POLICYHOLDERS BEING REQUIRED TO PAY A HIGHER PREMIUM RATE THAN REQUESTED BY THE REHABILITATOR AND HIGHER RATES THAN THEY WOULD PAY UNDER THE PLAN.

e. ALSO, APPROVAL OF THE RATE INCREASES IN THE AGGREGATE RATHER THAN SERIATIM COULD RESULT IN SOME POLICYHOLDERS PAYING A LOWER PREMIUM RATE THAN REQUESTED BY THE REHABILITATOR AND RECEIVING BENEFIT DOWNGRADES UNDER THE DEFAULT OPTION (OPTION A).

f. PRELIMINARY MODELING BY THE REHABILITATOR SUGGESTS THAT, IF A STATE WERE TO MAKE A RATE DETERMINATION FOR ALL OF THE LTC POLICIES ISSUED IN THAT STATE (INCLUDING THOSE WITH PREMIUM AT OR ABOVE IF KNEW PREMIUM AS TO WHICH THE REHABILITATOR DID NOT SEEK A RATE INCREASE) AS A GROUP, AS MANY AS 65% OF POLICYHOLDERS WILL PAY HIGHER PREMIUM RATES THAN THEY WOULD IF THE RATES WERE DETERMINED SERIATIM.

g. IN ADDITION, RATE APPROVAL IN THE AGGREGATE OR BY GROUP, RATHER THAN SERIATIM, MAY RESULT IN A MATERIAL INCREASE IN THE SUBSIDIZATION OF SOME POLICYHOLDERS BY OTHERS.

h. OPT-OUT POLICYHOLDERS MAY BE ADVISED BY THE REHABILITATOR THAT THE RESULTING PREMIUM RATES ARE THE RESULT OF DECISIONS MADE BY THE OPT-OUT STATE.

4. TREATMENT OF OPT-OUT POLICIES IN PHASE ONE - PREMIUM PAYING POLICIES

a. Holders of Opt-out Policies with Current Premium below the If Knew Premium, will be able to choose from among several options described below. These options are designed to preserve as much choice as reasonably possible while giving effect to the Opt-out State's rate decision and avoiding or minimizing subsidies by other policyholders. Holders of Opt-out Policies with Current Premiums equal to or greater than If Knew Premium will be unaffected and will retain their current policies without modification unless the Opt-out State mandated a change in their premium rates. That could occur if such policies were part of a group for which the Opt-out State mandated a premium rate increase for the entire group.

b. In Phase One of the Plan, the choices for holders of Opt-out Policies with Current Premium below the If Knew Premium, and which are not subject to a premium waiver (*i.e.,* those paying premiums), will be:

OPTION A:

Pay the required premium (including approved premium rate increases) and keep the current policy. However, every opt-out policy with premiums below the If Knew level (after implementing the rate increase approved by the Opt-out State) will be downgraded to the benefit level supported (on an If Knew Premium basis) by the premium approved by the Opt-out State. The downgrade will be calculated using a method substantially similar to the Plan downgrade mechanism (see Section III.A.1.c, page 43). The Downgrade Process for Option A has fewer steps than the Plan downgrade mechanism for Opt-in policies in that Benefit Reductions Eight (extension of elimination period) and Ten (removal of waiver of premium) do not apply to Opt-out policyholders. The downgrade will be adjusted so that the resulting Maximum Policy Value (MPV) is no lower than the lesser of the policy's current MPV or the applicable guaranty association limits (the "MPV floor"). This will be accomplished by implementing the downgrade and extending the policy's Maximum Benefit Period (MBP) as necessary so that the resulting MPV satisfies that requirement. In the event that the MPV floor applies, Benefit Reductions Eight (extension of elimination period) and Ten (removal of waiver of premium) do not apply to Opt-out policyholders. Option A will be the default option for Opt-out Policies with Current Premium below If Knew Premium.

NOTE THAT, BECAUSE THIS IS THE DEFAULT OPTION, THE BENEFITS PROVIDED BY A POLICY FOR WHICH THE RATE APPROVED BY THE OPT-OUT STATE IS BELOW THE IF KNEW PREMIUM RATE WILL AUTOMATICALLY BE DOWNGRADED. POLICYHOLDERS CAN AVOID SUCH DOWNGRADES BY SELECTING OPTION D AND PAYING IF KNEW PREMIUMS.

Opt-out Policies as to which the premiums, taking into account the Opt-out State's decision on the Rehabilitator's rate increase application, are at or above the If Knew Premium will not be downgraded if they select Option A.

OPTION B:

In lieu of the approved rate increase, elect a specified benefit downgrade calibrated to the Current Premium (omitting approved premium rate increases) on an If Knew basis. The downgrade will be determined by a calculation substantially similar to the Plan downgrade mechanism and policyholders will not be able to select specific benefit changes. Unlike OPTION A, the downgrade in this case will not be "floored" at the lesser of the current MPV or applicable guaranty association limit. This option allows policyholders to avoid any rate increase.

OPTION C:

Select the Opt-out State-required reduced paid-up policy ("RPU") or Non-forfeiture Option ("NFO"). If the state does not require a particular RPU or NFO,

policyholders will be offered the RPU or NFO currently specified in their policies. If no RPU or NFO is specified in the policies, policyholders selecting this Option will be provided an NFO used by SHIP before the Plan. In all of these cases, this will be a paid-up policy of moderate benefits for which no premium need ever be paid again. OPT-OUT POLICYHOLDERS WILL NOT BE ABLE TO SELECT THE ENHANCED NFO OFFERED UNDER THE PLAN, WHICH GENERALLY OFFERS A LONGER BENEFIT PERIOD.

OPTION D:

Keep the current policy benefits and accept a premium increase to the If Knew Premium for the benefits provided by the policy even though such a rate increase has not been approved by the Opt-out State. This is strictly an elective option that will never apply by default and is intended to provide policyholders the ability to retain the current benefits when they are able and willing to pay the required premium. In other words, this option strives to avoid taking contractual benefits away from policyholders who are willing to pay for them. THIS PROVISION IS INTENDED TO REDUCE POTENTIAL DISADVANTAGES OF OPTING OUT.

5. TREATMENT OF OPT-OUT POLICIES IN PHASE ONE - POLICIES ON PREMIUM WAIVER

a. Every Opt-out Policyholder on premium waiver will retain the waiver as long as required by the policy, but if the Current (waived) Premium is below the If Knew level and the policy's current MPV is greater than the GA limit, the policy's MBP will be reduced to the longer of (1) what can be supported by the Current Premium (had it not been waived) on an If Knew basis, and (2) the MBP required to make the MPV no less than the GA limit. If the current MPV is lower than the GA limit, or if the waived premium is at or above the If Knew level, the MBP will be left unchanged. This is designed to provide substantially no less benefits than what would happen in liquidation while minimizing involuntary subsidies by other policyholders.

b. Once the waiver expires, such policyholders with waived premium below the If Knew level will be required to resume paying premium at the current rates and retain the reduced MBP (if it has been reduced as explained above).

c. In Phase One, Opt-out policyholders on premium waiver will not be subject to rate increases and will not be able to choose any other option.

PHASE TWO

6. IMPLEMENTATION OF PHASE TWO FOR OPT-OUT POLICIES

a. In general, if and when Phase Two of the Plan is implemented for policies issued in Opt-in States, it will also be implemented for Opt-out Policies. The implementation

will be similar to that described for Phase One, above but based on Self-sustaining Premiums rather than If Knew Premium. If the Rehabilitator adopts an alternative premium structure for Phase Two it will apply to Opt-out Policies as well. See Section II.E.6, page 28.

b. In Phase Two, the Rehabilitator will file in the Opt-out State a new premium rate increase request for the Opt-out Policies the Current Premiums of which are below Self-sustaining Premiums and which are not on premium waiver. As in Phase One, the Phase Two rate increase application will be filed on a seriatim basis. The Opt-out State's decision as to the requested rate increases will govern the choices available to the holders of Opt-out Policies in Phase Two.

c. Because the Opt-out State has already been deemed to have opted out in Phase One, timely approval of the Phase Two requested rate increases in full for all Opt-out Policies will NOT result in the state being treated as if it had not opted out of the Plan. All of the policies issued in that state have been deemed Opt-out Policies in Phase One and remain so in Phase Two.

d. If the Opt-out State responds to the Phase Two rate increase application in the aggregate or by group rather than seriatim (policy-by-policy), the Rehabilitator will apply the resulting increases on a policy-by-policy basis. AS IN PHASE ONE, THIS COULD RESULT IN SOME POLICYHOLDERS BEING REQUIRED TO PAY A HIGHER PREMIUM RATE THAN REQUESTED BY THE REHABILITATOR AND HIGHER RATES THAN THEY WOULD PAY UNDER THE PLAN. That would occur if the state's approval exceeded the requested rate increase for one or more policies.

e. OPT-OUT POLICYHOLDERS MAY BE ADVISED BY THE REHABILITATOR THAT THE RESULTING PREMIUM RATES ARE THE RESULT OF DECISIONS MADE BY THE OPT-OUT STATE.

f. Holders of Opt-out Policies with Current Premiums equal to or greater than Self-sustaining Premiums will be unaffected and will retain their current policies without modification unless the Opt-out State mandated a change in their premium rates. That could occur if such policies were part of a group for which the Opt-out State mandated a premium rate increase for the entire group. The holders of the Opt-out Policies with Current Premium below Self-sustaining Premiums would not be able to elect from among the Plan options and would instead have the choices described above but based on Self-sustaining Premiums, determined according to how the Opt-out State responds to the Rehabilitator's premium rate increase request.

g. For purposes of calculating the Self-sustaining Premiums of Opt-out Policies in Phase Two, the Rehabilitator will use a separate pool of assets from those used in the calculation of Self-sustaining Premiums for policies in Opt-in States. Assets will be

allocated between the two pools in proportion to accumulated premium paid by the then current policyholders of each group of states.

7. TREATMENT OF OPT-OUT POLICIES IN PHASE TWO - PREMIUM PAYING POLICIES

   a. If and when Phase Two is implemented for policyholders participating in the Plan, the process described above (with the same options) will be repeated for premium-paying Opt-out Policies using Self-sustaining Premiums instead of If Knew Premium. However, policies that would be fully covered by the applicable guaranty association if SHIP were placed in liquidation, are Self-sustaining, or have elected the NFO or RPU would not be affected in this second phase.

   b. NOTE THAT THERE CAN BE A MATERIAL DIFFERENCE IN PHASE TWO PREMIUMS BETWEEN POLICIES THAT ARE FULLY COVERED AND THOSE THAT ARE NOT, EVEN IF THEY ARE OTHERWISE SIMILAR AND THEIR MPV DIFFERS BY A SMALL AMOUNT.

8. TREATMENT OF OPT-OUT POLICIES IN PHASE TWO - POLICIES ON PREMIUM WAIVER

   a. Much as in Phase One, every Opt-out Policyholder on premium waiver will retain the waiver in Phase Two as long as required by the policy. If the waived premium is below the Self-sustaining Premium level and the policy's current MPV is greater than the GA limit, the policy's MBP will be reduced to the longer of (1) what can be supported by the Current Premium (had it not been waived) on a Self-sustaining Premium basis, and (2) the MBP required to make the MPV no less than the GA limit. If the current MPV is lower than the GA limit, or if the waived premium is at or above the Self-sustaining Premium level, the MBP will be left unchanged.

   b. Once the waiver expires, such policyholders with waived premium below the Self-sustaining Premium level will be required to resume paying premium at the current rates and retain the reduced MBP (if it has been reduced as explained above).

   c. As in Phase One, Opt-out Policyholders on premium waiver will not be subject to rate increases in Phase Two and will not be able to choose any other option.

9. Other provisions of the Plan not affected by these provisions would remain as applicable to the Opt-out Policies as to other policies. Additional details of the opt-out provisions will be specified depending on further discussions with other regulators and the Orders of the Court.

10. This approach is designed to defer to the issue-state for rate approval by making its decision the default option. It would reduce or eliminate the requirement that other policyholders subsidize the Opt-out Policies prospectively and provides Opt-out Policyholders benefits at

least equal to, and in many cases exceeding, what they would receive in liquidation. It would offer policyholders benefit downgrade options in lieu of the approved rate increases as well as a reduced paid-up policy option. In addition, to reduce the disadvantage of being excluded from the Plan, these policyholders would also be offered the option of retaining the current coverage if they are able and inclined to pay the required premium.

COMPARISON OF OPTIONS FOR OPT-IN AND OPT-OUT POLICYHOLDERS IN PHASE ONE

11. The options available to Opt-out policyholders differ in some respects from those available to Opt-in policyholders.

a. Option One for Opt-in policyholders is the same as Option B for Opt-out policyholders.

b. Opt-in policyholders do not have the equivalent of opt-out Option A - pay the approved rate and be downgraded to what that rate buys on an If Knew basis subject to the GA floor. That is because the "approved rate" for Opt-in policyholders would be the If Knew Premium, which would make Option A the same as Option D. The Opt-in policyholder option most similar to Option A for Opt-out policyholders is Opt-in Option Two, the Basic Policy Endorsement which, like Opt-out Option A, might entail both premium increases and benefit reductions. Note, however, that Option A does not exempt Opt-out policyholders from modifications in Phase Two, while Opt-in policyholders who elect Option Two in Phase One will not face additional rate increases or Benefit Reductions in Phase Two.

c. Opt-out policyholders do not have the equivalent of Opt-in Option Two, the Basic Policy Endorsements (which is the Default Option for premium-paying Opt-in policyholders) and enhanced Basic Policy Endorsements. The Basic Policy Endorsements consist of specific Policy Modifications intended to provide reasonable benefits and premiums that, if selected in Phase One, will be immune from changes in Phase Two of the Plan. Opt-in policyholders making this election will not face additional modifications in Phase Two of the Plan, except that they may be required to pay full premium rather than Differential Premium if a Premium Waiver becomes inactive.

d. Both Opt-in policyholders and Opt-out policyholders have an NFO option (Option Three for Opt-in policyholders and Option C for Opt-out policyholders); however, it is likely to be "richer" for Opt-in policyholders. For Opt-out policyholders, this is the only option that ensures that they will not face potential premium rate increases or benefit reductions in Phase Two.

e. Both groups have the same If Knew premium option – Option Four for Opt-in policyholders and Option D for Opt out policyholders. Note that Option Four in

Phase One for Opt-in policyholders is based on Phase One premium (the greater of the current premium and the If Knew premium) while Option D for Opt-out policyholders is based simply on if knew premium. However, they operate the same way because Opt-out policyholders with premium at or above If Knew premium will have no modifications, rate increases, or options. Thus, both Opt-in and Opt-out policyholders already paying at least If Knew premiums will be exempt from mandatory modifications. Although Opt-in policyholders with current premiums at or above If Knew premiums (and who therefore are not required to elect modifications under the Plan) can voluntarily select other options, Opt-out Policyholders with premiums at or above If Knew Premium will not have that option. They will simply retain their current premium and benefits.

f. For policyholders on premium waiver, the major difference is that Opt-out policyholders will not be required to pay Differential Premium, while Opt-in policyholders will be required to pay a Differential Premium if they elect to keep their current benefits. However, if the waived premium for an Opt-out Policy is below the If Knew level and the policy's current MPV is greater than the GA limit, the policy's MBP will be reduced to the longer of (1) what can be supported by the current premium (had it not been waived) on an If Knew basis, and (2) the MBP required to make the MPV no less than the GA limit. If the current MPV is lower than the GA limit, or if the waived premium is at or above the If Knew level, the MBP will be left unchanged.

W. DISCLAIMERS AND SOURCES OF INFORMATION

The discussion of the Rehabilitation Plan in this document describes how it is proposed to be implemented by the Rehabilitator. If the Plan is modified by the Court or pursuant to subsequent amendments proposed by the Rehabilitator, its implementation may differ materially from the description herein.

The Plan includes information concerning SHIP's history and current and projected financial condition. This information was prepared based on information available to SHIP and the Rehabilitator, including information provided by SHIP to the Rehabilitator or available in historical public filings, and on actuarial projections that inherently include a degree of uncertainty. The Rehabilitator has yet to conclude an investigation of all the reasons that led to the Company's distressed financial condition. Pursuant to her statutory ability to do so, the Rehabilitator has delegated broad responsibility to the SDR and references in the Plan to the Rehabilitator should be interpreted as including the SDR unless specified otherwise. The Rehabilitator and SHIP do not make (and hereby disclaim) any warranty, express or implied, as to the accuracy or completeness of the information contained in the Plan. In particular, events and forces beyond the control of the Rehabilitator and SHIP may alter the assumptions upon which the disclosures in the Plan are based. The Plan Document includes certain projections, but they cannot forecast and reflect fully any events that may occur subsequent to the date hereof. Such events may have a material impact on the information contained in the Plan Document and any recovery or benefits that may be received by

policyholders and other creditors of the Company. The Rehabilitator may or may not update the Plan (including the financial information and underlying assumptions) or may only update it in part or only after the passing of substantial amounts of time. Therefore, the financial information and projections set forth in this Plan document may become outdated with the passage of time.

THE REHABILITATOR AND SHIP ARE NOT OFFERING LEGAL, BUSINESS, FINANCIAL, TAX OR OTHER ADVICE TO ANY PERSON AND THE PLAN SHOULD NOT BE CONSIDERED TO CONTAIN ANY ADVICE OR INSTRUCTION CONCERNING SUCH MATTERS. THE READER SHOULD CONSULT WITH HIS OR HER LEGAL, BUSINESS, FINANCIAL, TAX AND OTHER ADVISORS AS TO ANY MATTERS CONCERNING THE PLAN.

The Plan document is not required to be prepared in accordance with federal or state securities laws. None of the Securities and Exchange Commission ("SEC"), any state securities commission, or any similar governmental body has approved the Plan Document or has opined on the accuracy or adequacy of the statements contained therein. None of the financial information in the Plan Document was prepared to comply with published guidelines of the SEC, the American Institute of Certified Public Accountants, U.S. Generally Accepted Accounting Principles or prescribed statutory accounting principles, except as specifically described therein.

The Plan Document may not be relied upon for any purpose (including to trade, buy or sell claims or securities) other than to obtain information about the details of the Plan and the related proceeding. Nothing contained herein is intended as or constitutes an admission of any fact or any party's liability with regard to any claim or litigation, including, but not limited to, any proceeding involving the Rehabilitator, SHIP, or any other party, or any proceeding with respect to the legal effect of the transactions contemplated by the Plan. Nothing contained in the Plan Document constitutes an admission, or can be deemed evidence, of the tax or other legal effects of the Plan on SHIP or on holders of claims against, or equity interests in, SHIP or its affiliates. Statements as to the rationale underlying the treatment of claims and other matters under the Plan are not intended to, and will not, waive, compromise or limit any of the Rehabilitator's or SHIP's rights, defenses, or causes of action.

The Plan document contains statements that are, or may be deemed to be, "forward-looking statements" within the meaning of the Private Securities Litigation Reform Act of 1995. Any such forward-looking statements are based upon a variety of estimates and assumptions that, though considered reasonable by the Rehabilitator, may not be realized, and are inherently subject to significant business, economic and other uncertainties and contingencies. Some assumptions inevitably will not materialize and events and circumstances occurring subsequent to the date on which the statements were prepared may be significantly different from those assumed, or may be unanticipated, and thus may affect financial or other results in a material and possibly adverse manner. The statements, therefore, should not be relied upon as a guaranty or other assurance of the actual results that will occur.

To ensure compliance with Internal Revenue Service Circular 230, holders of claims and other interests are hereby notified that: (a) any discussion of United States federal tax issues contained or referred to in the Plan Document is not intended or written to be used, and cannot be used, by holders of claims and other interests for the purpose of avoiding penalties that may be imposed on them under the Internal Revenue Code; (b) such discussion is provided solely in connection with the transactions or matters addressed herein; and (c) holders of claims and other interests should seek advice based on their particular circumstances from an independent tax advisor.

All summaries of the Plan contained herein or in other materials prepared by the Rehabilitator or others, including other filings with the Court, are qualified in their entirety by reference to the Plan as set forth in its entirety herein. Summaries of the Plan herein are not complete and are subject to, and qualified in their entirety by, reference to the full text of the Plan.

VII. GLOSSARY

The following are terms used in, and helpful in understanding, the Plan.

1) **"Accumulated Premium"** means, for a policy or group of policies, the total Gross Premiums paid, and premium waived under Waiver of Premium provisions, from inception until the valuation date.

2) **"Accumulated Premium Method"** means allocation of assets in proportion to the Accumulated Premium of the relevant policies as is more fully explained in Section II.E.4.e, page 28.

3) **"Active Block"** means the LTC insurance policies issued or assumed by the Company that remain in force and are not on claim.

4) **"Active Policies"** or **"Active Policyholders"** referred to also as Policies Not On claim and Policyholders Not On claim, means respectively policies or policyholders that have not been terminated due to non-payment of premiums, cancellation, or exhaustion of benefits and also are not listed in the Company's records as having been approved for benefit payments and are not in the process of being approved for benefit payments as of the Determination Date.

5) **"Activities of Daily Living"** or **"ADL"** means eating, bathing, dressing, ambulating, transferring, toileting and continence.

6) **"Adult Day Care"** means a program for six or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly, or other disabled adults who can benefit from care in a group setting outside the home. It is generally administered as part of home health care benefits.

7) **"Agent"** means any insurance agent, broker or producer that solicited, sold or placed insurance business issued or assumed by the Company or any of its predecessors.

8) **"Allocable Assets"** is a notional determination consisting of the total value of the Company's liquid invested assets, after making provision for costs and expenses of administration, contingencies, accrued but unpaid claim payments, and certain debts of higher priority.

9) **"Allocated Assets"** means, for a LTC policy or group of policies, the portion of the Allocable Assets notionally allocated to that policy or group of policies in accordance with the terms of, and solely for the purposes described in, the Plan. All asset allocations are notional and do not give any policyholder a right to any Allocated Assets or any particular sum of money.

10) **"Approval Order"** means an Order from the Commonwealth Court approving the Plan.

11) **"Article V"** means Article V of the Pennsylvania Insurance Department Act of 1921, P.L. 780, as amended, 40 P.S. § 221.1, et. seq.

12) "**Asset/Premium Ratio"** means the ratio of Allocable Assets to the aggregate Accumulated Premiums for all LTC policies.

13) **"Basic Policy Endorsements"** means certain endorsements that together constitute the policyholder Option Two under the Plan. They consist of specific Policy Modifications described fully in Section III.A.2.d, page 48, intended to provide reasonable benefits and premiums that will be immune from changes in Phase Two of the Plan. Policyholders making this election will not face additional modifications under the Plan except that they may be required to pay full premium rather than Differential Premium if a Premium Waiver becomes inactive.

14) **"Benefit Triggers"** means the conditions that must be satisfied in order to be eligible for benefits under an LTC insurance policy.

15) **"Claim Waiver of Premium"** means a provision in a LTC insurance policy under which a policyholder who receives benefits under his or her policy for a specified period of time (such as 90 days) is no longer required to pay premiums for coverage after that time period as long as the policyholder remains eligible for benefits and/or receives a specified level of care.

16) **"Commonwealth Court"** means the Commonwealth Court of Pennsylvania, which is the rehabilitation court for SHIP and has exclusive jurisdiction over SHIP's rehabilitation.

17) **"Company"** means SHIP.

18) **"Court"** means for purposes of the Plan, and unless otherwise specified, the Commonwealth Court of Pennsylvania.

19) **"Covered Benefits"** means the amount of policy benefits provided by SHIP's insurance policies that, if SHIP were placed in liquidation, would be within the limits, conditions and scope of coverage of the responsible Guaranty Association taking into account the residence and other attributes of the policyholders as determined by the responsible Guaranty Association in accordance with applicable law.

20) **"Current Premium"** means the premium paid by or waived for a LTCI policy before the applicable Effective Date under the Plan. This is also equivalent to the Downgrade Target Premium for the Downgrade Process. See Section III.A.1.c, page 43.

21) **"Daily Benefit Amount"** or **"DBA"**, also called Maximum Daily Benefit (MDB), means a maximum daily dollar amount available on a covered day of care as specified in the policy.

22) **"Default Option"** means the Plan option selected automatically for a policyholder who fails to make a valid election by the required date.

23) **"Determination Date"** means July 31, 2021, the date as of which all the determinations and calculations required to construct the options available to each policyholder will be made by the Rehabilitator, which may vary among policyholders. For Phase One it will be before the applicable Policyholder Election Date to be selected by the Rehabilitator pursuant to the Plan. Different Determination Dates will be used for Phase One and Phase Two calculations. The Phase Two Determination Date will not be established until the components of Phase Two are finalized.

24) **"Differential Premium"** means the applicable premium (If Knew, Phase One, or Self-sustaining) less the Current Premium and is payable under the Plan in lieu of the applicable premium by policyholders on waiver. Under the terms of the Plan, differential premiums cannot be less than zero.

25) **"Disabled Life"** means a policyholder who is receiving, or has been approved to receive, policy benefits or a policy under which benefits are being provided, or have been approved, by the Company and is also referred to as a policyholder on claim.

26) **"Disabled Life Reserve"** or **"DLR"** means the present value of expected future benefits and expenses calculated for each policyholder listed in the Company's records as a policyholder on claim.

27) **"Downgrade Process"** means the process for reducing the benefits of a policy pursuant to Option One so that the policyholder may retain the Current Premium but reduce the benefits provided by that policy to those that premium can fund on an If Knew basis in Phase One and a Self-sustaining Basis in Phase Two. It is described in detail at Section III.A.1.c, page 43.

28) **"Downgrade Target Premium"** means the premium paid by, or waived for, a long-term care policy before the applicable Effective Date under the Plan. This is also equivalent to the Current Premium. See Section III.A.1.b, page 42.

29) **"Dual Waiver of Premium"** or **"Dual Waiver"** (DWOP), sometimes called Spousal Waiver of Premium, means a provision in a LTC insurance policy under which the premium of a spouse is also waived when the policyholder's premium is waived upon going on claim.

30) **"Effective Date"** means the date as of which the provisions of the Plan, including Policyholder Elections and modification of LTC policies, will become effective following the approval of the Plan. For most policyholders the Effective Date will be the Initial Plan Effective Date. For policyholders who have undergone Transitional Events (see definition at page 131) during the Policyholder Transition Period as described in Section II.L.3.c, page 38, the Effective Date will be the Supplemental Plan Effective Date. Other Effective Dates may apply to policies issued in Opt-out States.

31) **"Elimination Period"** or **"EP"** means the time period during which a policyholder's circumstances qualify for Long-term Care insurance benefits but for which no such benefits are yet payable by the Company. The Elimination Period is similar to a deductible or waiting period. The length of the elimination period varies by policy. The majority of the Company's policies include elimination periods of zero days, 30 days, 60 days, 90 days, and 110 days, although the Company has some policies with elimination periods up to 365 days.

32) **"Extension of Benefits"** provision means a provision in the policy permitting claim payments to continue for a policy on claim that lapses due to non-payment of premium.

33) **"Final Approval Date"** means the date upon which the Approval Order becomes final and non-appealable or upon which an appellate Order affirming the Approval Order has itself become final and no longer appealable.

34) **"Fully Covered"** means that the Maximum Policy Value projected for a particular policy is no greater than the limits of Guaranty Association coverage that would apply to that policy if SHIP were placed in liquidation. A Fully Covered policy has no Uncovered Benefits.

35) **"Funding Gap"** means the gap between: (a) the sum of: (1) the amount of SHIP's assets, (2) projected future premiums, and (3) projected earnings on investments, and (b) the sum of: (1) SHIP's future policy benefits, (2) related expense payment obligations, and (3) other expenses.

36) **"Fuzion"** means Fuzion Analytics, Inc., a subsidiary of SHIP that, among other things, provides management and administrative services to SHIP.

37) **"Gross Premium"** means the periodic payments that are required to keep the policy in force. In the absence of rehabilitation, the rates used to establish the Gross Premium are typically filed with, and subject to approval of, insurance regulators. Gross Premium includes provisions for expenses and profit margins.

38) **"Gross Premium Reserve"** or **"GPR"** means the present value as of the valuation date of expected benefits unpaid, expected expenses unpaid, and unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect. Expected expenses include commissions and premium taxes (if applicable). GPR is the reserve amount that results from performing a GPV. For a Self-sustaining Policy GPR is no more than the assets allocated to that policy under the Plan for calculation purposes only.

39) **"Gross Premium Valuation"** or **"GPV"** is the determination of the present value of expected future benefits and related expenses less the present value of expected future premiums at current and anticipated rates where "expected" consists of best estimate assumptions including a provision for moderately adverse deviation. The gross premium valuation process is used in determining the GPR.

40) **"Guaranty Association"** means the life, health and accident insurance Guaranty Association or equivalent entity in a particular state responsible for providing benefits to the policyholders of an insolvent long-term care insurer in liquidation.

41) **"HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, which among other things establishes data privacy and security safeguards for patient health information and which also provides that premiums paid for "Tax Qualified policies" as defined in the Act, may be deductible from federal income tax.

42) **"If Knew Differential Premium"** means the If Knew Premium less the Current Premium. It is the Differential Premium when the applicable premium is the If Knew Premium. Under the terms of the Plan differential premiums cannot be less than zero.

43) **"If Knew Premium"** means the premium that if charged from inception would have produced the greater of the initial target loss ratio or the minimum loss ratio applicable to the policy form. For the sake of simplicity, the Plan assumes a 60% target loss ratio. Thus, the If Knew Premium rate is the rate that, if charged from policy issue, would produce a 60% lifetime loss ratio. It is sometimes described as the premium the insurer would have charged from inception had it known then what it knows now.

44) **"Impaired Policy"** means an LTCI policy: (1) for which on Phase One the Current Premium is less than the If Knew Premium, and/or (2) that in Phase Two is Non-self-sustaining.

45) **"Inflation Protection"** means riders purchased by policyholders or policy features that provide for defined increases in benefits at regular intervals in order to protect against the effects of inflation on the cost of care.

46) **"Initial Funded Restructured Policy Value"** or **"IFRPV"** means a policy value equal to the portion of the liabilities arising under the policy that SHIP can reasonably be expected to meet based on future premiums and Allocated Assets. For a policy that is not an Impaired Policy, the IFRPV will be equal to the full amount of the liabilities currently expected to arise under the policy.

47) **"Initial Plan Effective Date"** is the Effective Date for most policyholders. It will not be the same specific day for all policyholders. For each policyholder, the Initial Plan Effective Date will be the policy's ***Monthiversary Date*** occurring during the ***Initial Plan Effective Month***. See definitions, pages 125 and 126. The Initial Plan Effective Month will be the same for all policyholders for whom the Effective Date is the Initial Plan Effective Date.

48) **"Initial Plan Effective Month"** means the calendar month immediately following the Plan Preparation Period. The Initial Plan Effective Month will be the same for all policyholders for whom the Effective Date is the Initial Plan Effective Date, that is, those who have not undergone Transitional Events during the Policyholder Transition Period as described in Section II.L.3.c, page 38 and whose policies were not issued in Opt-out States.

49) **"Lifetime Waiver of Premium" or "LWP"** means a provision in a LTC insurance policy under which the premium payments are permanently suspended upon the death of a covered spouse after a qualifying period (typically five, seven, or ten years).

50) **"Limited Benefit Period"** means any Maximum Benefit Period that is subject to a stated limit by the terms of the policy. It refers to a policy that is not a lifetime or unlimited benefit policy.

51) **"Liquidation Benefits"** means the benefits a policyholder would reasonably be expected to receive if SHIP were liquidated under the provisions of Article V, taking into account the Company's history, the orders of the Court, the risks and uncertainties of the liquidation process, and the effect of Guaranty Association coverage.

52) **"Long-term Care"** or **"LTC"** insurance means defined benefit accident and health insurance policies covering long-term care services, including confinement to nursing facilities and assisted living facilities, as well as home health care and adult day care.

53) **"LTCI"** means long-term care insurance.

54) **"Maximum Benefit Amount"** means the dollar maximum in benefits available under a LTC policy.

55) **"Maximum Benefit Period"** or **"MBP"** means the maximum time (typically stated as number of years or days, either lapsed time or of provided service) during which benefits will be available under a LTC policy. Benefits are usually defined in the contract to be a

maximum amount payable per day or per month, for a maximum number of years. However, in some policies, if the claimant uses less than the maximum amount permissible in a given period, the unused excess typically serves to lengthen the Maximum Benefit Period under what is known as the "pool of money'' clause. Benefits commence after satisfaction of an Elimination Period (EP) and continue until the recovery or death of the claimant or until the pool of money has been exhausted. In these cases the Maximum Benefit Period is sometimes expressed as a dollar amount, the Maximum Benefit Amount. Under other policies (sometimes called "days of care" policies) reducing the daily benefit amount utilized does not extend the benefit period. For these policies the Maximum Benefit Period is expressed as the number of days, months or years during which coverage remains available under the policies. In either case, modifications by the policyholder under the Plan may have the effect of reducing the Maximum Benefit Period.

56) **"Maximum Daily Benefit"** or **"MDB"** also called Daily Benefit Amount (DBA), means a maximum daily dollar amount available on a covered day of care as specified in the policy.

57) **"Maximum Policy Value"** or **"MPV"** means the product of a policy's Maximum Benefit Period times its Maximum Daily Benefit determined as of a specified date, adjusted for inflation protection. For Plan purposes, MPV will be calculated as if the policyholder went on claim on the Plan Effective Date.

58) **"Monthiversary Date"** means the day of the month upon which premium is due under a particular policy or would be due except for a Premium Waiver provision.

59) **"NAIC"** means the National Association of Insurance Commissioners.

60) **"Net Premium"** means the part of the Gross Premium that is intended to cover the cost of future claims, as opposed to future operating expenses and profit margin. The Net Premium is typically set at issue.

61) **"Non-core Policy Benefits"** means certain benefits provided by some SHIP LTC policies other than nursing home, facility, home health (which often includes hospice) or adult day care. They are enumerated in section II.H, page 33.

62) **"Non-forfeiture Option"** or **"NFO"** traditionally means an option to exchange an existing LTC policy for a reduced paid up contract on which no future premiums need be paid by the policyholder but under which benefits are limited to premiums previously paid less benefits previously received. NFO benefits are enhanced substantially under the Plan.

63) **"Non-Self-Sustaining Policy"** means a LTC policy the Projected Benefit Amount (PBA) of which exceeds its Projected Credit Amount (PCA). It is a policy for which Current Premium rates are inadequate given assets available to be allocated to it and its projected liability for benefits and expenses.

64) **"Non-Tax-Qualified"** or **"NTQ"** benefit triggers means LTC insurance policy provisions under which the conditions that must be satisfied to be eligible for benefits do not conform to the legal standards for Tax Qualified policies. Policies containing such provisions were formerly called "traditional" Long-term Care Insurance policies. They often include a benefit "trigger" called a "medical necessity" trigger under which the insurer is obligated to pay if the policyholder's own doctor, or that doctor in conjunction with someone from the insurance company, determines that the policyholder needs covered care for any medical reason. The United States Department of the Treasury has not fully clarified the tax status of premiums paid for and benefits received under a NTQ Long-term Care Insurance policy as precisely as the status of benefits received under a tax qualified policy. Therefore, the federal taxation of benefits under a NTQ policy is not certain. **The Rehabilitator makes no representation and does not offer any opinion regarding tax matters.**

65) **"Partnership-Qualified"** (PQ), means LTC policies that are intended to satisfy the requirements under the Deficit Reduction Act of 2006 entitling the policyholder to a dollar of asset disregard or spend-down credit with respect to Medicaid eligibility for every dollar of benefit received under the LTC policy.

66) **"On claim"** refers to a policyholder who is receiving, or has been approved to receive, policy benefits or a policy under which benefits are being provided by the Company.

67) **"Paid-Up Policy"** means an in-force policy that is paid in full and no longer requires premium payments under its terms.

68) **"Phase One Differential Premium"** means the Phase One Premium less the Current Premium. It is the Differential Premium when the applicable premium is the Phase One Premium. Under the terms of the Plan, the Phase One Differential Premium cannot be less than zero.

69) **"Phase One Premium"** means the premium calculated for a specified policy (or group of policies) on the If Knew basis, but not less than the Current Premium.

70) **"Phase Two Policyholder Election Package"** means the Policyholder Election Package sent to certain policyholders to inform them of options available in Phase Two of the Plan and to enable them to elect from among those options.

71) **"PID"** means the Pennsylvania Insurance Department.

72) **"Plan"** means this Rehabilitation Plan.

73) **"Plan Document"** means this document describing the Plan.

74) **"Plan Limits"** means the minimum and maximum modifications permitted by the Plan for a policy's Maximum Benefit Period (MBP) and Maximum Daily Benefit (MDB). Except

as noted in Section III.A.1.c.(4), page 43, a policy's MBP cannot be reduced by the Plan below the lower of (a) the current MBP or (b) four years, and cannot be increased by the Plan above the greater of (a) the current MBP or (b) six years. A policy's MDB cannot be reduced by the Plan below the lesser of 80% of current level and $300 for Nursing Home Care; the lesser of (a) 80% of current level or (b) $225 for Facility Care; and the lesser of (a) 80% of current level or (b) $150 for Home Health Care. The MDB cannot be increased by the Plan above the greater of (a) the current MDB or (b) $600 for Nursing Home Care, $450 for Facility Care and $300 for Home Health Care.

75) **"Plan Option"** means any of the options available to policyholders under the Plan, which are described on page 24.

76) **"Plan Premium"** means the premium that a policyholder must pay under the terms of the Plan. Depending on the policyholder's circumstances, it could be the Phase One Premium, If Knew Premium, Self-Sustaining Premium, Phase One Differential Premium, If Knew Differential Premium, or Self-sustaining Differential Premium.

77) **"Plan Preparation Period"** means the time between the Final Approval Date and the Effective Date of the Plan, during which preparatory steps necessary to implement the Plan will be completed. It includes the period during which policyholders will make elections under the Plan.

78) **"Policies Not On claim"** or **"Policyholders Not On claim,"** also called Active Policies or Policyholders, means policies or policyholders that have not been terminated due to non-payment of premiums, cancellation, or exhaustion of benefits and also are not listed in the Company's records as having been approved for benefit payments or in the process of being approved for benefit payments as of the Determination Date.

79) **"Policy Modifications"** means Premium Rate Increases or Benefit reductions selected by a policyholder, or made applicable, in accordance with the terms of the Plan.

80) **"Policyholder Election"** means the election by a policyholder to modify the premiums or benefits of a policy under the Plan.

81) **"Policyholder Election Date"** means the date by which the Rehabilitator must receive properly completed Policyholder Election Forms in order to give them effect.

82) **"Policyholder Election Form"** means the form on which a policyholder specifies whether, and if so how, he or she elects to modify his or her LTC policy in accordance with the terms of the Plan.

83) **"Policyholder Election Package"** means the materials, including the Policyholder Election Form, to be sent to policyholders by the Rehabilitator so that they may make the elections available under the Plan.

84) **"Policyholders"** means holders of insurance policies and certificate holders under group insurance policies.

85) **"Policyholder Transition Period"** means the period between the Plan Determination Date and the Initial Plan Effective Date during which policyholders may experience changes in circumstances (such as going on claim) as the result of which they may have to make new elections under the Plan.

86) **"Possible Benefit Reductions"** means the list of possible benefit reductions applicable to premium paying active policyholders who select a Downgrade option as described fully beginning on page 45.

87) **"Premium Waiver"** means a policy provision that allows a policyholder to discontinue paying premiums and maintain the policy in force during a period of covered care or under circumstances specified in the policy.

88) **"Projected Benefit Amount"** or **"PBA"** means the present value as of the valuation date of unpaid expected benefits and unpaid expected policy expenses. For purposes of this determination, "expected" consists of best estimate assumptions including a provision for moderately adverse deviation.

89) **" Projected Credit Amount"** or **"PCA"** means, for a LTC insurance policy, the sum of (a) the present value as of the valuation date of expected premiums, adjusted for future premium increases reasonably expected to be put into effect and (b) the assets allocated to that policy using the Accumulated Premium Method. For purposes of this determination, "expected" consists of best estimate assumptions including a provision for moderately adverse deviation.

90) **"Reduced Paid-up Policy"** or **"RPU"** means a policy offering reduced long-term care benefits but for which no more premium has to be paid and which will not lapse before the death of the policyholder. The Non-forfeiture Option offered under the Plan is a RPU.

91) **"Rehabilitation Plan"** means this Plan for the rehabilitation of SHIP's Long-term Care insurance business.

92) **"Rehabilitator"** means Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, and her successors in office, in the capacity of Statutory Rehabilitator of the Company. Pursuant to her statutory authority to do so, the Rehabilitator has delegated broad responsibility to the Special Deputy Rehabilitator and in the Plan documents references to the Rehabilitator should be interpreted as including the SDR unless specified otherwise.

93) **"Restoration of Benefits"** means a LTC insurance policy feature under which the benefit period for a policyholder who has received benefits will be restored to the original Maximum

Benefit Period after receiving some or all claim benefits if the policyholder does not need or receive care during a specified period of time (such as 180 days).

94) **"Restructured Policy"** means a policy that has been restructured as described in Section VI.H, page 91, to allocate the liabilities arising under the policy between its IFRPV and its UBL.

95) **"Return of Premium"** means a LTC insurance policy feature which provides for the return of a percentage of premium paid by the policyholder (such as 80%) if the policyholder does not make a claim (or has a limited expected amount of benefits paid) during a given period of time in which the policy was in force (such as ten years).

96) **"Self-sustaining"** means a policy for which its Projected Credit Amount (PCA) equals or exceeds its Projected Benefit Amount (PBA). It is a policy for which Current Premium rates are adequate given assets available to be allocated to it and its projected liability for benefits and claims expenses.

97) **"Self-sustaining Differential Premium"** means the Self-sustaining Premium less the Current Premium. It is the Differential Premium when the applicable premium is the Self-sustaining Premium. Under the terms of the Plan, differential premiums cannot be less than zero.

98) **"Self-sustaining Premium"** means the premium calculated by determining the amount of premium required to eliminate a policy's Shortfall Amount.

99) **"Senior Health Care Oversight Trust"** means the Pennsylvania business trust governed by an independent Board of Trustees comprised of former insurance regulators and an independent actuary, who also served as members of the board of directors of SHIP, created in 2008 to be the sole owner of SHIP.

100) **"SHIP"** means the Senior Health Insurance Company of Pennsylvania, the subject of this Rehabilitation Plan.

101) **"Shortfall Amount"** for a LTC policy means the difference between its Projected Benefit Amount and its Projected Credit Amount where the difference is more than zero. The Shortfall Amount can also be expressed as a policy's GPR less its Allocated Assets. If the difference is zero or less there is no shortfall and the policy is Self-sustaining.

102) **"Special Deputy Rehabilitator"** or **"SDR"** means Patrick H. Cantilo or his successors, appointed by the Rehabilitator to serve as the Special Deputy Rehabilitator for SHIP.

103) **"Statutory Reserve"** means the insurance reserve required by Pennsylvania insurance laws to be included in an insurer's financial statement on account of its insurance business in force.

104) **"Supplemental Plan Effective Date"** is the Effective Date for policyholders who undergo Transitional Events during the Policyholder Transition Period as described in Section II.L.3.c, page 38. It will occur on the policy's Monthiversary Date during the month specified by the Rehabilitator following the Policyholder Transition Period.

105) **"Tax Qualified"** or **"TQ"** benefit triggers means the conditions that must be satisfied to be eligible for benefits under a LTC insurance policy that is designed to conform to certain standards in federal law and may offer certain federal tax advantages. TQ policies were created as a result of HIPAA, which included provisions for favorable tax treatment of qualified Long Term Care Insurance contracts. To comply with those standards, TQ policies are required to cover services for a chronically ill individual, and do not have a "medical necessity" benefit trigger. A TQ benefit trigger requires that a person 1) be expected to require care for at least 90 days, and be unable to perform 2 or more Activities of Daily Living (eating, dressing, bathing, transferring, toileting, and continence) without substantial assistance (hands on or standby); or 2) for at least 90 days, need substantial assistance due to a severe cognitive impairment. In either case a licensed healthcare professional must certify a plan of care. Premiums paid for a TQ policy may be deductible from taxable income, and benefits from a TQ policy may not be subject to federal income tax. See the discussion in Section VI.B.7, page 83. **The Rehabilitator makes no representation and does not offer any opinion regarding tax matters.**

106) **"TQ Triggers"** means the requirements that must be met under a Tax Qualified LTC policy in order to receive benefits.

107) **"Transitional Events"** means the events described on page 38 as a result of which a policyholder must make an election after the Initial Policyholder Election Date and before the Supplemental Plan Effective Date.

108) **"Trust"** means the Senior Health Care Oversight Trust, as defined above.

109) **"Uncovered Benefits"** means the portion of the LTC policy benefits to which policyholders are contractually entitled on the Effective Date that exceed Guaranty Association statutory limits or otherwise are not covered by Guaranty Associations as determined by the responsible Guaranty Association in accordance with applicable law.

110) **"Unfunded Benefit Liability"** or **"UBL"** means the portion of a policy's Unmodified Policy Value that exceeds its IFRPV.

111) **"Waiver of Premium"** see Claim Waiver of Premium, Dual Waiver of Premium, and Lifetime Waiver of Premium.

APPENDIX B
SELECTED FINANCIAL INFORMATION

SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA
IN REHABILITATION

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

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

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

ASSETS

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

DETAILS OF WRITE-INS

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

LIABILITIES, SURPLUS AND OTHER FUNDS

		1 Current Year	2 Prior Year
1.	Aggregate reserve for life contracts $.....0 (Exhibit 5, Line 9999999) less $.....0 included in Line 6.3 (including $.....0 Modco Reserve)		
2.	Aggregate reserve for accident and health contracts (including $.....0 Modco Reserve)	2,766,443,751	2,608,580,649
3.	Liability for deposit-type contracts (Exhibit 7, Line 14, Col. 1) (including $.....0 Modco Reserve)		
4.	Contract claims:		
	4.1 Life (Exhibit 8, Part 1, Line 4.4, Col. 1 less sum of Cols. 9, 10 and 11)		
	4.2 Accident and health (Exhibit 8, Part 1, Line 4.4, sum of Cols. 9, 10 and 11)	37,734,617	35,658,375
5.	Policyholders' dividends/refunds to members $.....0 and coupons $.....0 due and unpaid (Exhibit 4, Line 10)		
6.	Provision for policyholders' dividends, refunds to members and coupons payable in following calendar year - estimated amounts:		
	6.1 Policyholders' dividends and refunds to members apportioned for payment (including $.....0 Modco)		
	6.2 Policyholders' dividends and refunds to members not yet apportioned (including $.....0 Modco)		
	6.3 Coupons and similar benefits (including $.....0 Modco)		
7.	Amount provisionally held for deferred dividend policies not included in Line 6		
8.	Premiums and annuity considerations for life and accident and health contracts received in advance less $.....0 discount; including $.....1,462,254 accident and health premiums (Exhibit 1, Part 1, Col. 1, sum of Lines 4 and 14)	1,462,254	1,655,643
9.	Contract liabilities not included elsewhere:		
	9.1 Surrender values on canceled contracts		
	9.2 Provision for experience rating refunds, including the liability of $.....0 accident and health experience rating refunds of which $.....0 is for medical loss ratio rebate per the Public Health Service Act		
	9.3 Other amounts payable on reinsurance, including $.....16,032 assumed and $.....1,910 ceded	17,942	35,585
	9.4 Interest Maintenance Reserve (IMR, Line 6)	4,746,341	1,564,865
10.	Commissions to agents due or accrued - life and annuity contracts $.....0, accident and health $.....0 and deposit-type contract funds $.....0	580,812	699,855
11.	Commissions and expense allowances payable on reinsurance assumed		
12.	General expenses due or accrued (Exhibit 2, Line 12, Col. 7)	6,629,583	3,792,089
13.	Transfers to Separate Accounts due or accrued (net) (including $.....0 accrued for expense allowances recognized in reserves, net of reinsured allowances)		
14.	Taxes, licenses and fees due or accrued, excluding federal income taxes (Exhibit 3, Line 9, Col. 6)	414,345	603,523
15.1	Current federal and foreign income taxes, including $.....0 on realized capital gains (losses)		(2,573,298)
15.2	Net deferred tax liability		
16.	Unearned investment income		
17.	Amounts withheld or retained by reporting entity as agent or trustee		
18.	Amounts held for agents' account, including $.....0 agents' credit balances		
19.	Remittances and items not allocated	329,763	336,270
20.	Net adjustment in assets and liabilities due to foreign exchange rates		
21.	Liability for benefits for employees and agents if not included above		
22.	Borrowed money $.....0 and interest thereon $.....0		
23.	Dividends to stockholders declared and unpaid		
24.	Miscellaneous liabilities:		
	24.01 Asset valuation reserve (AVR Line 16, Col. 7)	206,126	58,003
	24.02 Reinsurance in unauthorized and certified ($.....0) companies		
	24.03 Funds held under reinsurance treaties with unauthorized and certified ($.....0) reinsurers		
	24.04 Payable to parent, subsidiaries and affiliates		
	24.05 Drafts outstanding		
	24.06 Liability for amounts held under uninsured plans		
	24.07 Funds held under coinsurance		
	24.08 Derivatives		
	24.09 Payable for securities		
	24.10 Payable for securities lending	1,975,610	
	24.11 Capital notes $.....0 and interest thereon $.....0		
25.	Aggregate write-ins for liabilities	2,738,221	2,519,689
26.	Total liabilities excluding Separate Accounts business (Lines 1 to 25)	2,823,279,366	2,652,931,248
27.	From Separate Accounts Statement		
28.	Total liabilities (Line 26 and 27)	2,823,279,366	2,652,931,248
29.	Common capital stock	2,500,005	2,500,005
30.	Preferred capital stock	5,000,000	5,000,000
31.	Aggregate write-ins for other-than-special surplus funds	0	0
32.	Surplus notes	50,000,000	50,000,000
33.	Gross paid in and contributed surplus (Page 3, Line 33, Col. 2 plus Page 4, Line 51.1, Col. 1)	1,198,824,011	1,196,326,042
34.	Aggregate write-ins for special surplus funds	0	0
35.	Unassigned funds (surplus)	(2,172,422,245)	(1,720,699,022)
36.	Less treasury stock, at cost:		
	36.1 .....0.000 shares common (value included in Line 29 $.....0)		
	36.2 .....0.000 shares preferred (value included in Line 30 $.....0)		
37.	Surplus (Total Lines 31 + 32 + 33 + 34 + 35 - 36) (including $.....0 in Separate Accounts Statement)	(923,598,234)	(474,372,980)
38.	Totals of Lines 29, 30 and 37 (Page 4, Line 55)	(916,098,229)	(466,872,975)
39.	Totals of Lines 28 and 38 (Page 2, Line 28, Col. 3)	1,907,181,137	2,186,058,273

DETAILS OF WRITE-INS

2501.	Unclaimed funds	2,738,221	2,519,689
2502.			
2503.			
2598.	Summary of remaining write-ins for Line 25 from overflow page	0	0
2599.	Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	2,738,221	2,519,689
3101.			
3102.			
3103.			
3198.	Summary of remaining write-ins for Line 31 from overflow page	0	0
3199.	Totals (Lines 3101 through 3103 plus 3198) (Line 31 above)	0	0
3401.			
3402.			
3403.			
3498.	Summary of remaining write-ins for Line 34 from overflow page	0	0
3499.	Totals (Lines 3401 through 3403 plus 3498) (Line 34 above)	0	0

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

SUMMARY OF OPERATIONS

		1 Current Year	2 Prior Year
1.	Premiums and annuity considerations for life and accident and health contracts (Exhibit 1, Part 1, Line 20.4, Col. 1, less Col. 11)	78,564,611	1,237,392,658
2.	Considerations for supplementary contracts with life contingencies		
3.	Net investment income (Exhibit of Net Investment Income, Line 17)	69,898,620	81,934,412
4.	Amortization of Interest Maintenance Reserve (IMR) (Line 5)	497,421	192,717,772
5.	Separate Accounts net gain from operations excluding unrealized gains or losses		
6.	Commissions and expense allowances on reinsurance ceded (Exhibit 1, Part 2, Line 26.1, Col. 1)	244	945,401
7.	Reserve adjustments on reinsurance ceded		
8.	Miscellaneous Income:		
	8.1 Income from fees associated with investment management, administration and contract guarantees from Separate Accounts		
	8.2 Charges and fees for deposit-type contracts		
	8.3 Aggregate write-ins for miscellaneous income	0	0
9.	Totals (Lines 1 to 8.3)	148,960,896	1,512,990,242
10.	Death benefits		
11.	Matured endowments (excluding guaranteed annual pure endowments)		
12.	Annuity benefits (Exhibit 8, Part 2, Line 6.4, Cols. 4 + 8)		
13.	Disability benefits and benefits under accident and health contracts	371,758,091	390,323,186
14.	Coupons, guaranteed annual pure endowments and similar benefits		
15.	Surrender benefits and withdrawals for life contracts		
16.	Group conversions		
17.	Interest and adjustments on contract or deposit-type contract funds		
18.	Payments on supplementary contracts with life contingencies		
19.	Increase in aggregate reserves for life and accident and health contracts	157,863,106	1,391,115,603
20.	Totals (Lines 10 to 19)	529,621,197	1,781,438,788
21.	Commissions on premiums, annuity considerations and deposit-type contract funds (direct business only) (Exhibit 1, Part 2, Line 31, Col. 1)	5,172,110	6,133,056
22.	Commissions and expense allowances on reinsurance assumed (Exhibit 1, Part 2, Line 26.2, Col. 1)	482,173	569,135
23.	General insurance expenses and fraternal expenses (Exhibit 2, Line 10, Columns 1, 2, 3, 4 and 6)	29,395,680	34,197,614
24.	Insurance taxes, licenses and fees, excluding federal income taxes (Exhibit 3, Line 7, Cols. 1 + 2 + 3 + 5)	3,889,989	2,640,984
25.	Increase in loading on deferred and uncollected premiums		
26.	Net transfers to or (from) Separate Accounts net of reinsurance		
27.	Aggregate write-ins for deductions	0	12,570,929
28.	Totals (Lines 20 to 27)	568,561,149	1,837,550,486
29.	Net gain from operations before dividends to policyholders, refunds to members and federal income taxes (Line 9 minus Line 28)	(419,600,253)	(324,560,244)
30.	Dividends to policyholders and refunds to members		
31.	Net gain from operations after dividends to policyholders, refunds to members and before federal income taxes (Line 29 minus Line 30)	(419,600,253)	(324,560,244)
32.	Federal and foreign income taxes incurred (excluding tax on capital gains)	(1,632,614)	(463,908)
33.	Net gain from operations after dividends to policyholders, refunds to members and federal income taxes and before realized capital gains or (losses) (Line 31 minus Line 32)	(417,967,639)	(324,096,336)
34.	Net realized capital gains (losses) (excluding gains (losses) transferred to the IMR) less capital gains tax of $....2,815,978 (excluding taxes of $.....(977,935) transferred to the IMR)	(44,066,405)	(175,822,458)
35.	Net income (Line 33 plus Line 34)	(462,034,044)	(499,918,794)
	CAPITAL AND SURPLUS ACCOUNT		
36.	Capital and surplus, December 31, prior year (Page 3, Line 38, Col. 2)	(466,872,971)	12,649,170
37.	Net income (Line 35)	(462,034,044)	(499,918,794)
38.	Change in net unrealized capital gains (losses) less capital gains tax of $.....0	842,233	131,852
39.	Change in net unrealized foreign exchange capital gain (loss)		
40.	Change in net deferred income tax		
41.	Change in nonadmitted assets	9,616,707	(19,510,668)
42.	Change in liability for reinsurance in unauthorized and certified companies		11,626,473
43.	Change in reserve on account of change in valuation basis (increase) or decrease		
44.	Change in asset valuation reserve	(148,123)	28,148,996
45.	Change in treasury stock, (Page 3, Lines 36.1 and 36.2 Col. 2 minus Col. 1)		
46.	Surplus (contributed to) withdrawn from Separate Accounts during period		
47.	Other changes in surplus in Separate Accounts Statement		
48.	Change in surplus notes		
49.	Cumulative effect of changes in accounting principles		
50.	Capital changes:		
	50.1 Paid in		
	50.2 Transferred from surplus (Stock Dividend)		
	50.3 Transferred to surplus		
51.	Surplus adjustment:		
	51.1 Paid in	2,497,969	0
	51.2 Transferred to capital (Stock Dividend)		
	51.3 Transferred from capital		
	51.4 Change in surplus as a result of reinsurance		
52.	Dividends to stockholders		
53.	Aggregate write-ins for gains and losses in surplus	0	0
54.	Net change in capital and surplus for the year (Lines 37 through 53)	(449,225,258)	(479,522,141)
55.	Capital and surplus, December 31, current year (Lines 36 + 54) (Page 3, Line 38)	(916,098,229)	(466,872,971)

DETAILS OF WRITE-INS

08.301.			
08.302.			
08.303.			
08.398.	Summary of remaining write-ins for Line 8.3 from overflow page	0	0
08.399.	Totals (Lines 08.301 through 08.303 plus 08.398) (Line 8.3 above)	0	0
2701.	Termination of Roebling Reinsurance Agreement		12,570,929
2702.			
2703.			
2798.	Summary of remaining write-ins for Line 27 from overflow page	0	0
2799.	Totals (Lines 2701 through 2703 plus 2798) (Line 27 above)	0	12,570,929
5301.			
5302.			
5303.			
5398.	Summary of remaining write-ins for Line 53 from overflow page	0	0
5399.	Totals (Lines 5301 through 5303 plus 5398) (Line 53 above)	0	0

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

CASH FLOW

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

Note: Supplemental disclosures of cash flow information for non-cash transactions:

20.0001			

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

	1	Comprehensive		4	5	6	7	8	9	10	11	12	13
		2	3										
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Credit A&H	Disability Income	Long-Term Care	Other Health
ACTIVE LIFE RESERVE													
1. Unearned premium reserves	12,003,829											12,003,829	
2. Additional contract reserves (b)	1,223,633,993											1,223,633,993	
3. Additional actuarial reserves - Asset/Liability analysis	636,536,764											636,536,764	
4. Reserve for future contingent benefits	0												
5. Reserve for rate credits	0												
6. Aggregate write-ins for reserves	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Totals (Gross)	1,872,174,585	0	0	0	0	0	0	0	0	0	0	1,872,174,585	0
8. Reinsurance ceded	806,876											806,876	
9. Totals (Net)	1,871,367,710	0	0	0	0	0	0	0	0	0	0	1,871,367,710	0
CLAIM RESERVE													
10. Present value of amounts not yet due on claims	895,879,794											895,879,794	
11. Additional actuarial reserves - Asset/Liability analysis	0												
12. Reserve for future contingent benefits	0												
13. Aggregate write-ins for reserves	0	0	0	0	0	0	0	0	0	0	0	0	0
14. Totals (Gross)	895,879,794	0	0	0	0	0	0	0	0	0	0	895,879,794	0
15. Reinsurance ceded	803,753											803,753	
16. Totals (Net)	895,076,042	0	0	0	0	0	0	0	0	0	0	895,076,042	0
17. TOTALS (Net)	2,766,443,751	0	0	0	0	0	0	0	0	0	0	2,766,443,751	0
18. TABULAR FUND INTEREST	94,796,751											94,796,751	
DETAILS OF WRITE-INS													
0601.	0												
0602.	0												
0603.	0												
0698. Summary of remaining write-ins for Line 6 from overflow page	0	0	0	0	0	0	0	0	0	0	0	0	0
0699. Totals (Lines 0601 through 0603 plus 0698) (Line 6 above)	0	0	0	0	0	0	0	0	0	0	0	0	0
1301.	0												
1302.	0												
1303.	0												
1398. Summary of remaining write-ins for Line 13 from overflow page	0	0	0	0	0	0	0	0	0	0	0	0	0
1399. Totals (Lines 1301 through 1303 + 1398) (Line 13 above)	0	0	0	0	0	0	0	0	0	0	0	0	0

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

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

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EXHIBIT 8 - CLAIMS FOR LIFE AND ACCIDENT AND HEALTH CONTRACTS

PART 1 - Liability End of Current Year

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

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

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

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EXHIBIT 8 - CLAIMS FOR LIFE AND ACCIDENT AND HEALTH CONTRACTS

PART 2 - Incurred During the Year

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

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

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EXHIBIT OF NONADMITTED ASSETS

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

DETAILS OF WRITE-INS

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

NOTES TO FINANCIAL STATEMENTS

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NOTES TO FINANCIAL STATEMENTS

1. **Summary of Significant Accounting Policies**

A. Accounting Practices

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

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

	SSAP #	F/S Page	F/S Line #	2019	2018
NET INCOME					
(1) Senior Health Insurance Company of Pennsylvania state basis	XXX	XXX	XXX	$ (465,369,419)	$ (499,918,794)
(2) State Prescribed Practices that are an increase/decrease from NAIC SAP					
(3) State Permitted Practices that are an increase/decrease from NAIC SAP: Amortization of Interest Maintenance Reserve	7	4	4	161,958,913	176,638,177
Increase in Aggregate Reserves for Life and Accident and Health Company	54R	4	19	(45,730,229)	(68,622,724)
(4) NAIC SAP (1 – 2 – 3 = 4)	XXX	XXX	XXX	$ (581,598,103)	$ (607,934,247)
SURPLUS					
(5) Senior Health Insurance Company of Pennsylvania state basis	XXX	XXX	XXX	$ (919,285,952)	$ (466,872,975)
(6) State Prescribed Practices that increase/decrease from NAIC SAP					
(7) State Permitted Practices that increase/decrease from NAIC SAP: Amortization of Interest Maintenance Reserve	7	4	37	161,958,913	176,638,177
Increase in Aggregate Reserves for Life and Accident and Health Company	54R	4	37	(45,730,229)	(68,622,724)
(8) NAIC SAP (5 – 6 – 7 = 8)	XXX	XXX	XXX	$ (1,035,514,636)	$ (574,888,428)

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

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

C. Accounting Policy

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

In addition, the Company uses the following accounting policies:

(1) Short-term investments are stated at amortized cost.

(2) Bonds are stated at amortized cost using the scientific interest method, except those rated NAIC class 6, which are stated at the lower of amortized cost or fair value.

(3) Common stocks are stated at market value.

(4) Preferred stocks are stated at amortized cost, except those rated NAIC class 4 or lower quality, which are carried at the lower of cost or fair value.

(5) Mortgage loans on real estate are stated at the aggregate unpaid balance, excluding accrued interest.

(6) Loan-Backed securities are stated at amortized cost using the interest method including anticipated prepayments at the date of purchase; significant changes in estimated cash flows from the original purchase assumptions are accounted for using the retrospective method. These assumptions are generally consistent with the current interest rate and economic environment.

(7) The Company reports Fuzion Analytics, Inc., a non-insurance company, at audited GAAP equity.

(8) Ownership interests in joint ventures are classified as other invested assets on the balance sheet. The Company carries these interests based on its proportionate share of the underlying audited GAAP equity of the investee, adjusted for any distributions received.

NOTES TO FINANCIAL STATEMENTS

1. **Summary of Significant Accounting Policies,** continued

   (9) The Company has no investments in derivatives.

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

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

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

   (13) The Company receives no pharmaceutical rebates.

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

2. **Accounting Changes and Corrections of Errors**

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

3. **Business Combinations and Goodwill**

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

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

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

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

4. **Discontinued Operations**

   During 2019, the Company did not discontinue any operations.

NOTES TO FINANCIAL STATEMENTS

5. Investments

A. Mortgage Loans, including Mezzanine Real Estate Loans

(1) The Company originated no new loans in 2019.

(2) The maximum percentage of any one loan to the value of the security at the time of the loan, exclusive of insured, guaranteed or purchase money mortgages, was 65.00%.

	Current Year	Prior Year
(3) Taxes, assessments and any amounts advanced and not included in the mortgage loan total:	$ -	$ -

(4) Age Analysis of Mortgage Loans:

	Insured	Commercial All Other	Total
a. Current Year			
1. Recorded Investment			
a) Current	$ -	$ 12,681,751	$ 12,681,751
b) 30-59 Days Past Due	-	-	-
c) 60-89 Days Past Due	-	-	-
d) 90-179 Days Past Due	-	-	-
e) 180+ Days Past Due	-	-	-
2. Accruing Interest 90-179 Days Past Due			
a) Recorded Investment	-	-	-
b) Interest Accrued	-	-	-
3. Accruing Interest 180+ Days Past Due			
a) Recorded Investment	-	-	-
b) Interest Accrued	-	-	-
4. Interest Reduced			
a) Recorded Investment	-	-	-
b) Number of Loans	-	-	-
c) Percent Reduced	-	-	-
b. Prior Year			
1. Recorded Investment			
(a) Current	$ -	$ 17,540,853	$ 17,540,853
(b) 30-59 Days Past Due	-	-	-
(c) 60-89 Days Past Due	-	-	-
(d) 90-179 Days Past Due	-	-	-
(e) 180+ Days Past Due	-	-	-
2. Accruing Interest 90-179 Days Past Due			
a) Recorded Investment	-	-	-
b) Interest Accrued	-	-	-
3. Accruing Interest 180+ Days Past Due			
a) Recorded Investment	-	-	-
b) Interest Accrued	-	-	-
4. Interest Reduced			
a) Recorded Investment	-	-	-
b) Number of Loans	-	-	-
c) Percent Reduced	-	-	-

(5) Investment in Impaired Loans With or Without Allowance for Credit Losses:

	Insured	Commercial All Other	Total
a. Current Year			
1. With Allowance for Credit Losses	$ -	$ -	$ -
2. No Allowance for Credit Losses	-	-	-
b. Prior Year			
1. With Allowance for Credit Losses	-	-	-
2. No Allowance for Credit Losses	-	-	-

(6) Investment in Impaired Loans – Average Recorded Investment, Interest Income Recognized, Recorded Investment on Nonaccrual Status and Amt of Interest Income Recognized Using a Cash-Basis Method

	Insured	Commercial All Other	Total
a. Current Year			
1. Average Recorded Investment	$ -	$ -	$ -
2. Interest Income Recognized	-	-	-
3. Recorded Investments on Nonaccrual Status	-	-	-
4. Amt of Int Inc recognized Using Cash Basis	-	-	-
b. Prior Year			
1. Average Recorded Investment	-	-	-
2. Interest Income Recognized	-	-	-
3. Recorded Investments on Nonaccrual Status	-	-	-
4. Amt of Int Inc recognized Using Cash Basis	-	-	-

(7) Allowance for Credit Losses:

	Current Year	Prior Year
a. Balance at beginning of period	$ -	$ -
b. Additions charged to operations	-	-
c. Direct write-downs charged against the allowances	-	-
d. Recoveries of amounts previously charged off	-	-
e. Balance at end of period	-	-

(8) The Company has no mortgage loans derecognized because of foreclosure.
(9) Interest income on impaired loans is reported as collected when cash is received

NOTES TO FINANCIAL STATEMENTS

5. Investments, continued

B. Debt Restructuring

The Company has no investments involving troubled debt restructurings.

C. Reverse Mortgages

The Company has no investment in reverse mortgages.

D. Loan-Backed Securities

(1) The Company uses a proprietary model for loss assumptions and widely accepted models for prepayment assumptions in valuing mortgage-backed and asset-backed securities with inputs from major third-party data providers. It combines the effects of interest rates, volatility, and pre-payment speeds based on various scenario simulations (Monte Carlo) with credit loss analysis and resulting effective analytics (spreads, duration, convexity) and cash-flows on a monthly basis. Credit sensitive cash flows are calculated using a proprietary model which estimates future loan defaults in terms of timing and severity. Model assumptions are specific to asset class and collateral types and are regularly evaluated and adjusted where appropriate.

(2) The Company has no loan-backed securities with a recognized other-than-temporary impairment due to the intent to sell or the inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis.

(3) The Company has no loan-backed securities with a recognized other-than-temporary impairments for which the present value of cash flows expected to be collected is less than amortized cost as of December 31, 2019.

(4) Impaired loan-backed securities for which an other-than-temporary impairment has not been recognized in earnings as a realized loss are as follows:

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

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

E. Dollar Repurchase Agreements and/or Securities Lending Transactions

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

F. Repurchase Agreements Transactions Accounted for as Secured Borrowing

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

G. Reverse Repurchase Agreements Transactions Accounted for as Secured Borrowing

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

H. Repurchase Agreements Transactions Accounted for as a Sale

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

I. Reverse Repurchase Agreements Transactions Accounted for as a Sale

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

J. Real Estate

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

K. Low Income Housing Tax Credits ("LIHTC")

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

NOTES TO FINANCIAL STATEMENTS

5. **Investments**, continued

L. Restricted Assets

1) Restricted Assets (including Pledged)

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

NOTES TO FINANCIAL STATEMENTS

5. Investments, continued

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

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

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

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

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

M. Working Capital Finance Investments

The Company has no working capital finance investments.

N. Offsetting and Netting of Assets and Liabilities

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

O. 5GI Securities

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

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

P. Short Sales

The Company had no short sales during 2019.

Q. Prepayment Penalty and Acceleration Fees

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

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

NOTES TO FINANCIAL STATEMENTS

6. Joint Ventures, Partnerships and Limited Liability Companies

M. The Company has no investment in joint ventures, partnerships or limited liability companies that exceeds 10% of its admitted assets.

N. In 2018, the Company recognized other-than-temporary impairments of $43,264,419 on bond securities, common stock, joint venture, partnerships and limited liability companies within its portfolio. These assets are illiquid private placement investments that are in bankruptcy or work out status for which the fair value was determined based on a liquidation analysis. All the assets in the table below have been nonadmitted as of December 31, 2019.

CUSIP	Description	Actual Cost	Fair Value	Book/Adjusted Carrying Value	Current Year's OTTI Recognized
99Y800BE6	Agera Holdings LLC Equity Interest	$ 2,978,104	$ 0	$ 0	$ 2,978,104
00119@AA 4	Agera	7,500,000	0	0	7,500,000
00119@114	Agera	17,500,000	0	0	17,500,000
99Y801WR 2	Agera Parent LLC	2,500,000	0	0	2,500,000
99Y802HM8	Agera Parent LLC	470,000	0	0	470,000
99Y802ZP1	Agera Parent LLC	5,661,500	0	0	5,661,500
76016VAB9	RentPath LLC	2,213,829	0	0	2,213,829
99Y795QL6	Platinum Partners Value Arbitrage	500,000	0	0	500,000
99Y800JH1	Platinum Partners Master Fund	399,548	0	0	399,548
99Y801VN2	Platinum Partners Master Fund	51,000	0	0	51,000
99Y797TA3	Montsant Partners LLC	1,621,035	0	0	1,621,035
99Y798K13	Montsant Partners LLC	378,965	0	0	378,965
99Y802IJ4	Kingdom Energy Resources LLC	930,000	930,000	930,000	489,748
99Y802FD0	Equipment Finance SPE V LLC	7,010,089	7,010,089	7,010,089	1,000,000
608753109	Molycorp Inc	690	0	0	690
TOTAL		$ 49,714,760	$ 7,940,089	$ 7,940,089	$ 43,264,419

7. Investment Income

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

8. Derivative Instruments

The Company did not utilize derivatives in 2018 or 2019.

NOTES TO FINANCIAL STATEMENTS

9. Income Taxes

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

1. Components of Net Deferred Tax Asset

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

2. Admission Calculation Components

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

3.

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

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

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

NOTES TO FINANCIAL STATEMENTS

9. Income Taxes, continued

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

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

NOTES TO FINANCIAL STATEMENTS

9. Income Taxes, continued

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

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

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

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

E. Operating Loss Carryforwards and Income Taxes Available for Recoupment

(1) As of December 31,2019, the Company has a $256,523,608 operating loss carryforward which will begin to expire in 2031, an $250,130,490 operating loss carryforward with an indefinite carryforward period and a $2,060,618 AMT tax credit carryforward, which will be fully refunded by 2021. The Company also has a $32,018,399 capital loss carryforward, which will begin to expire in 2023.

(2) The amount of Federal income taxes incurred that are available for recoupment in the event of future net losses are $0 as the TCJA eliminated loss carrybacks for life insurance companies.

(3) The aggregate amount of deposits admitted under Section 6603 of the Internal Revenue Code are $0.

F. Consolidated Federal Income Tax Return

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

Senior Health Oversight Trust
Fuzion Analytics, Inc.

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

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

NOTES TO FINANCIAL STATEMENTS

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

A. Effective August 20, 2019, Senior Health Oversight Trust ("Oversight Trust") contributed all of its issued and outstanding stock in its wholly-owned subsidiary, Fuzion Analytics, Inc. ("Fuzion"), to the capital of the Company, resulting in Fuzion becoming a wholly-owned subsidiary of the Company. The Company's affiliated investment, Fuzion, has a current equity position of $2,975,269 for December 31, 2019, but is in draft form and could potentially increase by approximately $1.1 million after the filing of the Company's Annual Statement.

B. See Notes 10 F. and 10 I. below.

C. As of December 31, 2019, the Company recognizes an equity valuation for Fuzion of $2,975,269.

D. At December 31, 2019, the Company reported a net receivable from Fuzion of $49,541.

At December 31, 2019, the Company reported no receivable or payable from/to Oversight Trust.

Intercompany payables and receivables are settled on a monthly basis.

E. There are no guarantees or undertakings concerning parent, subsidiaries, affiliates or other related parties.

F. On March 1, 2014, the employees and operating assets of the Company were transferred to Fuzion in connection with the execution of a management services agreement under which Fuzion is responsible for the management of the Company's closed block of long-term care insurance business. First year fees under this agreement were fixed based on expenses the Company would have been expected to incur in the absence of the agreement. In the second and subsequent years of the agreement, fees decline based on the attrition of the Company's runoff block of long-term care business, subject to minimum and maximum annual decreases. The Company paid Fuzion $12,778,644 and $15,477,760 for services under this agreement in 2019 and 2018, respectively.

G. See note 10A and 10F. above.

H. See note 10A and 10F. above.

I. The Company has no investments in SCA entities that exceeds 10 percent of admitted assets.

J. The Company did not recognize any impairment write down for its investments in SCA entities during the statement period

K. The Company has no investments in foreign insurance subsidiaries.

L. The Company has an investment in downstream noninsurance holding companies, Fuzion Analytics, Inc.

M.

Balance Sheet Value of All SCA Entities

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

N. The Company has no investments in Insurance SCA entities.

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

11. Debt

A. The Company has no debt.

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

NOTES TO FINANCIAL STATEMENTS

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

A. Effective August 20, 2019, Senior Health Oversight Trust ("Oversight Trust") contributed all of its issued and outstanding stock in its wholly-owned subsidiary, Fuzion Analytics, Inc. ("Fuzion"), to the capital of the Company, resulting in Fuzion becoming a wholly-owned subsidiary of the Company. The Company's affiliated investment, Fuzion, has a current equity position of $2,975,269 for December 31, 2019, but is in draft form and could potentially increase by approximately $1.1 million after the filing of the Company's Annual Statement.

B. See Notes 10 F. and 10 I. below.

C. As of December 31, 2019, the Company recognizes an equity valuation for Fuzion of $2,975,269.

D. At December 31, 2019, the Company reported a net receivable from Fuzion of $49,541.

At December 31, 2019, the Company reported no receivable or payable from/to Oversight Trust.

Intercompany payables and receivables are settled on a monthly basis.

E. There are no guarantees or undertakings concerning parent, subsidiaries, affiliates or other related parties.

F. On March 1, 2014, the employees and operating assets of the Company were transferred to Fuzion in connection with the execution of a management services agreement under which Fuzion is responsible for the management of the Company's closed block of long-term care insurance business. First year fees under this agreement were fixed based on expenses the Company would have been expected to incur in the absence of the agreement. In the second and subsequent years of the agreement, fees decline based on the attrition of the Company's runoff block of long-term care business, subject to minimum and maximum annual decreases. The Company paid Fuzion $12,778,644 and $15,477,760 for services under this agreement in 2019 and 2018, respectively.

G. See note 10A and 10F. above.

H. See note 10A and 10F. above.

I. The Company has no investments in SCA entities that exceeds 10 percent of admitted assets.

J. The Company did not recognize any impairment write down for its investments in SCA entities during the statement period

K. The Company has no investments in foreign insurance subsidiaries.

L. The Company has an investment in downstream noninsurance holding companies, Fuzion Analytics, Inc.

M.

Balance Sheet Value of All SCA Entities

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

N. The Company has no investments in Insurance SCA entities.

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

11. Debt

A. The Company has no debt.

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

NOTES TO FINANCIAL STATEMENTS

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

A. Defined Benefit Plan

The Company has no defined benefit plan.

B. Not applicable

C. Not applicable

D. Not applicable

E. Not applicable

F. Multiemployer Plans

The Company does not participate in a multiemployer plan.

G. Consolidated/Holding Company Plans

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

H. Postemployment Benefits and Compensated Absences

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

I. Impact of Medicare Modernization Act on Postretirement Benefits

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

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

(1) The Company's capital consists of 200,000 common shares authorized and 166,667 issued and outstanding with a par value of $15 per share.

(2) The Company has 20,000 preferred shares authorized and 5,000 issued and outstanding, with a stated value of $1,000 per share.

(3) The Company may not pay any dividends without the prior written approval of the Pennsylvania Insurance Department.

(4) The Company paid no dividends to shareholders during 2019.

(5) See Note No.13 (3) above.

(6) The Company's parent, the Oversight Trust, is governed by an independent Board of Trustees comprised of former insurance regulators and financial experts. The Oversight Trust's purpose is to support the solvency of the Company and the interests of its policyholders. The Company and the Oversight Trust are subject to the oversight of the Pennsylvania Insurance Department in accordance with an order issued by the Pennsylvania Insurance Department on November 12, 2008.

(7) During 2019, the Company had no advances to surplus.

(8) During 2019, the Company held no stock for special purposes.

(9) During 2019, the Company had no special surplus funds.

(10) As of December 31, 2019, the portion of unassigned funds (surplus) represented or increased by cumulative net unrealized gains was $828,998.

(11) The Company issued a surplus note ("Note") on February 19, 2015 to Beechwood Re Investments, LLC for cash. Payment of principal and interest on the Note is not guaranteed and such payment is subordinated to claims of all policyholders, creditors, and other liabilities of the Company. Interest and principal payments on the Note require prior approval of the Commissioner.

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

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

NOTES TO FINANCIAL STATEMENTS

14. Liabilities, Contingencies and Assessments

A. Contingent Commitments

(1) The Company has not made any guarantees or undertakings for the benefit of an affiliate that would result in a material contingent exposure of the Company's or any affiliated insurer's assets to liability.

(2) The Company does not have any credit facility commitments at December 31, 2019.

(3) The Company has two credit facilities with Alliance Bernstein Private Credit Investors Middle Market Direct Lending Fund, L.P. The Company currently has investments of $22,500,000 and remaining commitments of $2,250,000 as of December 31, 2019. The Company no longer participates in new investments after December 31, 2018, however, the existing credit facilities may continue to have capital commitments according to the terms of the applicable loan documents. Alliance Bernstein anticipates full repayment of the debt obligations under the existing facilities over the next two years.

B. Assessments

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

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

(2) Assessments:

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

(3) Guaranty Fund Liabilities and Assets Related to Assessments from Insolvencies of Entities that Write Long-Term Care
a. Discount Rate Applied: Not Applicable

b. The Undiscounted and Discounted Amount of the Guaranty Fund Assessment and Related Assets by Insolvency are presented in the following table:

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

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

C. Gain Contingencies

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

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

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

E. Joint and Several Liabilities

The Company has no joint and several liability arrangements.

NOTES TO FINANCIAL STATEMENTS

14. Liabilities, Contingencies and Assessments, continued

F. All Other Contingencies

(1) Various lawsuits against the Company arise in the course of the Company's business. On December 19, 2018, the Receiver for Platinum Partners Credit Opportunities Funds filed an action against the Company, its affiliate Fuzion Analytics, Inc., Beechwood entities and others in the United States District Court for the Southern District of New York captioned *Melanie L. Cyganowski, as Equity Receiver for Platinum Partners Credit Opportunities Master Fund LP, et al. v. Beechwood RE Ltd., et al* ("PPCO Receiver Action"). The Company believes that this claim is not estimable at this time and has been tendered to the Company's insurance carrier. The Company is vigorously defending this matter. SHIP's motion for Summary Judgement was filed on February 14, 2020, which remains pending. In a related action, Company filed third party claims and crossclaims against a number of Beechwood and Platinum individuals and entities on April 19, 2019. Company has reached a settlement in principle for those third party claims and crossclaims. Notwithstanding the foregoing, an unfavorable resolution in the larger PPCO Receiver Action could have an adverse impact on the Company's financial position. The Company has a recorded value of $3.3 million for the PPCO asset, which could change as a result of the pending litigation.

(2) On June 24, 2019 the Company was served with a complaint filed on June 7, 2019 by the Joint Official Liquidators of Platinum Partners Value Arbitrage Fund against the Company in Delaware State Court captioned Principal Growth Strategies, LLC, a Delaware limited liability company; Platinum Partners Value Arbitrage Fund L.P. (in Official Liquidation), a Cayman Islands exempted limited partnership; and Martin Trott & Christopher Smith, Joint Official Liquidators of Platinum Partners Value Arbitrage Fund, L.P. (in official liquidation) v. AGH Parent LLC; Senior Health Insurance Company of Pennsylvania, et al. (the "PPVA Action"). Plaintiffs allege that several transactions involving Agera Energy resulted plaintiff Principal Growth Strategies losing its interests in Agera Energy in exchange for worthless Platinum Funds. Plaintiffs allege the Agera-related transactions were conceived by Beechwood and Platinum Partners insiders to benefit alleged Beechwood preferred investor clients, including the Company. The lawsuit has been removed to Delaware federal court, but a motion to remand is pending. The Company believes that this claim is not estimable at this time and it has been tendered to the Company's insurance carrier. The Company plans to vigorously defend this matter. Nevertheless, an unfavorable resolution could have an adverse impact on the Company's financial position.

(2) On April 10, 2019, David Levy filed a complaint against the Company in the United States District Court for the Southern District of New York captioned David Levy v. Senior Health Insurance Company of Pennsylvania ("Levy advancement action") seeking indemnification and advancement for his legal fees incurred in connection with various third-party actions filed against him, including the above-referenced PPCO Action and PPVA Action, pursuant to provisions in the Investment Management Agreements entered into between the Company and Beechwood entities. Contemporaneously with filing the complaint, Levy also filed a Motion for a Preliminary Injunction seeking the immediate advancement of legal fees incurred by him in connection with the third-party actions. On May 13, 2019, in the preliminary injunction, the court found that Levy is entitled to advancement of third-party claims, but limited fees to only those incurred in defending allegations of conduct by Levy in his role as investment adviser to the Company while an officer of Beechwood. On July 9, 2019, Levy was convicted of fraud and conspiracy to commit fraud in connection with the same scheme for which the court ordered the Company to advance litigation expenses. Following the jury's verdict, the Company moved for and was granted summary judgment in the Levy advancement action on the basis that Levy's criminal conduct eliminated any entitlement to indemnification or advancement. In light of the criminal conviction, on August 7, 2019, the Company filed its notice of appeal of the Preliminary Injunction ruling regarding advancement and posted a bond with the registry of the court in the amount of $765,630. In late September 2019, the judge in Levy's criminal trial granted Levy a post-trial acquittal, which the government has appealed. In light of the appeal of the criminal action, on January 22, 2020, the parties filed a Joint Motion to Stay the Appeal of the Preliminary Injunction Pending Outcome of Pending Criminal Appeal. On February 20, 2020, the court granted the Company's voluntary dismissal and request to withdraw the $765,360 from the registry of the Court, plus interest, less any administrative fees. This settlement has not been reflected in the December 31, 2019 financial statement and will be recorded in 2020.

(3) On May 16, 2019, several Beechwood entities and individuals filed an action for advancement and indemnification for third-party expenses, along with a motion for summary judgment on the advancement claim in the United States District Court of the Southern District of New York captioned BAM et al. v. Senior Health Insurance Company. Similar to the Levy action, the court granted the Beechwood Parties' motion for summary judgment for third-party expenses, which the Company appealed. The parties have reached a settlement in principle which makes the appeal moot. By Order dated February 22, the court ordered that the Company's deposit of $519,252.81, plus interest, less any administrative fees, be returned. This settlement has not been reflected in the December 31, 2019 financial statement and will be recorded in 2020.

(4) Under an assignment agreement effective October 1, 2008 with Conseco Life Insurance Company ("Conseco Life"), all the assets and liabilities pertaining to the Company's non-long-term care business were assigned and assumed by Conseco Life. The Company remains contingently liable for the assigned business in the event Conseco Life fails to perform its obligations under the assignment agreement. In recognition of this liability, Conseco Life is required to maintain assets in a trust account of which the Company is beneficiary, with an aggregate fair market value equal to the estimated reserves of the assigned business. Assets are deposited or withdrawn from the trust on a quarterly basis as needed to maintain the aggregate market value of the trust assets. As of December 31, 2019, the required trust amount was $152,701,732. The market value of trust assets was $154,131,222.

15. Leases

A. Lessee Leasing Arrangements

(1) The Company has no lessee leasing arrangements.

(2) The Company has no initial or remaining noncancelable lessee terms in excess of one year.

(3) The Company has no sale-leaseback transactions.

B. Lessor Leasing Arrangements

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

NOTES TO FINANCIAL STATEMENTS

(2) The Company has no leveraged leases.

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

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

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

A. During 2019, the Company had no transfers of receivables reported as sales.

B. Transfer and Servicing of Financial Assets

(1) During 2019, the Company had no transfers or servicing of financial assets.

(2) During 2019, the Company had no transfers or servicing of financial assets and liabilities.

(3) During 2019, the Company had no transfers or servicing of financial assets and liabilities.

(4) During 2019, the Company had no asset-backed financing arrangements and similar transfers accounted for as sales.

(5) During 2019, the Company had no transfers of financial assets accounted for as secured borrowing.

(6) During 2019, the Company had no transfers of receivables with recourse.

(7) During 2019, the Company had no securities subject to repurchase and reverse repurchase agreements.

C. Wash Sales

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

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

A. The Company does not serve as administrator of any ASO plans.

B. The Company does not serve as administrator of any ASC plans.

C. The Company has no Medicare or similarly structured cost-based reimbursement contracts.

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

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

NOTES TO FINANCIAL STATEMENTS

20. Fair Value Measurement

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

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

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

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

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

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

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

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

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

(4) See Note 20 A.

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

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

NOTES TO FINANCIAL STATEMENTS

20. Fair Value Measurement, continued

C. Aggregate fair value for all financial instruments.

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

D. Not applicable

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

21. Other Items

A. Unusual or Infrequent Items

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

B. Troubled Debt Restructuring

The Company had no troubled debt restructuring.

C. Other Disclosures

(1) Assets with statement values totaling $18,726,442 and $19,834,582 at December 31, 2019 and 2018, respectively, were on deposit with government authorities or trustees as required by law.

(2) The Pennsylvania Department of Insurance has approved a permitted practice to a one-time release of the Interest Maintenance Reserve ('IMR") of $192.502,234 million effective January 1, 2018. This permitted practice also created a premium deficiency reserve of $120,000,000 million which ultimately increased surplus a net $72,576,741 million between the two transactions.

(3) On September 28, 2018, the Bruckner Investment Trust Class A and Class B Notes were terminated in exchange for the transfer to the Company of Sutton Capital Trust securities and a cash payment. The termination of the Bruckner Class A and B Notes resulted in a net loss to the Company of $9,916,628.

(4) In order to meet the Equity Limited Partnership threshold according to the Pennsylvania Investment statute, the Company nonadmitted $9,916,628 of its holdings in Alliance Bernstein Private Credit Investors Middle Market Direct Lending Fund, L.P. The Company holds this investment at $19,435,088 based upon the October 31, 2019 statements at fair market value (FMV). The December 31, 2019 financial statements received late February reflect a FMV of $17,706,269 and the change in value of $1.7 million will be recorded in 2020.

(5) On July 24, 2018, Senior Health Insurance Company of Pennsylvania ("SHIP") filed a Complaint in the United States District Court for the Southern District of New York entitled Senior Health Insurance Company of Pennsylvania v. Beechwood Re Ltd., B Asset Manager, L.P., Beechwood Bermuda International, Ltd., Beechwood Re Investments, LLC a/k/a Beechwood Re Investors, LLC, Illumin Capital Management, LP, Moshe M. Feuer a/k/a Mark Feuer, Scott A. Taylor, David I. Levy, Dhruv Narain, and John Does 1-20, Case No. 1:18-cv-6658 (JSR) seeking damages for breach of three Investment Management Agreements, fraud, gross negligence, unjust enrichment, and conspiracy (the "SHIP Action"). SHIP filed amended complaints in the SHIP Action on December 14, 2018 and December 28, 2018. The action is currently stayed as to defendant David Levy due to a pending criminal matter. Fact and expert discovery in the SHIP Action as to the remaining parties is now complete. The final pretrial conference is set for April 2, 2020.

NOTES TO FINANCIAL STATEMENTS

21. Other Items, continued

(6) On July 31, 2019 the Company filed litigation in the United States District Court for the Southern District of New York captioned Senior Health Insurance Company of Pennsylvania v. Lincoln International LLC, Lincoln Advisors LLC. The Company filed a Second Amended Complaint on October 31, 2019 seeking damages for aiding and abetting fraud, aiding and abetting breach of fiduciary duty, conspiracy and contribution and indemnity and unjust enrichment/constructive trust. On February 14, 2020, Defendants moved for Summary Judgement. Company's opposition to Defendants Motion for Summary Judgement is due March 6, 2020.

D. The Company had no business interruption insurance recoveries.

E. The Company had no state transferable or non-transferable tax credits at December 31, 2019.

F. Subprime Mortgage Related Risk Exposure

(1) The company has exposure to subprime lending in the fixed maturity (bond) investment portfolio, which contains securities collateralized by mortgages that have characteristics of subprime lending such as low FICO score, adjustable rate mortgages and alternative documentation mortgages. These investments are in the form of asset-backed securities and collateralized mortgage obligations which are collateralized by subprime mortgages. The Company reviews its mortgage-backed investments for other than temporary impairments and records losses to the extent it believes it is probable that not all payments due under these investments will be collected subject to the Company's ability and intent to hold these investments to a point of recovery. The risk to subprime mortgage investments is mitigated through portfolio diversification.

(2) The Company had no direct investments in subprime mortgage loans at December 31, 2019.

(3) At December 31, 2019, the Company had subprime mortgage related risk exposure through mortgage-backed securities as presented below:

Direct Exposure Through Other Investments:

	Actual Cost	Book/Adjusted Carrying Value (excluding interest)	Fair Value	OTTI Losses Recognized
Residential mortgage-backed securities	$ 868,704	$ 854,534	$ 886,263	$ -

(4) The Company does not write Mortgage Guaranty or Financial Guaranty insurance.

G. The Company has no retained assets for 2019 and 2018.

H. Insurance-Linked Securities (ILS) Contracts

The Company has no insurance-linked securities (ILS) contracts.

22. Events Subsequent

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

NOTES TO FINANCIAL STATEMENTS

23. Reinsurance

A. Ceded Reinsurance Report
Section 1 - General Interrogatories

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

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

Section 2 - Ceded Reinsurance Report - Part A

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

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

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

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

Section 3 - Ceded Reinsurance Report - Part B

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

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

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

B. Uncollectible Reinsurance

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

C. Commutation of Ceded Reinsurance

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

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

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

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

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

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

24. Retrospectively Rated Contracts & Contracts Subject to Redetermination

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

NOTES TO FINANCIAL STATEMENTS

25. Change in Incurred Losses and Loss Adjustment Expenses

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

26. Intercompany Pooling Arrangements

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

27. Structured Settlements

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

28. Health Care Receivables

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

29. Participating Policies

The Company has no participating policies.

30. Premium Deficiency Reserves

Premium deficiency reserves were necessary.

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

31. Reserves for Life Contracts and Deposit-type Contracts

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

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

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

33. Premium and Annuity Considerations Deferred and Uncollected

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

34. Separate Accounts

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

35. Loss/Claim Adjustment Expenses

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

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

GENERAL

1.1 Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer? If yes, complete Schedule Y, Parts 1, 1A and 2. — Yes [X] No [ ]

1.2 If yes, did the reporting entity register and file with its domiciliary State Insurance Commissioner, Director or Superintendent or with such regulatory official of the state of domicile of the principal insurer in the Holding Company System, a registration statement providing disclosure substantially similar to the standards adopted by the National Association of Insurance Commissioners (NAIC) in its Model Insurance Holding Company System Regulatory Act and model regulations pertaining thereto, or is the reporting entity subject to standards and disclosure requirements substantially similar to those required by such Act and regulations? — Yes [X] No [ ] N/A [ ]

1.3 State regulating? PENNSYLVANIA

1.4 Is the reporting entity publicly traded or a member of publicly traded group? — Yes [ ] No [X]

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

2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity? — Yes [ ] No [X]

2.2 If yes, date of change:

3.1 State as of what date the latest financial examination of the reporting entity was made or is being made. — 12/31/2018

3.2 State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released. — 12/31/2018

3.3 State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date). — 12/31/2018

3.4 By what department or departments?
PENNSYLVANIA

3.5 Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with departments? — Yes [ ] No [ ] N/A [X]

3.6 Have all of the recommendations within the latest financial examination report been complied with? — Yes [X] No [ ] N/A [ ]

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

4.11 sales of new business? — Yes [ ] No [X]

4.12 renewals? — Yes [ ] No [X]

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

4.21 sales of new business? — Yes [ ] No [X]

4.22 renewals? — Yes [ ] No [X]

5.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement? — Yes [ ] No [X]

If the answer is YES, complete and file the merger history data file with the NAIC.

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

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

6.1 Has the reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? — Yes [X] No [ ]

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

7.1 Does any foreign (non-United States) person or entity directly or indirectly control 10% or more of the reporting entity? — Yes [ ] No [X]

7.2 If yes,

7.21 State the percentage of foreign control — %

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

1 Nationality	2 Type of Entity

8.1 Is the company a subsidiary of a bank holding company regulated with the Federal Reserve Board? — Yes [ ] No [X]

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

8.3 Is the company affiliated with one or more banks, thrifts or securities firms? — Yes [ ] No [X]

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

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

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

10.1 Has the insurer been granted any exemptions to the prohibited non-audit services provided by the certified independent public accountant requirements as allowed in Section 7H of the Annual Financial Reporting Model Regulation (Model Audit Rule), or substantially similar state law or regulation? — Yes [ ] No [X]

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

10.3 Has the insurer been granted any exemptions related to other requirements of the Annual Financial Reporting Model Regulation as allowed for in Section 18A of the Model Regulation, or substantially similar state law or regulation? — Yes [ ] No [X]

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

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

10.5	Has the reporting entity established an Audit Committee in compliance with the domiciliary state insurance laws?	Yes [X] No [ ] N/A [ ]
10.6	If the response to 10.5 is no or n/a, please explain:	
11.	What is the name, address and affiliation (officer/employee of the reporting entity or actuary/consultant associated with an actuarial consulting firm) of the individual providing the statement of actuarial opinion/certification? Allen J Schmitz, F.S.A, M.A.A.A. Actuary/Consultant with Milliman, Inc., 15800 West Bluemound Road Suite 100, Brookfield, WI 53005	
12.1	Does the reporting entity own any securities of a real estate holding company or otherwise hold real estate indirectly?	Yes [ ] No [X]
12.11	Name of real estate holding company	
12.12	Number of parcels involved	0
12.13	Total book/adjusted carrying value	$ 0
12.2	If yes, provide explanation	
13.	**FOR UNITED STATES BRANCHES OF ALIEN REPORTING ENTITIES ONLY:**	
13.1	What changes have been made during the year in the United States manager or the United States trustees of the reporting entity?	
13.2	Does this statement contain all business transacted for the reporting entity through its United States Branch on risks wherever located?	Yes [ ] No [ ]
13.3	Have there been any changes made to any of the trust indentures during the year?	Yes [ ] No [ ]
13.4	If answer to (13.3) is yes, has the domiciliary or entry state approved the changes?	Yes [ ] No [ ] N/A [ ]
14.1	Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards?	Yes [X] No [ ]
(a)	Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;	
(b)	Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;	
(c)	Compliance with applicable governmental laws, rules and regulations;	
(d)	The prompt internal reporting of violations to an appropriate person or persons identified in the code; and	
(e)	Accountability for adherence to the code.	
14.11	If the response to 14.1 is no, please explain:	
14.2	Has the code of ethics for senior managers been amended?	Yes [ ] No [X]
14.21	If the response to 14.2 is yes, provide information related to amendment(s).	
14.3	Have any provisions of the code of ethics been waived for any of the specified officers?	Yes [ ] No [X]
14.31	If the response to 14.3 is yes, provide the nature of any waiver(s).	
15.1	Is the reporting entity the beneficiary of a Letter of Credit that is unrelated to reinsurance where the issuing or confirming bank is not on the SVO Bank List?	Yes [ ] No [X]
15.2	If the response to 15.1 is yes, indicate the American Bankers Association (ABA) Routing Number and the name of the issuing or confirming bank of the Letter of Credit and describe the circumstances in which the Letter of Credit is triggered.	

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

BOARD OF DIRECTORS

16.	Is the purchase or sale of all investments of the reporting entity passed upon either by the Board of Directors or a subordinator committee thereof?	Yes [X] No [ ]
17.	Does the reporting entity keep a complete permanent record of the proceedings of its Board of Directors and all subordinate committees thereof?	Yes [X] No [ ]
18.	Has the reporting entity an established procedure for disclosure to its Board of Directors or trustees of any material interest or affiliation on the part of any of its officers, directors, trustees or responsible employees that is in conflict or is likely to conflict with the official duties of such person?	Yes [X] No [ ]

FINANCIAL

19.	Has this statement been prepared using a basis of accounting other than Statutory Accounting Principles (e.g., Generally Accepted Accounting Principles)?	Yes [ ] No [X]
20.1	Total amount loaned during the year (inclusive of Separate Accounts, exclusive of policy loans):	
20.11	To directors or other officers	$ 0
20.12	To stockholders not officers	$ 0
20.13	Trustees, supreme or grand (Fraternal only)	$ 0
20.2	Total amount of loans outstanding at the end of year (inclusive of Separate Accounts, exclusive of policy loans):	
20.21	To directors or other officers	$ 0
20.22	To stockholders not officers	0
20.23	Trustees, supreme or grand (Fraternal only)	0
21.1	Were any assets reported in this statement subject to a contractual obligation to transfer to another party without the liability for such obligation being reporting in the statement?	Yes [ ] No [X]
21.2	If yes, state the amount thereof at December 31 of the current year:	
21.21	Rented from others	$ 0
21.22	Borrowed from others	$ 0
21.23	Leased from others	$ 0
21.24	Other	$ 0
22.1	Does this statement include payments for assessments as described in the *Annual Statement Instructions* other than guaranty fund or guaranty association assessments?	Yes [ ] No [X]
22.2	If answer is yes:	
22.21	Amount paid as losses or risk adjustment	$ 0
22.22	Amount paid as expenses	$ 0
22.23	Other amounts paid	$ 0
23.1	Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement?	Yes [X] No [ ]

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

23.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount: $ 0

INVESTMENT

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

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

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

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

24.05 If answer to 24.04 is yes, report amount of collateral for conforming programs. $ 0

24.06 If answer to 24.04 is no, report amount of collateral for other programs $ 0

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

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

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

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

24.101 Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2: $ 0

24.102 Total book adjusted/carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2: $ 0

24.103 Total payable for securities lending reported on the liability page: $ 0

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

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

25.21	Subject to repurchase agreements	$ 0
25.22	Subject to reverse repurchase agreements	$ 0
25.23	Subject to dollar repurchase agreements	$ 0
25.24	Subject to reverse dollar repurchase agreements	$ 0
25.25	Placed under option agreements	$ 0
25.26	Letter stock or securities restricted as sale – excluding FHLB Capital Stock	$ 0
25.27	FHLB Capital Stock	$ 513,300
25.28	On deposit with states	$ 18,762,440
25.29	On deposit with other regulatory bodies	$ 0
25.30	Pledged as collateral – excluding collateral pledged to an FHLB	$ 0
25.31	Pledged as collateral to FHLB – including assets backing funding agreements	$ 0
25.32	Other	$ 0

25.3 For category (25.26) provide the following:

1 Nature of Restriction	2 Description	3 Amount
		$

26.1 Does the reporting entity have any hedging transactions reported on Schedule DB? Yes [ ] No [X]

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

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

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

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

26.41 Special accounting provision of SSAP No. 108 Yes [ ] No [ ]

26.42 Permitted accounting practice Yes [ ] No [ ]

26.43 Other accounting guidance Yes [ ] No [ ]

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

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

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

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

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

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

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

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

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

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

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

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

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

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

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

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

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

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

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

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

29.2 If yes, complete the following schedule:

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

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

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

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

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

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

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

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

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

31.3 If the answer to 31.2 is no, describe the reporting entity's process for determining a reliable pricing source for purposes of disclosure of fair value for Schedule D:

Prices are obtained from the dealer/market makers for these securities. These prices are non-binding but represent the best estimate of fair value per market conditions.

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

32.2 If no, list exceptions:

33. By self-designating 5GI securities, the reporting entity is certifying the following elements for each self-designation 5GI security:

a. Documentation necessary to permit a full credit analysis of the security does not exist or an NAIC CRP credit rating for an FE or PL security is not available.

b. Issuer or obligor is current on all contracted interest and principal payments.

c. The insurer has an actual expectation of ultimate payment of all contracted interest and principal.

Has the reporting entity self-designated 5GI securities? Yes [ ] No [X]

34. By self-designating PLGI securities, the reporting entity is certifying the following elements of each self-designated PLGI security:

a. The security was purchased prior to January 1, 2018.

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

c. The NAIC Designation was derived from the credit rating assigned by an NAIC CRP in its legal capacity as an NRSRO which is shown on a current private letter rating held by the insurer and available for examination by state insurance regulators.

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

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

Has the reporting entity self-designated PLGI securities? Yes [ ] No [X]

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

a. The shares were purchased prior to January 1, 2019.

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

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

d. The fund only or predominantly holds bonds in its portfolio.

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

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

Has the reporting entity assigned FE to Schedule BA non-registered private funds that complied with the above criteria? Yes [ ] No [X]

OTHER

36.1 Amount of payments to trade associations, service organizations and statistical or rating bureaus, if any? $ 0

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

1 Name	2 Amount Paid
	$

37.1 Amount of payments for legal expenses, if any? $ 1,182,189

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

1 Name	2 Amount Paid
Stradley Ronon Stevens & Young LLP	$ 486,310

38.1 Amount of payments for expenditures in connection with matters before legislative bodies, officers or departments of government, if any? $ 0

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

1 Name	2 Amount Paid
	$

GENERAL INTERROGATORIES

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

Life, Accident and Health Companies/Fraternal Benefit Societies:

1.1	Does the reporting entity have any direct Medicare Supplement Insurance in force?		Yes [ ] No [X]
1.2	If yes, indicate premium earned on U.S. business only.		$ 0
1.3	What portion of Item (1.2) is not reported on the Medicare Supplement Insurance Experience Exhibit?		$ 0
	1.3 Reason for excluding:		
1.4	Indicate amount of earned premium attributable to Canadian and/or Other Alien not included in Item (1.2) above.		$ 0
1.5	Indicate total incurred claims on all Medicare Supplement insurance.		$ 0
1.6	Individual policies:		
	Most current three years:		
	1.61 Total premium earned		$ 0
	1.62 Total incurred claims		$ 0
	1.63 Number of covered lives		$ 0
	All years prior to most current three years:		
	1.64 Total premium earned		$ 0
	1.65 Total incurred claims		$ 0
	1.66 Number of covered lives		$ 0
1.7	Group policies:		
	Most current three years:		
	1.71 Total premium earned		$ 0
	1.72 Total incurred claims		$ 0
	1.73 Number of covered lives		$ 0
	All years prior to most current three years:		
	1.74 Total premium earned		$ 0
	1.75 Total incurred claims		$ 0
	1.76 Number of covered lives		$ 0

2. Health Test:

		1 Current Year	2 Prior Year
2.1	Premium Numerator	$ 0	$ 0
2.2	Premium Denominator	$ 78,564,611	$ 1,237,392,658
2.3	Premium Ratio (2.1/2.2)	0.0%	0.0%
2.4	Reserve Numerator	$ 49,738,445	$ 49,770,059
2.5	Reserve Denominator	$ 2,167,641,605	$ 2,270,616,300
2.6	Reserve Ratio (2.4/2.5)	2.3%	2.2%

3.1	Does the reporting entity have Separate Accounts?	Yes [ ] No [X]
3.2	If yes, has a Separate Accounts statement been filed with this Department	Yes [ ] No [ ] N/A[ ]
3.3	What portion of capital and surplus funds of the reporting entity covered by assets in the Separate Accounts statement, is not currently distributable from the Separate Accounts to the general account for use by the general account?	$ 0
3.4	State the authority under which Separate Accounts are maintained:	
3.5	Was any of the reporting entity's Separate Accounts business reinsured as of December 31?	Yes [ ] No [ ]
3.6	Has the reporting entity assumed by reinsurance any Separate Accounts business as of December 31?	Yes [ ] No [ ]
3.7	If the reporting entity has assumed Separate Accounts business, how much, if any, reinsurance assumed receivable for reinsurance of Separate Accounts reserve expense allowances is included as a negative amount in the liability for "Transfers to Separate Accounts due or accrued (net)?"	$ 0
4.	For reporting entities having sold annuities to another insurer where the insurer purchasing the annuities has obtained a release of liability from the claimant (payee) as the result of the purchase of an annuity from the reporting entity only:	
4.1	Amount of loss reserves established by these annuities during the current year:	$ 0
4.2	List the name and location of the insurance company purchasing the annuities and the statement value on the purchase date of the annuities.	

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

5.1	Do you act as a custodian for health savings accounts?	Yes [ ] No [X]
5.2	If yes, please provide the amount of custodial funds held as of the reporting date.	$ 0
5.3	Do you act as an administrator for health savings accounts?	Yes [ ] No [X]
5.4	If yes, please provide the balance of the funds administered as of the reporting date.	$ 0
6.1	Are any of the captive affiliates reported on Schedule S, Part 3, authorized reinsurers?	Yes [ ] No [ ] N/A [X]

GENERAL INTERROGATORIES

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

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

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

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

7.1	Direct premiums written	$ 0
7.2	Total incurred claims	$ 0
7.3	Number of covered lives	0

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

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

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

Life, Accident and Health Companies Only:

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

9.2 Net reimbursement of such expenses between reporting entities:

9.21	Paid	$ 12,778,644
9.22	Received	$ 0

10.1 Does the reporting entity write any guaranteed interest contracts? Yes [ ] No [X]

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

10.21	Page 3, Line 1	$ 0
10.22	Page 4, Line 1	$ 0

11. For stock reporting entities only:

11.1	Total amount paid in by stockholders as surplus funds since organization of the reporting entity:	$ 1,198,824,011

12. Total dividends paid stockholders since organization of the reporting entity:

12.11	Cash	$ 217,094,930
12.12	Stock	$ 140,004

13.1 Does the reporting entity reinsure any Workers' Compensation Carve-Out business defined as: Yes [ ] No [X]

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

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

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

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

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

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

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

Fraternal Benefit Societies Only:

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

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

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

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

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

FIVE-YEAR HISTORICAL DATA

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

$000 omitted for amounts of life insurance

		1 2019	2 2018	3 2017	4 2016	5 2015
	Life Insurance in Force (Exhibit of Life Insurance)					
1.	Ordinary - whole life and endowment (Line 34, Col. 4)					
2.	Ordinary - term (Line 21, Col. 4, less Line 34, Col. 4)					
3.	Credit life (Line 21, Col. 6)					
4.	Group, excluding FEGLI/SGLI (Line 21, Col. 9 less Lines 43 & 44, Col. 4)					
5.	Industrial (Line 21, Col. 2)					
6.	FEGLI/SGLI (Lines 43 & 44, Col. 4)					
7.	Total (Line 21, Col. 10)	0	0	0	0	0
7.1	Total in force for which VM-20 deterministic/stochastic reserves are calculated				XXX	XXX
	New Business Issued (Exhibit of Life Insurance)					
8.	Ordinary - whole life and endowment (Line 34, Col. 2)					
9.	Ordinary - term (Line 2, Col. 4, less Line 34, Col. 2)					
10.	Credit life (Line 2, Col. 6)					
11.	Group (Line 2, Col. 9)					
12.	Industrial (Line 2, Col. 2)					
13.	Total (Line 2, Col. 10)	0	0	0	0	0
	Premium Income - Lines of Business (Exhibit 1-Part 1)					
14.	Industrial life (Line 20.4, Col. 2)					
15.1	Ordinary life insurance (Line 20.4, Col. 3)					
15.2	Ordinary individual annuities (Line 20.4, Col. 4)					
16.	Credit life (group and individual) (Line 20.4, Col. 5)					
17.1	Group life insurance (Line 20.4, Col. 6)					
17.2	Group annuities (Line 20.4, Col. 7)					
18.1	A&H - group (Line 20.4, Col. 8)	1,422,165	25,442,802	1,042,753	(25,926,020)	2,790,823
18.2	A&H - credit (group and individual) (Line 20.4, Col. 9)					
18.3	A&H - other (Line 20.4, Col. 10)	77,142,447	1,211,949,856	44,419,490	(1,127,056,295)	133,931,987
19.	Aggregate of all other lines of business (Line 20.4, Col. 11)					
20.	Total	78,564,611	1,237,392,658	45,462,243	(1,152,982,315)	136,722,811
	Balance Sheet (Pages 2 and 3)					
21.	Total admitted assets excluding Separate Accounts business (Page 2, Line 26, Col. 3)	1,907,181,137	2,186,058,273	2,688,468,510	2,744,535,287	2,879,794,716
22.	Total liabilities excluding Separate Accounts business (Page 3, Line 26)	2,823,279,366	2,652,931,248	2,675,819,343	2,716,512,099	2,824,037,145
23.	Aggregate life reserves (Page 3, Line 1)					
23.1	Excess VM-20 deterministic/stochastic reserve over NPR related to Line 7.1				XXX	XXX
24.	Aggregate A&H reserves (Page 3, Line 2)	2,766,443,751	2,608,580,649	1,217,465,047	1,296,352,123	2,635,480,160
25.	Deposit-type contract funds (Page 3, Line 3)					
26.	Asset valuation reserve (Page 3, Line 24.01)	206,126	58,003	28,206,999	32,191,000	37,970,000
27.	Capital (Page 3, Lines 29 & 30)	7,500,005	7,500,005	7,500,005	7,500,005	7,500,005
28.	Surplus (Page 3, Line 37)	(923,598,234)	(474,372,980)	5,149,161	20,523,182	48,257,565
	Cash Flow (Page 5)					
29.	Net cash from operations (Line 11)	(251,697,543)	(228,071,464)	(180,642,597)	(1,386,055,168)	(172,813,814)
	Risk-Based Capital Analysis					
30.	Total adjusted capital	(915,731,212)	(486,814,972)	40,856,166	60,214,187	93,727,570
31.	Authorized control level risk-based capital	59,722,365	51,352,310	28,828,614	36,717,738	58,321,985
	Percentage Distribution of Cash, Cash Equivalents and Invested Assets (Page 2, Col. 3) (Line No. /Page 2, Line 12, Col. 3) x 100.0					
32.	Bonds (Line 1)	91.3	92.6	72.5	80.5	81.2
33.	Stocks (Lines 2.1 and 2.2)	4.8	5.1	2.9	5.2	3.3
34.	Mortgage loans on real estate (Lines 3.1 and 3.2)	0.7	0.8	1.2	1.8	2.1
35.	Real estate (Line 4.1, 4.2 and 4.3)					
36.	Cash, cash equivalents and short-term investments (Line 5)	2.5	1.0	19.1	6.6	3.1
37.	Contract loans (Line 6)					
38.	Derivatives (Line 7)					
39.	Other invested assets (Line 8)	0.8	0.5	4.2	5.7	10.4
40.	Receivables for securities (Line 9)	0.0		0.0	0.2	
41.	Securities lending reinvested collateral assets (Line 10)					
42.	Aggregate write-ins for invested assets (Line 11)					
43.	Cash, cash equivalents and invested assets (Line 12)	100.0	100.0	100.0	100.0	100.0

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

FIVE-YEAR HISTORICAL DATA

(continued)

		1 2019	2 2018	3 2017	4 2016	5 2015
	Investments in Parent, Subsidiaries and Affiliates					
44.	Affiliated bonds (Sch. D Summary, Line 12, Col. 1)					
45.	Affiliated preferred stocks (Sch. D Summary, Line 18, Col. 1)					
46.	Affiliated common stocks (Sch. D Summary, Line 24, Col. 1)	2,975,269				
47.	Affiliated short-term investments (subtotal included in Sch. DA, Verif., Col. 5, Line 10)					
48.	Affiliated mortgage loans on real estate					
49.	All other affiliated					
50.	Total of above Lines 44 to 49	2,975,269	0	0	0	0
51.	Total investment in parent included in Lines 44 to 49 above					
	Total Nonadmitted and Admitted Assets					
52.	Total nonadmitted assets (Page 2, Line 28, Col. 2)	9,949,027	19,565,734	55,065	53,950	57,595
53.	Total admitted assets (Page 2, Line 28, Col. 3)	1,907,181,137	2,186,058,273	2,688,468,510	2,744,535,287	2,879,794,716
	Investment Data					
54.	Net investment income (Exhibit of Net Investment Income)	69,898,628	81,934,413	100,395,540	148,680,691	159,278,380
55.	Realized capital gains (losses) (Page 4, Line 34, Column 1)	(44,066,405)	(175,822,458)	6,491,743	(23,658,295)	10,206,450
56.	Unrealized capital gains (losses) (Page 4, Line 38, Column 1)	842,233	131,852	3,163,766	6,180,235	(15,016,725)
57.	Total of above Lines 54, 55 and 56	26,674,456	(93,756,193)	110,051,048	131,202,632	154,468,106
	Benefits and Reserve Increase (Page 6)					
58.	Total contract/certificate benefits - life (Lines 10, 11, 12, 13, 14 and 15, Col. 1 minus Lines 10, 11, 12, 13, 14 and 15, Cols. 6, 7 & 8)					
59.	Total contract/certificate benefits - A&H (Lines 13 & 14, Col. 6)	371,758,091	390,323,186	199,171,910	308,511,558	413,521,598
60.	Increase in life reserves - other than group and annuities (Line 19, Col. 2)					
61.	Increase in A&H reserves (Line 19, Col. 6)	157,863,106	1,391,115,603	(78,887,076)	(1,339,128,038)	(100,507,595)
62.	Dividends to policyholders and refunds to members (Line 30, Col 1)					
	Operating Percentages					
63.	Insurance expense percent (Page 6, Col. 1, Lines 21, 22, & 23 less Line (6) / (Page 6, Col. 1, Line 1 plus Exhibit 7, Col. 2, Line 2) x 100.00	44.6	3.2	47.7	(2.7)	29.4
64.	Lapse percent (ordinary only) [(Exhibit of Life Insurance, Col. 4, Lines 14 & 15) / 1/2 (Exhibit of Life Insurance, Col. 4, Lines 1 & 21)] x 100.00					
65.	A&H loss percent (Schedule H, Part 1, Lines 5 & 6, Col. 2)	659.3	51.5	259.1	89.2	263.6
66.	A&H cost containment percent (Schedule H, Part 1, Line 4, Col. 2)	0.2	0.0	1.2	(0.1)	0.3
67.	A&H expense percent excluding cost containment expenses (Schedule H, Part 1, Line 10, Col. 2)	48.1	3.4	49.7	(2.9)	30.7
	A&H Claim Reserve Adequacy					
68.	Incurred losses on prior years' claims - group health (Sch. H, Part 3, Line 3.1, Col. 2)	21,441,957	23,710,984	12,030,545	16,093,686	26,958,966
69.	Prior years' claim liability and reserve - group health (Sch. H, Part 3, Line 3.2, Col. 2)	23,338,313	22,699,092	11,990,691	26,759,010	24,321,970
70.	Incurred losses on prior years' claims - health other than group (Sch. H, Part 3, Line 3.1, Col. 1 less Col. 2)	961,510,874	981,095,409	511,372,752	611,712,185	1,004,808,131
71.	Prior years' claim liability and reserve - health other than group (Sch. H, Part 3, Line 3.2, Col. 1 less Col. 2)	935,631,618	909,860,269	484,840,984	958,623,938	958,289,818
	Net Gains From Operations After Dividends to Policyholders/Members' Refunds and Federal Income Taxes by Lines of Business (Page 6.x, Line 33)					
72.	Industrial life (Page 6.1, Col. 2)					
73.	Ordinary - life (Page 6.1, Col. 1 less Cols. 2, 10 and 12)					
74.	Ordinary - individual annuities (Page 6, Col. 4)					
75.	Ordinary - supplementary contracts	XXX				
76.	Credit life (Page 6.1, Col. 10 plus Page 6.2, Col. 7)					
77.	Group life (Page 6.2, Col. 1 less Col. 7 less Col. 9)					
78.	Group annuities (Page 6, Col. 5)					
79.	A&H - group (Page 6.5, Col. 3)		(5,330,981)	(737,443)	1,168,637	(4,122,548)
80.	A&H - credit (Page 6.5, Col. 10)					
81.	A&H - other (Page 6.5, Col. 1 less Cols. 3 and 10)	(417,967,639)	(318,765,355)	(19,704,154)	(23,507,603)	(15,105,585)
82.	Aggregate of all other lines of business (Page 6, Col. 8)					
83.	Fraternal (Page 6, Col. 7)					
84.	Total (Page 6, Col. 1)	(417,967,639)	(324,096,336)	(20,441,597)	(22,338,965)	(19,228,134)

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

If no, please explain:

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

76325201943059100

DIRECT BUSINESS IN GRAND TOTAL DURING THE YEAR

NAIC Group Code.....0 NAIC Company Code.....76325

LIFE INSURANCE

	1 Ordinary	2 Credit Life (Group and Individual)	3 Group	4 Industrial	5 Total
DIRECT PREMIUMS AND ANNUITY CONSIDERATIONS					
1. Life insurance					0
2. Annuity considerations					0
3. Deposit-type contract funds		XXX		XXX	0
4. Other considerations					0
5. Totals (Sum of Lines 1 to 4)	0	0	0	0	0
DIRECT DIVIDENDS TO POLICYHOLDERS/REFUNDS TO MEMBERS					
Life insurance:					
6.1 Paid in cash or left on deposit					0
6.2 Applied to pay renewal premiums					0
6.3 Applied to provide paid-up additions or shorten the endowment or premium-paying period					0
6.4 Other					0
6.5 Totals (Sum of Lines 6.1 to 6.4)	0	0	0	0	0
Annuities:					
7.1 Paid in cash or left on deposit					0
7.2 Applied to provide paid-up annuities					0
7.3 Other					0
7.4 Totals (Sum of Lines 7.1 to 7.3)	0	0	0	0	0
8. Grand Totals (Lines 6.5 + 7.4)	0	0	0	0	0
DIRECT CLAIMS AND BENEFITS PAID					
9. Death benefits					0
10. Matured endowments					0
11. Annuity benefits					0
12. Surrender values and withdrawals for life contracts					0
13. Aggregate write-ins for miscellaneous direct claims and benefits paid	0	0	0	0	0
14. All other benefits, except accident and health					0
15. Totals	0	0	0	0	0
DETAILS OF WRITE-INS					
1301.					0
1302.					0
1303.					0
1398. Summary of remaining write-ins for Line 13 from overflow page	0	0	0	0	0
1399. Total (Lines 1301 through 1303 plus 1398)(Line 13 above)	0	0	0	0	0

NONE

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

NONE

(a) Includes Individual Credit Life Insurance, prior year $.....0 current year $.....0.
Includes Group Credit Life Insurance Loans less than or equal to 60 months at issue, prior year $.....0 current year $.....0.
Loans greater than 60 months at issue BUT NOT GREATER THAN 120 MONTHS, prior year $.....0 current year $.....0.

ACCIDENT AND HEALTH INSURANCE

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

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

EXHIBIT 1

(PART 2)

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

SUPPLEMENTARY CONTRACTS

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

ANNUITIES

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

ACCIDENT AND HEALTH INSURANCE

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

DEPOSIT FUNDS AND DIVIDEND ACCUMULATIONS

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

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

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

FORM FOR CALCULATING THE INTEREST MAINTENANCE RESERVE

Interest Maintenance Reserve

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

Amortization

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

ASSET VALUATION RESERVE

	Default Component			Equity Component			7
	1 Other Than Mortgage Loans	2 Mortgage Loans	3 Total (Cols. 1 + 2)	4 Common Stock	5 Real Estate and Other Invested Assets	6 Total (Cols. 4 + 5)	Total Amount (Cols. 3 + 6)
1. Reserve as of December 31, prior year	0	58,003	58,003	0	0	0	58,004
2. Realized capital gains/(losses) net of taxes - General Account	(26,746,425)		(26,746,425)	167,638	(7,552,704)	(7,385,066)	(34,131,491)
3. Realized capital gains/(losses) net of taxes - Separate Accounts			0			0	0
4. Unrealized capital gains/(losses) - net of deferred taxes - General Account	301,032		301,032	84,644		84,644	385,676
5. Unrealized capital gains/(losses) - net of deferred taxes - Separate Accounts			0			0	0
6. Capital gains credited/(losses charged) to contract benefits, payments or reserves			0			0	0
7. Basic contribution	2,698,383	29,414	2,727,797		823	823	2,728,620
8. Accumulated balances (Lines 1 through 5, minus 6 plus 7)	(23,747,010)	87,417	(23,659,593)	252,282	(7,551,881)	(7,299,599)	(30,959,192)
9. Maximum reserve	15,336,443	133,838	15,470,281	601,632	2,079,196	2,680,831	18,151,112
10. Reserve objective	10,013,298	102,680	10,115,978	599,784	2,076,400	2,676,185	12,792,163
11. 20% of (Line 10 minus Line 8)	6,752,062	3,053	6,755,114	69,500	1,925,656	1,995,157	8,750,271
12. Balance before transfers (Lines 8 + 11)	(16,994,948)	90,469	(16,904,479)	321,783	(5,626,225)	(5,304,442)	(22,208,921)
13. Transfers	45,235	(45,235)	(0)	(160,891)	160,891	(0)	(1)
14. Voluntary contribution			0			0	0
15. Adjustment down to maximum/up to zero	16,949,714		16,949,714		5,465,334	5,465,334	22,415,048
16. Reserve as of December 31, current year (Lines 12 + 13 + 14 + 15)	0	45,234	45,235	160,891	0	160,892	206,126

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ASSET VALUATION RESERVE

Basic Contribution, Reserve Objective and Maximum Reserve Calculations

Default Component

Line Number	NAIC Desig-nation	Description	1 Book/Adjusted Carrying Value	2 Reclassify Related Party Encumbrances	3 Add Third Party Encumbrances	4 Balance for AVR Reserve Calculations (Cols. 1 + 2 + 3)	Basic Contribution 5 Factor	Basic Contribution 6 Amount (Cols. 4 x 5)	Reserve Objective 7 Factor	Reserve Objective 8 Amount (Cols. 4 x 7)	Maximum Reserve 9 Factor	Maximum Reserve 10 Amount (Cols. 4 x 9)
		LONG-TERM BONDS										
1		Exempt obligations	23,648,054	XXX	XXX	23,648,054	0.0000	0	0.0000	0	0.0000	0
2	1	Highest quality	1,236,645,801	XXX	XXX	1,236,645,801	0.0005	618,323	0.0016	1,976,633	0.0033	4,080,931
3	2	High quality	410,591,075	XXX	XXX	410,591,075	0.0021	862,241	0.0064	2,627,783	0.0106	4,352,265
4	3	Medium quality	14,285,525	XXX	XXX	14,285,525	0.0099	141,427	0.0263	375,709	0.0376	537,136
5	4	Low quality	19,255,293	XXX	XXX	19,255,293	0.0245	471,755	0.0572	1,101,403	0.0817	1,573,157
6	5	Lower quality	6,462,482	XXX	XXX	6,462,482	0.0630	407,136	0.1128	728,968	0.1880	1,214,947
7	6	In or near default	11,000,000	XXX	XXX	11,000,000	0.0000	0	0.2370	2,607,000	0.2370	2,607,000
8		Total unrated multi-class securities acquired by conversion		XXX	XXX	0	XXX		XXX		XXX	
9		Total long-term bonds (sum of Lines 1 through 8)	1,721,888,230	XXX	XXX	1,721,888,230	XXX	2,500,862	XXX	9,419,496	XXX	14,365,436
		PREFERRED STOCKS										
10	1	Highest quality		XXX	XXX	0	0.0005	0	0.0016	0	0.0033	0
11	2	High quality	84,177,542	XXX	XXX	84,177,542	0.0021	176,773	0.0064	538,736	0.0106	892,282
12	3	Medium quality	2,093,750	XXX	XXX	2,093,750	0.0099	20,728	0.0263	55,066	0.0376	78,725
13	4	Low quality		XXX	XXX	0	0.0245	0	0.0572	0	0.0817	0
14	5	Lower quality		XXX	XXX	0	0.0630	0	0.1128	0	0.1880	0
15	6	In or near default		XXX	XXX	0	0.0000	0	0.2370	0	0.2370	0
16		Affiliated life with AVR		XXX	XXX	0	0.0000	0	0.0000	0	0.0000	0
17		Total preferred stocks (sum of Lines 10 through 16)	86,271,292	XXX	XXX	86,271,292	XXX	197,501	XXX	593,802	XXX	971,007
		SHORT-TERM BONDS										
18		Exempt obligations		XXX	XXX	0	0.0000	0	0.0000	0	0.0000	0
19	1	Highest quality		XXX	XXX	0	0.0005	0	0.0016	0	0.0033	0
20	2	High quality		XXX	XXX	0	0.0021	0	0.0064	0	0.0106	0
21	3	Medium quality		XXX	XXX	0	0.0099	0	0.0263	0	0.0376	0
22	4	Low quality		XXX	XXX	0	0.0245	0	0.0572	0	0.0817	0
23	5	Lower quality		XXX	XXX	0	0.0630	0	0.1128	0	0.1880	0
24	6	In or near default		XXX	XXX	0	0.0000	0	0.2370	0	0.2370	0
25		Total short-term bonds (sum of Lines 18 through 24)	0	XXX	XXX	0	XXX	0	XXX	0	XXX	0
		DERIVATIVE INSTRUMENTS										
26		Exchange traded		XXX	XXX	0	0.0005	0	0.0016	0	0.0033	0
27	1	Highest quality		XXX	XXX	0	0.0005	0	0.0016	0	0.0033	0
28	2	High quality		XXX	XXX	0	0.0021	0	0.0064	0	0.0106	0
29	3	Medium quality		XXX	XXX	0	0.0099	0	0.0263	0	0.0376	0
30	4	Low quality		XXX	XXX	0	0.0245	0	0.0572	0	0.0817	0
31	5	Lower quality		XXX	XXX	0	0.0630	0	0.1128	0	0.1880	0
32	6	In or near default		XXX	XXX	0	0.0000	0	0.2370	0	0.2370	0
33		Total derivative instruments	0	XXX	XXX	0	XXX	0	XXX	0	XXX	0
34		Total (Lines 9 + 17 + 25 + 33)	1,808,159,522	XXX	XXX	1,808,159,522	XXX	2,698,383	XXX	10,013,298	XXX	15,336,443

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ASSET VALUATION RESERVE (continued)

Basic Contribution, Reserve Objective and Maximum Reserve Calculations

Default Component

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

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ASSET VALUATION RESERVE

Basic Contribution, Reserve Objective and Maximum Reserve Calculations

Equity and Other Invested Asset Component

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

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ASSET VALUATION RESERVE (continued)

Basic Contribution, Reserve Objective and Maximum Reserve Calculations

Equity and Other Invested Asset Component

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

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ASSET VALUATION RESERVE (continued)

Basic Contribution, Reserve Objective and Maximum Reserve Calculations

Equity and Other Invested Asset Component

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

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

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SCHEDULE H - ACCIDENT AND HEALTH EXHIBIT

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

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

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SCHEDULE H - ACCIDENT AND HEALTH EXHIBIT (continued)

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

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

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

PART 4 - REINSURANCE

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

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

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SCHEDULE H - PART 5 - HEALTH CLAIMS

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

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

SCHEDULE T - PREMIUMS AND ANNUITY CONSIDERATIONS (b)

Allocated by States and Territories

States, Etc.	1 Active Status (a)	Direct Business Only: Life Contracts 2 Life Insurance Premiums	3 Annuity Considerations	4 Accident and Health Insurance Premiums, Including Policy, Membership and Other Fees	5 Other Considerations	6 Total Columns 2 through 5	7 Deposit-Type Contracts
1. Alabama AL	L			106,514		106,514	
2. Alaska AK	L			33,188		33,188	
3. Arizona AZ	L			1,421,606		1,421,606	
4. Arkansas AR	L			294,050		294,050	
5. California CA	L			5,183,274		5,183,274	
6. Colorado CO	L			650,164		650,164	
7. Connecticut CT	N			104,227		104,227	
8. Delaware DE	L			158,088		158,088	
9. District of Columbia DC	L			37,270		37,270	
10. Florida FL	L			5,102,403		5,102,403	
11. Georgia GA	L			972,991		972,991	
12. Hawaii HI	L			144,435		144,435	
13. Idaho ID	L			119,857		119,857	
14. Illinois IL	L			3,374,402		3,374,402	
15. Indiana IN	L			1,634,548		1,634,548	
16. Iowa IA	L			1,397,413		1,397,413	
17. Kansas KS	L			1,018,522		1,018,522	
18. Kentucky KY	L			839,943		839,943	
19. Louisiana LA	L			413,911		413,911	
20. Maine ME	L			465,326		465,326	
21. Maryland MD	L			1,807,150		1,807,150	
22. Massachusetts MA	L			510,020		510,020	
23. Michigan MI	L			1,467,232		1,467,232	
24. Minnesota MN	L			853,598		853,598	
25. Mississippi MS	L			338,643		338,643	
26. Missouri MO	L			1,530,613		1,530,613	
27. Montana MT	L			263,422		263,422	
28. Nebraska NE	L			653,491		653,491	
29. Nevada NV	L			148,496		148,496	
30. New Hampshire NH	L			112,549		112,549	
31. New Jersey NJ	L			1,210,622		1,210,622	
32. New Mexico NM	L			262,823		262,823	
33. New York NY	N			340,722		340,722	
34. North Carolina NC	L			2,114,765		2,114,765	
35. North Dakota ND	L			679,940		679,940	
36. Ohio OH	L			2,692,556		2,692,556	
37. Oklahoma OK	L			1,049,596		1,049,596	
38. Oregon OR	L			270,698		270,698	
39. Pennsylvania PA	L			7,288,325		7,288,325	
40. Rhode Island RI	N			32,940		32,940	
41. South Carolina SC	L			744,826		744,826	
42. South Dakota SD	L			471,979		471,979	
43. Tennessee TN	L			936,968		936,968	
44. Texas TX	L			5,707,739		5,707,739	
45. Utah UT	L			372,626		372,626	
46. Vermont VT	N			34,790		34,790	
47. Virginia VA	L			1,326,097		1,326,097	
48. Washington WA	L			1,386,979		1,386,979	
49. West Virginia WV	L			116,884		116,884	
50. Wisconsin WI	L			827,992		827,992	
51. Wyoming WY	L			72,529		72,529	
52. American Samoa AS	N					0	
53. Guam GU	N					0	
54. Puerto Rico PR	N					0	
55. US Virgin Islands VI	L					0	
56. Northern Mariana Islands MP	N					0	
57. Canada CAN	N			6,481		6,481	
58. Aggregate Other Alien OT	XXX	0	0	13,907	0	13,907	0
59. Subtotal	XXX	0	0	59,120,134	0	59,120,134	0
90. Reporting entity contributions for employee benefit plans	XXX					0	
91. Dividends or refunds applied to purchase paid-up additions and annuities	XXX					0	
92. Dividends or refunds applied to shorten endowment or premium paying period	XXX					0	
93. Premium or annuity considerations waived under disability or other contract provisions	XXX			14,626,335		14,626,335	
94. Aggregate other amounts not allocable by State	XXX	0	0	0	0	0	0
95. Totals (Direct Business)	XXX	0	0	73,746,469	0	73,746,469	0
96. Plus reinsurance assumed	XXX			4,795,804		4,795,804	
97. Totals (All Business)	XXX	0	0	78,542,273	0	78,542,273	0
98. Less reinsurance ceded	XXX			10,295		10,295	
99. Totals (All Business) less reinsurance ceded	XXX	0	0	(c) 78,531,977	0	78,531,977	0
DETAILS OF WRITE-INS							
58001. Aggregate Other Alien	XXX			13,907		13,907	
58002.	XXX					0	
58003.	XXX					0	
58998. Summ. of remaining write-ins for line 58 from overflow page	XXX	0	0	0	0	0	0
58999. Total (Lines 58001 thru 58003 plus 58998) (Line 58 above)	XXX	0	0	13,907	0	13,907	0
9401.	XXX					0	
9402.	XXX					0	
9403.	XXX					0	
9498. Summ. of remaining write-ins for line 94 from overflow page	XXX	0	0	0	0	0	0
9499. Total (Lines 9401 thru 9403 plus 9498) (Line 94 above)	XXX	0	0	0	0	0	0

(a) Active Status Counts:

L - Licensed or Chartered - Licensed insurance carrier or domiciled RRG 48
E - Eligible - Reporting entities eligible or approved to write surplus lines in the state 0
R - Registered - Non-domiciled RRGs 0
Q - Qualified - Qualified or accredited reinsurer 0
N - None of the above - Not allowed to write business in the state 9

(b) Explanation of basis of allocation by states, etc., of premiums and annuity considerations.

(c) Column 4 should balance with Exhibit 1, Lines 6.4, 10.4 and 16.4, Cols. 8, 9, and 10, or with Schedule H, Part 1, Column 1, Line 1. Indicate which:

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

SCHEDULE T - PART 2

INTERSTATE COMPACT - EXHIBIT OF PREMIUMS WRITTEN

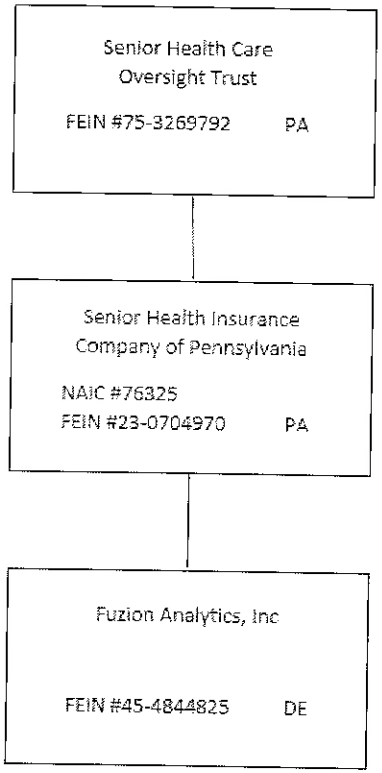
Allocated by States and Territories

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

NONE

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

PART 1 – ORGANIZATIONAL CHART



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SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

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

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SCHEDULE Y

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

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

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Senior Health Insurance Company in Rehabilitation

Balance Sheet

($ in thousands)

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

Senior Health Insurance Company in Rehabilitation

Income Statement

($ in thousands)

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

Senior Health Insurance Company in Rehabilitation

Income Statement

($ in thousands)

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

Senior Health Insurance Company in Rehabilitation

Balance Sheet

($ in thousands)

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

Senior Health Insurance Company in Rehabilitation
Investment Summary

Core Portfolio

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

Non-Core Portfolio

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

Senior Health Insurance Company in Rehabilitation

Income Statement

($ in thousands)

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

Senior Health Insurance Company in Rehabilitation

Balance Sheet

($ in thousands)

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

EXHIBIT 6

Received 9/21/2021 5:38:47 PM Commonwealth Court of Pennsylvania

Filed 9/21/2021 5:38:47 PM Commonwealth Court of Pennsylvania
1 SHP 2020

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

IN RE: SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)	**:**	**No. 1 SHP 2020**

JESSICA K. ALTMAN, INSURANCE COMMISSIONER OF THE COMMONWEALTH OF PENNSYLVANIA, IN HER CAPACITY AS STATUTORY REHABILITATOR
and
SUPERINTENDENT OF INSURANCE OF THE STATE OF MAINE, COMMISSIONER OF INSURANCE OF THE COMMONWEALTH OF MASSACHUSETTS, INSURANCE COMMISSIONER OF THE STATE OF WASHINGTON, THE NATIONAL ORGANIZATION OF LIFE AND HEALTH GUARANTY ASSOCIATIONS, 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, UNITED INSURANCE GROUP AGENCY, INC., ANTHEM, INC., HEALTH CARE SERVICE CORPORATION, HORIZON HEALTH CARE SERVICES, INC. D/B/A HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY, UNITEDHEALTHCARE INSURANCE COMPANY, JAMES LAPINSKI, and GEORGIANNA PARISI, INTERVENORS

NOTICE OF APPEAL

Notice is hereby given that 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, intervenors in this matter, hereby appeal to the Supreme Court of Pennsylvania from:

(1) The Order entered in this matter on August 24, 2021 granting the Application for Approval of the Plan of Rehabilitation for Senior

Health Insurance Company of Pennsylvania ("SHIP") and approving the Second Amended Plan of Rehabilitation;

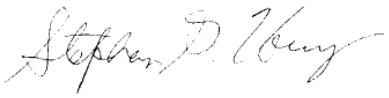
(2) The oral Order entered in this matter on May 21, 2021 granting the Rehabilitator's oral motion regarding state issue rate approval option; and

(3) The Order entered in this matter on August 25, 2021 denying the Intervenor State Insurance Regulator's Application to Reconsider Order Granting the Rehabilitator's Oral Motion Regarding State Issue Rate Approval Option.

The first and third orders have been entered in the docket as evidenced by the attached copy of the docket entries. The second order was an oral ruling as evidenced by the attached copy of the transcript pages.

Transcripts of the pre-hearing and hearing proceedings have been lodged.

Respectfully submitted,



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Attorneys for the Maine Superintendent of Insurance, the Massachusetts Commissioner

of Insurance, and the Washington Insurance Commissioner

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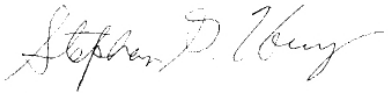
(admitted *pro hac vice*)

Counsel to the Maine Superintendent of Insurance, the Massachusetts Commissioner of Insurance, and the Washington Insurance Commissioner and Massachusetts Special Assistant Attorneys General and Washington Special Assistant Attorneys General

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.

Respectfully submitted,



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Attorneys for the Maine Superintendent of Insurance, the Massachusetts Commissioner of Insurance, and the Washington Insurance Commissioner

Of Counsel:

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Counsel to the Maine Superintendent of Insurance, the Massachusetts Commissioner of Insurance, and the Washington Insurance Commissioner and Massachusetts Special Assistant Attorneys General and Washington Special Assistant Attorneys General

1:51 P.M.

Sealed Documents

Senior Health Insurance Company of Pennsylvania Docket Sheet

Commonwealth Court of Pennsylvania

Docket Number: 1 SHP 2020

September 13, 2021

CAPTION

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

CASE INFORMATION

Initiating Document:	Complaint		
Case Status:	Closed		
Case Processing Status:	August 25, 2021	Completed	
Journal Number:			
Case Category:	Miscellaneous	Case Type(s):	Insurance Rehabilitation

CONSOLIDATED CASES

RELATED CASES

COUNSEL INFORMATION

Plaintiff **Insurance Commissioner of the Commonwealth of Pennsylvania**

Pro Se: No

IFP Status:

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Attorney:	Hamilton, Dexter Ryan		
Law Firm:	Cozen O'Connor		
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Attorney:	Buckman, Preston M.		
Law Firm:	Pennsylvania Insurance Department		
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Phone No:	(717) 886-2080	Fax No:	

Attorney:	Greenspan, Leslie Miller		
Law Firm:	Tucker Law Group, LLC		
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Phone No:	(215) 875-0609	Fax No:	

1:51 P.M.
Sealed Documents

Senior Health Insurance Company of Pennsylvania Docket Sheet

Commonwealth Court of Pennsylvania

Docket Number: 1 SHP 2020

September 13, 2021

DOCKET ENTRY

Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
July 21, 2021	Application for Approval of Settlement Agreement			
	Broadbent, Michael John	Insurance Commissioner of the Com	Plaintiff	
	Broadbent, Michael John	Altman, Jessica K.	Plaintiff	
	Broadbent, Michael John	Senoir Health Insurance Company o	Defendant	
Document Name:	Joint Application for Approval of Settlement Agreement			
July 26, 2021	Sealed Formal Comment			
	Boyd, Richard Blair, IV		Commenter	
Document Name:	Sealed Re: Proposed Settlement Agreement of the Rehabilitator an Intervening Agents and Brokers			
August 2, 2021	Application to Strike			
	Lapinski, James F.		Intervenor	
Document Name:	Intervenor, Agen & Broker, J. Lapinski's Motion to Strike Joint Application for Approval of Settlemt			
August 10, 2021	Filed - Other			
	Hickok, Dorothy Alicia	National Organization of Life and He	Intervenor	
Document Name:	Objections to Errors in the Transcript of Proceedings			
August 20, 2021	Answer to Application to Strike			
	Broadbent, Michael John	Insurance Commissioner of the Com	Plaintiff	
	Broadbent, Michael John	Altman, Jessica K.	Plaintiff	
	Broadbent, Michael John	Senoir Health Insurance Company o	Defendant	
Document Name:	Answer in Opposition to Intervenor James Lapinski's Combined Applicatoin to Strike and to Sanction			
August 24, 2021	Memorandum Opinion Filed			08/25/2021
	Leavitt, Mary Hannah			
Document Name:	Second Amended Plan of Rehabilitation is Approved with Exception to Section VI.N			

Comment: AND NOW this 24th day of August, the Court hereby ORDERS as follows:

1. The Application for Approval of the Plan of Rehabilitation for Senior Health Insurance Company of Pennsylvania (SHIP) filed by Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as Statutory Rehabilitator of SHIP, is GRANTED. The Second Amended Plan of Rehabilitation, filed on May 3, 2021, is APPROVED, with the exception of Section VI.N of the Plan (relating to suspension of agent and broker commissions).

2. The Court defers resolution of the Joint Application for Approval of Settlement Agreement, filed by the Rehabilitator and Intervenors ACSIA Long Term Care, Inc., Global Commission Funding LLC, LifeCare Health Insurance Plans, Inc, Senior Commission Funding LLC, Senior Health Care Insurance Services, Ltd., LLP, and United Insurance Group Agency, Inc., pending a hearing to be scheduled by separate order. The Rehabilitator shall continue paying commissions until Phase One of the Second Amended Plan of Rehabilitation is implemented.

3. The Rehabilitator shall promptly submit an actuarial memorandum in support of the If Known Premium rates to be used in Phase One of the Second Amended Plan of Rehabilitation to the Pennsylvania Insurance Department for its review and approval.

4. The Rehabilitator, in her capacity as Insurance Commissioner, shall designate an appropriate deputy insurance commissioner to review the actuarial memorandum submitted to the Insurance Department. Thereafter, the Rehabilitator shall submit the approved actuarial memorandum to the Court.

1:51 P.M.

Sealed Documents

Senior Health Insurance Company of Pennsylvania Docket Sheet

Commonwealth Court of Pennsylvania

Docket Number: 1 SHP 2020

September 13, 2021

DOCKET ENTRY

Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
August 25, 2021	Order Denying Application for Reconsideration			08/25/2021
	Leavitt, Mary Hannah			
Document Name:	State Insurance Regulators' Application for Reconsideration filed 6/1/2021 is Denied.			
Comment:	AND NOW this 25th day of August, 2021, Intervenor State Insurance Regulators' Application to Reconsider Order Granting the Rehabilitator's Oral Motion Regarding Issue State Rate Approval Option is DENIED for the reasons set forth in the Court's Memorandum Opinion and Order filed August 24, 2021.			
August 26, 2021	Order Filed			08/27/2021
	Leavitt, Mary Hannah			
Document Name:	re: Jt Application for Approval of Settlement Agreement/Hearing Scheduled.			
Comment:	AND NOW this 26th day of August, 2021, upon consideration of the Joint Application for Approval of Settlement Agreement filed by the Statutory 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., the Court ORDERS as follows: 1. The Court will conduct a hearing via WebEx videoconferencing on September 8, 2021, at 10:00 a.m. 2. Counsel of record and pro se parties who wish to participate shall provide the Court with their email addresses and telephone numbers by September 1, 2021. The contact email address is: CommCourtRemote@pacourts.us. The Court will provide participants with instructions for connecting to the hearing. Participants are directed to connect to the hearing 10 minutes before the starting time. Please see the Protocol for WebEx Video Proceedings attached to this order. 3. The Rehabilitator shall secure the services of a court reporter.			
September 1, 2021	Application for Relief			
	Lapinski, James F.		Intervenor	
Document Name:	Motions to Order Teachers Protective Mutual, Transamerica, Conseco to Pay Lapiniski's Unpaid			
Comment:	Commissions from Senior Health Insurance Company fo Pennsylvania in Rehabilitation			
September 1, 2021	Sealed Exhibit			
	Lapinski, James F.		Intervenor	
Document Name:	Sealed Exhibits B & C to Lapinski Application for Relief			
September 7, 2021	Application for Relief			
	Lapinski, James F.		Intervenor	
Document Name:	Amended Motions to Order Teachers Protective Mutual, Transamerica, Conseco to Pay Lapinskis			
Comment:	Unpaid Commissions from Seniro Health Insurance Company of Pennsylvania in Rehbilitation			
September 7, 2021	Sealed Exhibit			
	Lapinski, James F.		Intervenor	
Document Name:	Sealed Exhibits B & C to Lapinski's Amended Motions			

1:51 P.M.

Sealed Documents

Senior Health Insurance Company of Pennsylvania Docket Sheet

Commonwealth Court of Pennsylvania

Docket Number: 1 SHP 2020

Page 57 of 57

September 13, 2021

DOCKET ENTRY

Filed Date	Docket Entry / Filer	Representing	Participant Type	Exit Date
September 13, 2021	Memorandum Opinion Filed Leavitt, Mary Hannah			09/13/2021

Document Name: Joint Application for Approval of Settlement Agreement Granted

Comment: AND NOW, this 13th day of September, 2021, upon consideration of the Joint Application for Approval of Settlement Agreement filed by Insurance Commissioner Jessica K. Altman, in her capacity as the Statutory Rehabilitator (Rehabilitator) of Senior Health Insurance Company of Pennsylvania (SHIP), and 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., it is ORDERED that the Joint Application is GRANTED and the proposed Settlement Agreement filed as Exhibit A to the Joint Application is APPROVED. It is further ORDERED that:

1. The Rehabilitator is authorized to make any payments required under the Settlement Agreement so long as SHIP is in rehabilitation.
2. In accordance with Paragraph 1 of the Court's order of August 24, 2021, approving the Second Amended Plan of Rehabilitation for SHIP, the Court approves Section VI.N of the Plan, subject to the following modification to be inserted at the end of Section VI.N: "Certain Agents and Brokers formally objected to this Section VI.N, but per settlement with the Rehabilitator, withdrew their objections as moot."
3. Prior to implementing the approved Second Amended Plan, the Rehabilitator shall file with the Court an amended rehabilitation plan which includes the modification identified in Paragraph 2.
4. Intervenor James Lapinski's Motion to Strike the Joint Application is DENIED.

REARGUMENT / RECONSIDERATION / REMITTAL

Filed Date: June 1, 2021
Disposition: Order Denying Application for Reconsideration
Disposition Date: August 25, 2021

Record Remittal:

IN THE COMMONWEALTH OF PENNSYLVANIA

- - -

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

- - -

Friday, May 21, 2021

Day Five/Afternoon Session

Pages 976-1003

- - -

Proceeding in the above-captioned matter held before THE HONORABLE MARY HANNAH LEAVITT, at the Commonwealth Court of Pennsylvania, 601 Commonwealth Avenue, Harrisburg, Pennsylvania, commencing at 12:49 p.m., on the above date, by Melissa Bartman, RPR.

* * *

VERITEXT LEGAL SOLUTIONS
MID-ATLANTIC REGION
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APPEARANCES:
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insurers have nothing further for the record.

JUDGE LEAVITT: All right. Thank you.

The record is closed.

MR. BROADBENT: Thank you, Your Honor.

So at this time, Your Honor, the rehabilitator would respectfully apply to this Court for judgment in the nature of a directed verdict on the issue of the rehabilitator's right to effect policy modifications otherwise known as the issue state rate approval option.

It's the rehabilitator's view that the record and the evidence clearly and unambiguously supports judgment in the rehabilitators favor on that issue.

State insurance regulators are the only party which have raised it in this Court, and in their intervention papers, in fact, they sought no relief but in their prehearing memoranda they asked that the Court disapprove the plan. And one basis on one which they requested that disapproval was on this issue state of rate approval option.

But the fact remains, Your Honor, we've come to the end of this hearing and the state insurance regulators have failed to put on any evidence which would or could support an interest they purport to

represent with respect to the issues state rate approval option.

This Court directly asked Mr. Leslie to identify the interest of the regulators. And he first stated, quote, the plan affects policyholders across the United States not just in Pennsylvania, closed quote.

Now, I don't really understand, frankly, what basis Mr. Leslie or his clients would have for purporting to represent policyholders outside of their own states and, in fact, I would assume that many of those policyholders would object to the state insurance regulators of Maine, Massachusetts, and Washington purporting to speak for them.

But putting that aside, the Court went on to ask Mr. Leslie if they were here in a parens patriae capacity. And I believe Mr. Leslie said the regulators were not.

The Court further asked Mr. Leslie to identify the harm suffered by the state insurance regulators and he could not do so.

The Court further asked Mr. Leslie to identify whether the state insurance regulators believe that their authority was being usurped, and he did not say that it was. And we have the transcript if that would be helpful. But I will continue unless the Court

wants to see it.

Ultimately, in that exchange with the Court, Mr. Leslie did not in any way reference the issue state rate approval option. In fact, the issue identified as being most critical, in his words, were that the plan is a bad deal for policyholders and hurts policyholders all over the United States, and we want to be able to talk about that.

So the adverse effect of policyholders which may, in fact, be adverse effect on policyholders in the final but principally promises to be here. I think that was on page 534.

Mr. Leslie did raise the issue of whether the rehabilitator would argue that the plan was res judicata, which, of course, we will. But Mr. Leslie clarified his clients were here because they believed the plan was unconstitutional and unlawful, and bad for policyholders.

But, now, Your Honor, at the end of a week, the only testimony or evidence we've heard in that respect from the regulators came from Mr. Edwards who purported to do some mathematical calculations showing that on a net present value basis, certain policyholders had a greater net present value liquidation than rehab. But that may or may not be true depending on how you

look at his numbers. But that's not the -- well, frankly that's not the test in our view nor is it the only data on which the rehabilitator might rely.

But more importantly, Your Honor, none of that testimony went to whether the states and their regulators were harmed by the -- by the issue state rate approval option.

And there are four key points there I'd like to make, and I'll only need a few more minutes of the Court's time.

First, as to the rates themselves, there's been no testimony from any actuarial or regulatory witness that the -- if the new methodology proposed by the regulator violates any state statute or regulation in Maine, Massachusetts, or Washington. There's been no testimony that any premium which is tied to a lifetime loss ratio of 60 percent, as if knew does, would violate state laws of those states.

There's been no testimony from any regulatory witness that the state insurance regulators would disapprove of a new fee rate as the rehabilitator proposes to be done on a seriatim basis here.

And really they can't because there's no objection to that from a policyholder basis or from a regulator basis because the end result is that

individual policyholders pay an if knew premium. They don't pay on the basis of an average, which could result in some policyholders underpaying and some policyholders overpaying subsidized their coverage.

Second point is there's been no testimony from the regulators of those states, or any other state for that matter, that the state regulators reject the options themselves as unlawful.

And the regulators and their witnesses focused -- their witness, Mr. Edwards, focused on the impact of the options on policyholders as opposed to liquidation. But there's been no evidence showing that those options are illegal under those states' laws or that the regulators would not allow them.

Third, I've not heard testimony from any of the state insurance regulators that any policyholder whose premiums would otherwise be governed by Maine, Massachusetts, or Washington law suffered any harm. There's no policyholder from those states that's here in this Court to assert that he or she has no option that he or she wants them in the plan.

No policyholder has asserted that he or she would be harmed by the rehabilitator of this Court as opposed to the state insurance regulators of Maine, Massachusetts, and Washington reviewing and approving

the rates under an actuarially justified standard as Mr. Bodnar and Mr. Cantilo testified.

That's likely true, Your Honor, because no such policyholders would exist. There's no absolute or inviolate right of those policyholders to have the regulators of the issue state decide what their premiums should be either as a matter of statute or as a matter of the policy terms.

Finally, Your Honor, it's important for the rehabilitator to note that no witness has explained how the issue of the issue state rate approval opt-out process does not hand control to the regulators in the way that Mr. Cantilo has explained and as is set out in the plan.

In our view, absent any testimony as to the ways in which a regulator is constrained or harmed by that option, the regulators here have no argument to present which would show that it does not sufficiently address the concerns that they have raised at some earlier stake in these proceedings. Although it may be that they have abandoned those issues had they not raised them here in Court.

Now, I imagine Mr. Leslie will have something to say about this, and I'll just preemptively note that this is not a purely legal issue in the way he

may seek to suggest. Without actual evidence from the state insurance regulators on the impact of the plan with respect to their ability to regulate, and that is without factual testimony, showing the regulators could not control the rates or that the regulators would reject the options available to opt-out state policyholders, there's no basis for argument the plan is unlawful.

In closing, Your Honor, it's become clear to me over the last week that the intervener state insurance regulators are here as a resource. While they purport to be opponents of the plan, Mr. Leslie stated and this will be 530, page 530, of the transcript, the quote, we are not seeking to impose our views. All we can do is offer our views and the Court will decide what's best. On that issue, Mr. Leslie and I, in fact, agree.

So with the idea that the regulators are a resource to the rehabilitator in the Court, we thank them for their opinions. But we respectfully reject them. And we continue to seek approval of the plan.

And of course, the issue of the remaining questions under the plan and the rehabilitator's discretion will be taken up by the Court in its opinion.

At this time, Your Honor, we respectfully request that the Court enter judgment in the nature of a directed verdict on the issue of the issue state rate approval option, and deny that that issue could form a basis on which the plan may not be approved. Thank you.

JUDGE LEAVITT: Thank you. Mr. Leslie.

MR. LESLIE: Your Honor, you'll be unsurprised to know that I was -- of course, the first I've heard of this. Much like when I was about to begin my opening statement, I first heard the objection to our witness, notwithstanding the fact that we had identified that witness in our April filings including his exhibits. Notwithstanding that no objection had been raised at the prehearing conference. And obviously, that was a speaking motion, and I responded to it as best I could at the time.

I believe I preserved all of the legal arguments that we had raised in our briefs -- in our prehearing memoranda.

This has been an evidentiary hearing. There are important legal questions that have to be addressed that are foundational. This is a -- the rehabilitation plan proposed in this case is unique. Nothing like this has ever been done in the United

States with regard to a rehabilitation.

To take a $1.2 billion deficiency and address it as the rehabilitator proposes is extraordinary. It's unique. It's unusual for state regulators to object to other -- another state regulator's decision.

It's only because of the extraordinary nature of this, because of the precedential effect that it has, it matters. It matters nationally and it matters to my clients.

I appear here on behalf of them in their official capacity. I appear here on behalf of the attorneys general of Washington and Massachusetts in the furtherance of the public rights and interests of those regulators. And, honestly, I am shocked that the Pennsylvania Commissioner of Insurance would seek to prevent her sister commissioners from being heard on this issue of such critical significance.

So summing up on the legal issue, there are significant open legal issues. This case is not ripe to be decided on a directed verdict. Our witness testified directly to the question of constitutional compliance does this plan comply with the constitutional standard set forth in Neblett. It doesn't.

Our witness provided testimony and

raised the question of fact as to whether, in fact, using the very methodology that the rehabilitator chose to use in its comparison file, using that data provided by Oliver Wyman, offered by the rehabilitator to explain why the plan met the constitutional standard. He offered testimony as to how it didn't.

He offered testimony as to why option two does not afford guarantee association benefits. He offered testimony as to why those options as they play out, particularly option four, are an illusion.

And that illusion is particularly true in the case of Mr. Cantilo's testimony that this rehabilitation plan is most likely not going to solve the insolvency of SHIP. Those are factual questions and it's appropriate for those factual questions to be addressed with the findings of fact and conclusions of law that the Court expects from the parties who have been granted intervention in this case, including us.

These are questions the Court should consider, these are questions that the Court should consider after briefing, and a directed verdict, Your Honor, is not justified under these circumstances.

JUDGE LEAVITT: Thank you. Just to clarify, Mr. Leslie, Mr. Edwards was not qualified as an expert, correct?

MR. LESLIE: No, he was called as a fact witness, Your Honor.

JUDGE LEAVITT: All right.

MR. BROADBENT: Your Honor, may I take just two minutes?

JUDGE LEAVITT: Yes.

MR. BROADBENT: It seems Mr. Leslie is confused about what I'm doing.

To be clear, we're only seeking the directed verdict on the issue state rate approval option 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 plan is fair and equitable or the exercise of the rehabilitator's discretion generally.

This is a narrow motion, Your Honor, on the issue state rate approval option and the opt-out offer thereunder.

The only other two items to raise -- and frankly, Your Honor, Mr. Edwards didn't testify to that and Mr. Leslie didn't identify any.

Two final points. Mr. Leslie mentioned attorneys general. I think he misspoke. But that may be worth clarifying because the attorneys general are

not parties here in this proceeding.

And second, ultimately, Your Honor, the question is this, if there is no harm to the state regulators, how can there be relief that is offered to them and how can they have an objection?

And that's, again, focused on that narrow issue of the issue state rate approval option rather than the entire plan. I just want to make sure that was clear in terms of what we were seeking.

Thank you.

JUDGE LEAVITT: Mr. Leslie?

MR. LESLIE: The rate review and approval question is a legal question. It's not a factual question. And it's an open question because it hasn't been fully briefed. So this is a legal question and not addressing it with factual testimony during this hearing doesn't mean that that legal question is waived, Your Honor.

It's a legal question the Court needs to address as part of its ruling on the proposed plan. That's what I have to say on that, Your Honor. Thank you.

JUDGE LEAVITT: Do you believe that you preserved the issue notwithstanding the fact that you informed the Court that that was not why you were

presenting evidence?

MR. LESLIE: Your Honor, I was explaining why Mr. Edward's testimony was being offered.

JUDGE LEAVITT: No.

MR. LESLIE: At the time.

JUDGE LEAVITT: Well --

MR. LESLIE: And the Court asked me a number of questions about our issues.

JUDGE LEAVITT: Well, because we had an objection to Mr. Edwards.

MR. LESLIE: Yes, and I responded to those questions, Your Honor, by saying all of the legal questions that were -- that were addressed in our memoranda were on the table.

JUDGE LEAVITT: And so --

MR. LESLIE: And the question of approval of rates is a legal question, and it's still on the table.

Your Honor, I also think it's extremely unfair to take a highly technical view of what is said in response to a speaking motion that was never discussed in advance and to use that in a way to try to preclude government officials from being heard on the question.

This is an important point. And it's a

legal point. And I don't think it's fair, Your Honor, to parse through those words said without any advanced notice, without any opportunity to consider the issue. And I did the very best, I think appropriately, to preserve those issues through that colloquy I had with you, Your Honor.

JUDGE LEAVITT: Yes, the question is -- well, nevertheless, there is an opt-out option that preserves the right of the issue -- state of issue to pursue a state rate approval powers and your witness did not address why the plan was deficient in some way on that -- in that way.

MR. LESLIE: Your Honor, we addressed the issue of state rate, the opt-out in our prehearing memoranda.

It's a legal question. It's not a factual question. It's a question of the interpretation of that language. That opt-out language by the language itself, it's a legal question, provides meaningless, meaningless benefits to state regulators.

Mr. Cantilo himself testified as to the consequences of opt-out and how it will, in fact, benefit the estate by reducing the amount of assets -- of liabilities otherwise available should any regulator choose to follow that opt-out.

There's a factual record based on the testimony offered by the rehabilitator in this case on that question and it can be looked at within the context of the legal question in interpreting that provision.

It is primarily a legal question. It should be reserved and dealt with in the briefing. It is not a question that we -- we certainly did not waive it. There are many other provisions of the plan we did not address during this evidentiary hearing.

This was not a hearing to deal with the legal questions. Your Honor will recall that I had proposed that we deal with the legal questions first. The Court preferred to deal with the factual questions. We understood that, and we played within the ground rules that were established for that purpose.

This hearing was a hearing on factual and evidentiary issues. It's now closed. This is a legal question. And it's been preserved and it should be able to be addressed as part of the briefing.

JUDGE LEAVITT: All right. Thank you.

MR. LESLIE: Thank you.

JUDGE LEAVITT: The Court is going to grant the motion. Mr. Leslie, on behalf of your clients, you may make your case in your post-hearing filing on why the Court should reconsider that motion

grant.

Anything else, Mr. Broadbent?

MR. BROADBENT: One item not yet on Your Honor's to-do list would be just to remind the Court because we did hear some testimony from the policyholder witnesses today with regard to the restructuring application, I just wanted to make sure it was clear that the rehabilitator intended to file an application addressed to the restructuring issues.

There was some confusion, I think inaccurate and misunderstandings on the policyholders. But when we file the application for restructuring, which I know Your Honor understands what's involved there, we will file an application and will, in part, explain that issue more broadly to everybody.

JUDGE LEAVITT: And that will be an amended -- amendment to the second amended plan?

MR. BROADBENT: No, it's a second application. We had hoped to have it done. Perhaps part of the plan, we will file a separate application to address the restructuring issue.

JUDGE LEAVITT: All right.

MR. BROADBENT: And finally, Your Honor, although I'd be happy to allow Your Honor to be the one to drive this conversation, yesterday, Your Honor, you

PROOF OF SERVICE

I, Stephen G. Harvey, hereby certify that on September 21, 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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1 SHP 2020

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

IN RE: SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)	:	**No. 1 SHP 2020**

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

JURISDICTIONAL STATEMENT

1. This is a direct appeal from orders approving the Second Amended Plan of Rehabilitation ("Plan") for Senior Health Insurance Company of Pennsylvania ("SHIP"). The Commonwealth Court ("Court") issued an unreported Memorandum Opinion re: Application for Approval of the Plan of Rehabilitation for SHIP appended as Appendix "A".

2. The jurisdiction of the Supreme Court is based on the following:

   a. Section 723(a) of the Judicial Code, 42 Pa.C.S. § 723(a);
   b. Pa.R.A.P. 1101(a)(1); and
   c. As an appealable final order under Pa.R.A.P. 341(b)(1) or, in the alternative, as an appeal as of right of an interlocutory order under Pa.R.A.P. 311(a)(2).

3. The Orders in question are (1) the Order entered on August 24, 2021 granting the Rehabilitator's Application for Approval of the Plan of Rehabilitation

for SHIP (appended as Appendix "B"), (2) the oral Order entered May 21, 2020 granting the Rehabilitator's oral motion regarding issue state rate approval option (transcript appended as Appendix "C"), and (3) the Order entered on August 25, 2021 denying the Intervenor State Insurance Regulator's Application to Reconsider Order Granting the Rehabilitator's Oral Motion Regarding State Issue Rate Approval Option (appended as Exhibit "D").

4. The pertinent procedural history is as follows:

The Pennsylvania Insurance Commissioner filed a petition for order of rehabilitation on January 23, 2020. On January 29, 2020, the Court issued a Rehabilitation Order placing SHIP in rehabilitation and appointing the Commissioner as Rehabilitator.

On April 22, 2020, the Rehabilitator filed an Application for Approval of Plan of Rehabilitation for SHIP. On June 12, 2020, the Court issued a Case Management Order for Comments and Hearing on the Proposed Plan of Rehabilitation setting a schedule for interested persons to provide comments, to seek to intervene, and to make filings regarding witness narratives and exhibits.

By application filed July 31, 2020 and joinder filed September 15, 2020, 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 (the "State Insurance Regulators") applied to intervene in the

proceedings on the Proposed Plan of Rehabilitation. The Court allowed the State Insurance Regulators to intervene by orders entered September 15 and 18, 2020.

After receiving comments, the Rehabilitator filed an Amended Plan of Rehabilitation for SHIP on October 21, 2020. Intervenors subsequently submitted amended comments and filings concerning witnesses and exhibits.

On February 24, 2021, the Court held a pre-hearing conference.

On May 3, 2021, the Rehabilitator filed the Second Amended Plan of Rehabilitation.

The Court held a hearing on the Plan from May 17 to May 21, 2021. On May 21, 2021, the Rehabilitator made an oral motion "in the nature of a directed verdict" concerning the "issue state rate approval option." The Court granted the motion from the bench (Appendix "C"). On June 1, 2021, the State Insurance Regulators filed an Application to Reconsider that order.

On August 24, 2021, the Court issued its Memorandum Opinion (Appendix "A") addressing the Rehabilitator's Application for Approval of the Plan and the State Insurance Regulators' Application to Reconsider. On August 24, 2021, the Court entered its Order granting the Rehabilitator's Application and approving the Plan (Appendix "B"), and on August 25, 2021, the Court issued its Order denying the State Insurance Regulators' Application to Reconsider (Appendix "D").

5. Questions presented for review:

A. Whether the Court erred as a matter of law in holding that the Plan is not required to be feasible and in approving the Plan that the Rehabilitator acknowledges is not reasonably likely to restore SHIP to solvency.

B. Whether the Court erred as a matter of law in approving the Plan where it does not provide policyholders with a value in rehabilitation at least equal to the value in liquidation as required by the Due Process Clause, Contracts Clause and *Neblett v. Carpenter*, 305 U.S. 297 (1938).

C. Whether the Court erred as a matter of law in approving the Plan as within the Rehabilitator's discretion based on a "legitimate and significant public purposes" standard rather than the classic test of the best financial interest of policyholders in that the Plan places the entire $1.224 billion insolvency on the remaining policyholders and avoids triggering guaranty associations that would provide $887 million in additional support.

D. Whether the Court erred as a matter of law in approving the Plan where it substantially impairs policyholders' contract rights without a legitimate public purpose, since it is unlikely to restore SHIP to solvency, and thereby unreasonably imposes economic harm on policyholders in violation of the Contracts Clause.

E. Whether the Court erred as a matter of law in approving the Plan where it does not treat policyholders in all states equally as required by 40 P.S. § 221.44 and § 221.61 and *Neblett v. Carpenter*, 305 U.S. 297 (1938).

F. Whether the Court erred as a matter of law in approving the Plan where it violates the Full Faith and Credit Clause and exceeds the statutory authority of 40 P.S. § 221.15 and § 221.16 by seeking to set rates in States other than Pennsylvania and supersede the authority of insurance regulators in other States.

G. Whether the Court erred as a matter of law in holding that the "issue state rate approval" provision cures the Plan's improper attempt to supersede the authority of insurance regulators in other states and in granting the Rehabilitator's motion "in the nature of directed verdict" on this issue.

Respectfully submitted,

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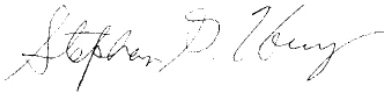
PUBLIC ACCESS POLICY CERTIFICATE OF COMPLIANCE

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.

Respectfully submitted,



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WORD COUNT CERTIFICATE OF COMPLIANCE

Pursuant to Pa. R.A.P. 910(b) and (c)(1), I certify the following:

This Jurisdictional Statement is under five (5) pages and, excluding the caption and signature block, contains 909 words.

Dated: September 21, 2021

/s/ Stephen G. Harvey
Stephen G. Harvey (PA 58233)

Appendix A

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

RE: Application for Approval of the Plan of Rehabilitation for Senior Health Insurance Company of Pennsylvania

BEFORE: HONORABLE MARY HANNAH LEAVITT, Judge

OPINION NOT REPORTED FILED: August 24, 2021

MEMORANDUM OPINION AND ORDER

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I. Introduction

Before the Court is the application of Jessica K. Altman, Pennsylvania Insurance Commissioner, which she filed in her capacity as Statutory Rehabilitator of Senior Health Insurance Company of Pennsylvania (SHIP). By this application, the Rehabilitator seeks approval of her Second Amended Plan of Rehabilitation (Second Amended Plan or Plan) for SHIP pursuant to Section 516(d) of Article V of The Insurance Department Act of 1921 (Article V), Act of May 17, 1921, P.L. 789, *added by* the Act of December 14, 1977, P.L. 280, 40 P.S. §221.16(d). The Rehabilitator has the statutory responsibility to develop a plan to correct the conditions that caused SHIP's hazardous financial condition. Giving deference to the Rehabilitator's discretion in formulating this Plan, this Court must decide whether to approve the Plan, approve the Plan with modifications, or disapprove the Plan.

At present, SHIP has approximately $1.4 billion in assets and $2.6 billion in liabilities, producing a deficit of approximately $1.2 billion (also referred to as the Funding Gap). The Second Amended Plan's ultimate goal is to eliminate the Funding Gap by increasing premium revenue and modifying the existing terms of most of the approximately 39,000 policies in force. The Plan is structured to maximize policyholder choice in several ways. Depending on his circumstances and preferences, a policyholder may choose to continue his policy with all benefits and terms unchanged by paying the actuarially justified annual premium for that policy. Alternatively, the policyholder may choose to reduce some policy coverages as more suitable to the policyholder's current circumstances in order to avoid or temper a premium increase. A policyholder who is 95, for example, may decide to reduce the

maximum coverage period from 10 to 5 years in lieu of paying the premium required for a policy with a 10-year period of coverage.

The Second Amended Plan also seeks to correct SHIP's discriminatory premium rate structure. At present, SHIP policyholders pay substantially different premiums for the same coverages. The difference in premiums is attributed to the decisions of different state regulators on SHIP's proposed rate increases. The state where the policy is issued retains authority for all rate increases, even after the policyholder moves to another state. Policyholders whose state of issue has approved the requested rate increase pay more for the same coverages than policyholders whose state of issue has disapproved the requested rate increase. As a result, the former group of policyholders pays more than its fair share of the costs of providing the coverages and the latter group pays less than its fair share. The Second Amended Plan seeks to eliminate these inequities.

The Court conducted a hearing on the Second Amended Plan from May 17, 2021, through May 21, 2021. The parties submitted post-hearing briefs on June 21, 2021, and June 28, 2021. On July 21, 2021, the Rehabilitator and Intervening Agents and Brokers filed an application for the Court's approval of a settlement agreement, which will amend Part VI.N of the Plan. The Rehabilitator's application for approval of the Second Amended Plan is ready for disposition, with the exception of Part VI.N, on which a decision will be deferred for 30 days to allow a hearing on the Rehabilitator's settlement agreement with the Intervening Agents and Brokers.

II. Findings of Fact

A. Business and History of SHIP

SHIP is a Pennsylvania life and health insurance company. Its origins date to 1887, when its corporate predecessor, the Home Beneficial Society,

commenced business. By the 1980s, the company was known as American Travelers Insurance Company and was primarily writing long-term care insurance. In 1996, the company was acquired by, and merged into, CIHC, Inc., a wholly-owned subsidiary of 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 waiver[3] or have previously taken a non-forfeiture option, which allows the policyholder to discontinue paying premiums in exchange for a period of coverage equal to the premiums previously paid to the company less any benefits previously received. Approximately 13% of SHIP's long-term care policyholders are on claim, and the Rehabilitator expects that number to rise to 32% of all policyholders by 2050. Ex. RP-56 at 21. The Rehabilitator also expects the volume of SHIP's claims to continue outpacing its premium collections. Specifically, in the absence of the Rehabilitator's plan, SHIP will pay another $3 billion in claims but collect only $230 million in premiums. *Id*. at 20.

B. SHIP's Financial Condition

SHIP has approximately $1.4 billion in assets and $2.6 billion in liabilities, *i.e.,* a Funding Gap of $1.2 billion. Ex. RP-31 at 1-2. The major causes

[3] Approximately 99% of SHIP's long-term care policies provide that a policyholder who receives benefits under his policy for a specified period of time (such as 90 days) is no longer required to pay premiums for coverage after that time period as long as the policyholder remains eligible for benefits or receives a specified level of care. "Once the policyholder's eligibility for benefits ends, the policyholder is required to resume paying premiums." Ex. RP-55 at 86 (Second Amended Plan).

of SHIP's insolvency were the use of erroneous actuarial assumptions to develop initial premium rates, poor investment returns, high operating costs, and the inability to obtain the approval of actuarially justified rate increases from state insurance regulators. Two significant adverse events exacerbated SHIP's financial situation. In 2018, following the appointment of a Special Deputy Rehabilitator and a revision of SHIP's key actuarial assumptions, SHIP recorded a $374 million premium deficiency reserve; a $44 million increase in claim reserves; and a $176 million investment loss from the so-called Beechwood investment program. These accounting entries increased SHIP's 2018 deficit by $500 million. *See* Ex. RP-56 at 23. In 2019, revised actuarial assumptions required an increase in reserves, thereby adding another $400 million to SHIP's deficit. *Id*. SHIP's annual premium revenue as of December 31, 2020, is $58 million. *Id*. at 14.

C. Rehabilitation Plan

Given SHIP's negative capital and surplus, the Insurance Department applied to this Court for an order placing SHIP in rehabilitation, with the consent of the Senior Health Care Oversight Trust and SHIP's directors. On January 29, 2020, the Court granted the application and appointed the Pennsylvania Insurance Commissioner to serve as Rehabilitator of SHIP; to take steps to address SHIP's financial challenges; and to protect its policyholders and other creditors.

The Rehabilitator engaged a Special Deputy Rehabilitator, Patrick Cantilo, and actuarial consultants, including Oliver Wyman, to study SHIP's financial condition and to manage the company while they developed corrective measures. On April 22, 2020, the Rehabilitator filed a plan for the rehabilitation of SHIP. The Court issued a case management order which, *inter alia*, solicited formal

and informal comments from any interested person. Several intervened to offer comments on the rehabilitation plan and participate in any proceedings, including:[4]

1) The Maine Superintendent of Insurance, the Massachusetts Commissioner of Insurance, and the Washington Insurance Commissioner (Intervening Regulators);

2) The National Organization of Life and Health Guaranty Associations (NOLHGA);

3) ACSIA Long Term Care, Inc.; Global Commission Funding LLC; LifeCare Health Insurance Plans, Inc.; Senior Commission Funding LLC; Senior Health Care Insurance Services, Ltd., LLP; and United Insurance Group Agency, Inc. (Intervening Agents and Brokers);

4) Anthem, Inc.; Health Care Service Corporation; Horizon Health Care Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey; and UnitedHealthcare Insurance Company (Intervening Health Insurers); and

5) James Lapinski, a policyholder and agent, and Georgianna Parisi, a policyholder.

After reviewing the formal and informal comments, the Rehabilitator filed an amended rehabilitation plan on October 21, 2020. Following a second comment period and a pre-hearing conference, the Rehabilitator filed the Second Amended Plan on May 3, 2021.

The Second Amended Plan is designed to be implemented in three phases. Phase One, beginning immediately upon Court approval, is the principal phase and seeks to reduce substantially or eliminate the Funding Gap. This phase identifies the SHIP policies that require modification because their current premium

[4] The original intervening persons also included Transamerica Life Insurance Company and Primerica Life Insurance Company, both of which issued policies reinsured and administered by SHIP. These parties are no longer actively participating in the proceeding.

falls below the "If Knew Premium" for the benefits provided by the policies. Ex. RP-55 at 10. The If Knew Premium rate is the rate that, if charged from inception, would have produced an underwriting loss ratio of 60% for each policy form. *Id*. at 27. If Knew Premium rates are intended to price policies adequately on a lifetime basis, but not to recoup losses due to inadequate pricing in the past. Further, the policyholder's age and current medical condition are not taken into account when setting the If Knew Premium rate. The If Knew Premium is an accepted methodology for setting premiums for long-term care insurance policies.

Policyholders whose current premium (including the premium they would be paying but for a premium waiver) falls below the If Knew Premium for the policy's benefits will be required to elect one of four options:

> Option 1: continue paying the current premium or maintain the premium waiver if one is in effect, but if the current or waived premium is less than the If Knew Premium, have the policy benefits reduced in accordance with Plan provisions so that the premium for the reduced benefits (including waived premium) is equal on an If Knew Premium basis to the current premium. The benefit reductions will be selected automatically by the Plan.
>
> Option 2: select certain policy endorsements that provide essential benefits (sometimes greater than the benefits provided by Option 1) for an actuarially justified premium. The maximum benefit period is capped at four years, the maximum daily benefit is capped at $300 and inflation protection is capped at 1.5%.
>
> Option 2A: an enhanced alternative with a five-year benefit period and 2% inflation rider. Options 2 and 2A will not be subject to further rate increases or benefit reductions in Phase Two of the Plan. Options 2 and 2A are designed to provide reasonable coverage at reasonable premium rates.
>
> Option 3: Non-forfeiture Option (NFO) through which the policyholder will receive a Reduced Paid-up (RPU) policy providing limited benefits but for which no future premiums will

> be charged. Under the Plan, this option will include more generous benefits than the typical industry non-forfeiture option or reduced paid-up policy, most notably in that it will offer as much as a 30-month benefit period unless the current policy has a shorter benefit period. Moreover, policyholders who select this option will never have to pay additional premiums and this policy will never lapse.
>
> Option 4: retain the current policy benefits and pay the corresponding If Knew Premium (unless equal to or lower than the policyholder's current premium). For many policyholders this may require a substantial increase in premium.

See Ex. RP-55 at 11-12. Policyholders who presently pay a premium at or above the If Knew Premium may elect Option 2 or Option 3 if preferable, given their present circumstances. Otherwise, these policyholders will not have their policies modified in any respect.

Before making an election, each policyholder will receive information detailing the premiums and benefits associated with each option. Special elections will apply to policyholders who are not currently paying premium due to a premium waiver provision in their or their spouses' policies. Most of these policyholders have a current premium (what they would be paying but for the waiver) that is lower than the If Knew Premium. These policyholders will be required to pay a differential premium, which represents the difference between (1) the premium they would be paying but for the premium waiver in effect (the current premium), and (2) the If Knew Premium appropriate for their policy coverages. Ex. RP-55 at 12. Should the premium waiver terminate, these policyholders will then be required to pay the full applicable If Knew Premium. Similar options will be offered to policyholders on claim.

For every policyholder there will be a default option that applies automatically if no election is made. For the policyholder whose current premium falls at or above the If Knew Premium, the default option leaves the policy unchanged. For the policyholder whose current premium falls below the If Knew Premium, the default option will be identified in the election materials. For policyholders on premium waiver, the default option will be Option 1 (the benefit downgrade). Where the nonforfeiture option would provide these policyholders better benefits than the downgrade, Option 3 will be the default option. For policyholders paying premium, Option 2 (basic policy endorsements) will be the default option.

In Phase Two of the Second Amended Plan, the results of Phase One will be evaluated to determine whether additional policy modifications may be necessary for certain policies that are still underpriced. It is expected that modifications in Phase Two will largely be based on achieving a self-sustaining premium for every policy. The goal of Phase Two will be to eliminate any Funding Gap not eliminated in Phase One. In Phase Three, the Rehabilitator will complete the run-off of SHIP's long-term care insurance business remaining in force.

The Second Amended Plan corrects the condition that caused SHIP's insolvency: the underpricing of policies. The Plan will address the Funding Gap by increasing premiums or modifying policy coverages. The Rehabilitator has concluded that a modification of coverages will do more to reduce the Funding Gap than premium increases. Further, many policyholders are paying for more coverage than they are likely to use.

The Rehabilitator designed the Plan around the core principle of policyholder choice. All policyholders will have at least one option for preserving

their current coverage (by paying an increased premium) and at least one option for preserving their current premium (by reducing policy benefits). The Plan's premium rate structure takes rate increase history and product differences into account, and it will develop premium rate increases based solely on the characteristics of each policy and not on the policyholder's state of residence or the state where the policy was issued.

The payment of commissions owed to agents under agreements made prior to the inception of rehabilitation proceedings will be suspended under the Second Amended Plan until policyholders' claims have been paid in full and adequate provision made for reasonably anticipated future claims. Accrual of commissions will also be suspended as of the effective date of the Plan, *i.e.,* the date the policyholder elections become effective. Claims for commissions owed to agents and brokers will be subordinated to policyholder claims. The Plan's treatment of agent and broker commissions reflects the Rehabilitator's belief that most policyholders do not maintain a close relationship with their agent after purchasing their policy. They typically contact SHIP or another trusted professional when they have questions about their policy.

D. Hearing on Second Amended Plan

At the hearing on the Second Amended Plan, the Rehabilitator offered testimony from the following witnesses: Special Deputy Rehabilitator Patrick Cantilo, who was admitted as an expert in insurer insolvency matters, specifically as to long-term care insurers; Marc Lambright, an actuarial consultant to the Rehabilitator, who testified as a fact witness; and Vincent Bodnar, an actuarial consultant to the Rehabilitator, who was admitted as an actuarial expert and as an expert on long-term care insurance, including product development and sales

practices, the rate setting and approval process for insurers, and the liquidation of financially troubled insurers.

i. Rehabilitator's Evidence

a. Patrick Cantilo

Special Deputy Rehabilitator Patrick Cantilo provided the history of the business of SHIP, summarized above, and his involvement in the rehabilitation since 2018.

He first discussed the effects of the COVID-19 pandemic on SHIP's business and financial condition. Cantilo testified that since the beginning of the pandemic in 2020, SHIP has experienced a moderate increase in mortality, *i.e.*, more of its insureds died than would normally be expected, which generated a moderate increase in policy lapses. There was a small increase in morbidity, *i.e.*, the expected incidence of disease. The pandemic adversely affected SHIP's expected yield on invested assets. Cantilo opined that the aggregate effects of the pandemic had a relatively moderate impact on SHIP's financial condition and are not material to the Second Amended Plan.

Cantilo focused his testimony on the approximately 39,000 long-term care policies of SHIP. Approximately 53% of SHIP's current policyholders are paying premium, generating $58 million in revenue as of year-end 2020. The remaining 47% of policyholders are on claim, have previously selected a non-forfeiture option or are on premium waiver. *See* Ex. RP-56 at 14. Many policyholders have been paying less premium than is necessary to fund their coverages, and this premium deficiency has existed for years. SHIP policies that create the greatest liability have a 5% compounded inflation rider; unlimited lifetime benefits; and are non-tax qualified, meaning that they have lower benefit triggers

and shorter elimination periods. The effect of the inflation rider has been to increase the maximum daily benefit up to $650, without regard to actual inflation levels or the actual cost of the policyholder's care. Cantilo testified that the inflation rider is a "big contributor" to SHIP's overall deficit. Notes of Testimony (N.T.), 5/17/2021, at 34.

Cantilo testified that the majority of policyholders pay an annual premium of less than $2,500 per year. N.T., 5/17/2021, at 37-38. *See* Ex. RP-56 at 14. The group is 71% female, and the majority are in their 80s and 90s. Approximately 70% of the policies in force provide comprehensive coverage for both home health care and facility care in either an assisted living facility or nursing home. Inflation protection is a feature of 47% of these policies. The majority of policies, 54%, provide between one and four years of benefits; and 27% provide lifetime benefits. Ex. RP-56 at 17.

Cantilo opined that SHIP's claims, when compared to premiums, do not present "a good picture." N.T., 5/17/2021, at 41. The number of policies in force has declined since SHIP began operating in 2009, and at present, the cost of claims outpace the premium revenue. Of the total premium revenue that SHIP is expected to collect prior to the expiration of the policies in force, approximately $7.4 billion, it has already collected $7.1 billion. Stated otherwise, SHIP expects to collect only about $300 million in additional premium. On the other hand, SHIP's expected claims during that same period total approximately $11 billion; it has paid only $7.7 billion so far. In short, SHIP can expect to pay another $3 billion in claims but to collect only $300 million in premium, unless its business is restructured in a rehabilitation.

Cantilo testified that SHIP is not atypical in the industry. Long-term care insurers collect more premium than needed in the early years of writing policies. They invest the excess, put it aside, and then tap into those invested assets to pay claims. When a company stops writing new business, as SHIP did 18 years ago, the premium curve begins to flatten and the claim curve begins to rise. Cantilo testified that the assets set aside for the purpose of paying claims did not earn the expected income that was needed to meet liabilities.

Cantilo discussed the reasons for SHIP's insolvency, beginning with the erroneous actuarial assumptions made when the policies were first issued. SHIP underestimated the number of people who would become ill and qualify for benefits. At the same time, SHIP overestimated how quickly people would recover and stop needing care, referred to in the industry as morbidity improvement. SHIP overstated mortality by assuming more people would die before submitting claims than actually did. Relatedly, SHIP overestimated the number of policies that would lapse by reason of death or non-payment of premium. Cantilo estimated that through 2040, when most of the block of business will have terminated, the aggregate effect of the erroneous actuarial assumptions approximately equals the total deficit of $1.2 billion. *See* Ex. RP-56 at 29.

Another factor in SHIP's insolvency is its investment history. SHIP experienced lower market yields than it anticipated while it was selling and pricing its long-term care policies. To counter the effects of economic conditions, in 2009, SHIP invested in two programs, the Beechwood program and Roebling Re. Instead, these programs produced investment losses between $150 million and $300 million (as reported in 2018).

Cantilo testified that a significant cause of SHIP's insolvency is its discriminatory premium rate structure. As SHIP management realized its premium rates were inadequate, it began seeking premium rate increases from state regulators across the country from 2009 to 2021. SHIP received wildly different rate approvals. *See* Ex. RP-56 at 45. Cantilo testified that from 2009 to 2019, SHIP lost $312 million in cumulative premium due to rejected rate increase filings, or $371 million using an assumed 3.5% interest rate of return on investments. N.T., 5/17/2021, at 63-64; Ex. RP-56 at 50-51. The different responses of state regulators to SHIP's requested rate increases have created a discriminatory rate structure, which has been the focus of criticism in the regulatory community. Policyholders whose state of issue has approved rate increases are effectively subsidizing policyholders whose state of issue has not approved rate increases. Similarly situated policyholders are paying vastly different premiums for the same coverage. Cantilo opined that this has created an unfortunate side effect: states inclined to approve actuarially justified rate requests become hesitant to do so because of the failure of other states to act in kind.

The Rehabilitator's team had to decide whether to pursue a rehabilitation or liquidation of SHIP. Cantilo testified that the team chose rehabilitation because SHIP is financially able to provide a reasonable package of coverages to the remaining 39,000 policyholders. The Rehabilitator also considered that, in a liquidation, guaranty association coverage will be triggered, resulting in taxpayers contributing hundreds of millions of dollars to pay claims of policyholders who have not paid an appropriate premium. Rather than shifting the burden of the inadequate premium to taxpayers, the team concluded that the better course was to right-size the existing policies to an actuarially justified premium. Acknowledging that no rehabilitation plan will magically restore SHIP to solvency, Cantilo testified

the Second Amended Plan will, at a minimum, substantially reduce the Funding Gap and correct SHIP's inequitable premium rate structure. He explained that the Plan must be implemented quickly because of the advanced age of the policyholders.

In preparing the Second Amended Plan, the Rehabilitator relied on the combined expertise of Cantilo; Vincent Bodnar and other actuarial analysts at Oliver Wyman; Robert Robinson, who was appointed Chief Rehabilitation Officer of SHIP and who served as Chief Rehabilitation Officer and Chief Liquidation Officer for Penn Treaty;[5] Pennsylvania Insurance Department legal counsel and staff; and SHIP technical staff. The Rehabilitator also sought and considered the input of state insurance regulators, staff of the National Association of Insurance Commissioners, policyholders and other formal and informal commenters. The Rehabilitator's team prepared extensive analyses of SHIP's finances, its policyholders, the long-term care insurance market, and other matters relevant to SHIP's condition and prospects for rehabilitation. Key data and information have been made available to interested persons through a data site, which included actuarial files relating to assumptions and analyses, a seriatim actuarial file for every policy at issue, and tailored reports related to the Second Amended Plan.

Cantilo explained how the Second Amended Plan will operate. He described it as "completely scaleable," meaning that the elements of the Plan can respond to changes in the amount of the Funding Gap as SHIP moves through Phase

[5] Penn Treaty Network America Insurance Company, a Pennsylvania insurer, and its subsidiary, American Network Insurance Company (collectively, Penn Treaty), provided long-term care insurance to over 126,000 policyholders in all 50 states and the District of Columbia. Penn Treaty became insolvent for many of the same reasons that SHIP is insolvent, *i.e.*, benefit-rich policies were underpriced at inception and the company's active live reserves became understated. Penn Treaty was placed into rehabilitation by the Pennsylvania Insurance Commissioner on January 6, 2009. Rehabilitation ultimately proved unsuccessful, and on March 1, 2017, this Court ordered the liquidation of Penn Treaty.

One and into Phase Two and Phase Three. N.T., 5/17/2021, at 97. In Phase One, the policyholder's options are based on the If Knew Premium, and in Phase Two the options will be developed to establish a self-sustaining premium structure.[6] Cantilo testified that it was important to give each policyholder at least two options: (i) retain his current coverages by paying the actuarially justified premium (Option 4) or (ii) retain his current premium by adjusting coverages to match that premium (Option 1). Between those two options there is a non-forfeiture option (Option 3) that is more generous than a non-forfeiture option in liquidation and basic policy options (Options 2 and 2A), which provide a reasonable package of long-term care coverage at an affordable price.

Cantilo testified that the If Knew Premium was selected as the target premium in Phase One because it is generally accepted by regulators across the country; it was the methodology used by guaranty associations to increase premium rates for policyholders in the Penn Treaty liquidation; it is an easy rate methodology to explain to policyholders; and it achieves the goal of putting policyholders on a level playing field when it is calculated on a seriatim basis.

Cantilo explained in detail each Phase One option in the Second Amended Plan. Option 1 is the downgrade option. It allows the policyholder to keep his current premium but reduces benefits until the premium is adequate, on an If Knew basis. The policyholder will not choose which benefits to downgrade, which was discovered to be too complicated in the Penn Treaty liquidation. The methodology for reducing benefits under Option 1 will proceed in the following sequence: elimination of benefit restoration provisions; elimination of benefit

[6] The scope of Phase Two can only be determined after the completion of Phase One and an assessment of the remaining Funding Gap. Cantilo anticipates that the Rehabilitator will return to the Court at that point in the rehabilitation process.

extension provisions; adoption of tax-qualified benefit triggers; discontinuation of return of premium provisions; removal of inflation protection and locking of maximum daily benefit at current levels; conversion from indemnity to reimbursement of actual expenses up to the maximum daily benefit amount; reduction in the maximum daily benefit; extension of any elimination period to 90 days and applying it to each period of care; reduction in the policy's maximum benefit period; elimination of all premium waiver provisions; and conversion of the policy to a pool of money with a reduction of the maximum benefit period to the amount required to match the current premium. Ex. RP-55 at 45-46; Ex. RP-56 at 69. If the first revision is sufficient to match the policy's coverages to the existing premium, no further coverage modifications will be made.

Under Option 2, the policyholder selects basic policy coverages and a corresponding If Knew Premium. After extensive policyholder outreach, the Rehabilitator selected the key components of long-term care that most policyholders desire if they cannot afford the most expensive package of coverages. These include a maximum benefit period equal to the lesser of the current benefit period or four years; a maximum daily benefit equal to the lesser of 80% of the current daily benefit or $300 for nursing facility care;[7] and an annual inflation adjustment capped at 1.5%. Option 2A, which is an enhanced version of Option 2, provides a maximum benefit period of five years and an annual inflation adjustment of 2% for a higher premium. Policyholders who elect Option 2 or 2A will not be expected to participate in Phase Two of the Second Amended Plan.

Option 3 is the non-forfeiture option, which offers the policyholder a maximum benefit period of 2.5 years and a maximum daily benefit equal to the lesser

[7] The maximum daily benefit for facility care other than nursing home care is $225. The maximum daily benefit for home health care is $150.

of 80% of the current daily benefit or $300 for nursing facility care.[8] Cantilo contrasted Option 3 with the standard non-forfeiture option in the industry, which offers the policyholder the equivalent of accumulated premium less claims. Typically, this results in only several months of coverage, particularly where the policy is rich in benefits. By contrast, Option 3 provides a reasonable alternative to a "luxurious" policy. Policyholders who election Option 3 will not be required to participate in Phase Two of the Plan.

Option 4 allows the policyholder to keep his current coverages by paying the If Knew Premium. Cantilo testified that this option is the least favored by the Rehabilitator because if the majority of policyholders choose this option the Funding Gap will only be reduced by half. N.T., 5/17/2021, at 191. This is because the If Knew Premium does not cover the prior years of premium inadequacy.

Cantilo explained that the options will vary depending on whether the policyholder is on claim or paying premium. A policyholder on premium waiver may choose to pay a differential premium, *i.e.*, the difference between the waived premium and the If Knew premium. The policyholder may choose not to pay the differential premium, but the benefits of his policy will be reduced in a commensurate amount. Cantilo testified that the rationale behind the differential premium is to apportion the burden of rehabilitation among all policyholders, not just the subset still paying premium. It would be unfair for the 13% of policyholders on premium waiver to be immunized from a premium adjustment at the expense of the other 87%.

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

[8] The maximum daily benefit for facility care other than nursing home care is $225. The maximum daily benefit for home health care is $150.

sections. The first section describes the policyholder's current policy, including the monthly premium, available benefits, maximum policy value and the applicable statutory guaranty association limit were SHIP to be liquidated. The second section provides information on each option and how it changes the key provisions of his policy, *e.g.*, duration of benefit period and maximum daily benefit amount. The amount of the maximum policy value not covered by the applicable guaranty association is also provided. The third section contains two key pieces of information: the policyholder's estimated annual premium should a liquidation be ordered and the policyholder's estimated self-sustaining premium in Phase Two of the rehabilitation. Cantilo explained that these two numbers will enable policyholders to better choose among the options, especially since Options 1 and 4 will subject them to Phase Two.

To create user-friendly policyholder election materials, the Rehabilitator has engaged consultants who specialize in preparing Medicare supplement materials. The election forms will use graphics and be intuitively easy to follow. The Rehabilitator also plans to post a video tutorial online to guide the policyholder through the election forms. Cantilo testified that the Rehabilitator's goal is 100% policyholder participation. If a policyholder whose current premium is below the If Knew Premium does not make an election by the deadline, there are default options. For policyholders on premium waiver, the default option is Option 1, the downgrade option, unless Option 3 will provide better coverage, in which case it will be the default. For policyholders paying premium, the default option is Option 2, the basic policy endorsements.

The Rehabilitator conducted considerable outreach about the rehabilitation of SHIP beginning in the early stages of the rehabilitation. The

Rehabilitator participated in regular meetings of the National Association of Insurance Commissioners and organized numerous meetings and conference calls with state regulators. The goal was to design a rehabilitation plan to address all concerns, particularly those expressed about state-of-issue responsibility for premium rate review. The Rehabilitator set up a secure data site for interested persons that contains all of the exhibits to this proceeding, including the seriatim actuarial files for every policy. Individual reports were generated for each state explaining how resident policyholders of that state would fare under the plan.

To date, the Rehabilitator has received comments from approximately 100 policyholders. Cantilo testified that this was far fewer than the number of comments in Penn Treaty. As expected, most policyholder concerns related to reduction of benefits and rate increases. Cantilo was surprised how many policyholders were supportive of a rehabilitation and the plans submitted by the Rehabilitator.

The principal concerns raised by state insurance regulators related to the following areas: (1) treatment of reinsurance assumed; (2) setting of premium rates by the Rehabilitator and this Court rather than by state-of-issue regulators; (3) desirability of liquidation instead of rehabilitation; and (4) feasibility of the Second Amended Plan. Cantilo discussed each of these areas in turn.

On the first concern, Cantilo explained that SHIP's assumed reinsurance involved approximately 2,000 long-term care policies originally issued by American Health and Life, Primerica and TransAmerica, or the predecessors of those companies. SHIP's predecessors entered into agreements to reinsure 100% of these policies and administer claims. In the case of TransAmerica, on December 29, 2020, this Court approved an agreement by which TransAmerica recaptured its

policies from SHIP. Cantilo opined that the recapture was consistent with industry norms.

With regard to premium rates, Cantilo acknowledged the objections of the Intervening Regulators. They contend that the state where the policyholder resided when the policy was issued is solely responsible for the regulation of the policy's premium rate. Cantilo opined that this makes sense for solvent insurers, but when an insurer enters rehabilitation, the domiciliary state has sole responsibility for the insolvent insurer and the restructuring of its business. This responsibility includes the adjustment of premiums and policy coverages where necessary to correct the insurer's financial condition.

Cantilo testified that the Intervening Regulators' legal assertion that they have the right to review and approve premium rates for policies issued by SHIP in their states creates "some ironic consequences." N.T., 5/17/2021, at 157. For example, 34 policies issued in Maine, 84 policies issued in Massachusetts and 89 policies issued in Washington are held by policyholders who now reside in other states. Thus, the Intervening Regulators assert the right to set the rates for 207 policyholders who live outside of their states. Ex. RP-56 at 97. Further, 21 policyholders who reside in Maine, 83 policyholders who reside in Massachusetts and 87 policyholders who reside in Washington had their policies issued in other states. Under the Intervening Regulators' legal assertion, other state regulators would set the rates for 191 policyholders residing in the states represented by Intervening Regulators. *Id*. at 98. In short, their inflexible view of rate regulation results in approximately 400 policyholders residing in Maine, Massachusetts and Washington having their rates set by states in which they do not reside. The better approach, in Cantilo's view, is for the domiciliary regulator of an insurer in

rehabilitation to manage rate and contract modifications as part of a comprehensive rehabilitation plan.

Nevertheless, the Second Amended Plan contains an Issue State Rate Approval Option. As Cantilo explained, every state will be given the option of opting out of the rate approval section of the Second Amended Plan. If a state opts out, the Rehabilitator will file an application to increase premium rates for policies issued in that state to the If Knew Premium level. No rate increase will be sought for policies on premium waiver or which are already at or above the If Knew Premium. The Rehabilitator will file the application on a seriatim basis to eliminate subsidies and restore a level playing field. The regulator for the opt-out state will then render a decision on the application; if it is only partially approved, the Rehabilitator will downgrade the benefits for the affected policies.[9] Cantilo testified that this is essential to eliminate the subsidies that exist between policyholders across states by virtue of uneven rate increase approvals over the years. Each opt-out state policyholder will still have four options, which are not exactly the same as those offered in the Second Amended Plan. They are: (1) pay the approved premium and have benefits reduced to match; (2) accept a downgrade of benefits to match the current premium; (3) accept an issue-state non-forfeiture option; or (4) keep the current benefits and pay the If Knew Premium. Cantilo pointed out that the non-forfeiture option available to opt-out policyholders will not be as generous as the enhanced non-forfeiture option in Option 3 of the Second Amended Plan. There will also be no "basic policy benefits" option, *i.e.,* Option 2 in the Plan.

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

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

Intervening Regulators focus on the present value of future benefits less the present value of future premiums, also referred to as the "Carpenter value," to support their view that policyholders would fare better in a liquidation. N.T., 5/17/2021, at 175.[10] Cantilo criticized this measure because it does not give an accurate picture of a policyholder's situation. He offered the example of an actual 92-year-old SHIP policyholder currently paying $2,761 for a policy with unlimited benefits. Ex. RP-56 at 102. Using the Intervening Regulators' preferred methodology, the "Carpenter value" of that policy is $33,890, which is higher than the "Carpenter value" produced under any of the four Plan options. However, to receive this value of $33,890, the policyholder would have to pay $11,520 in annual premium. By contrast, this policyholder could choose Option 3, a paid-up policy with a slightly lower "Carpenter value" of $33,550. With a paid-up policy, however, this policyholder would receive 2.5 years of coverage and never pay another premium. Cantilo offered other examples where Option 3 would be the best option for a policyholder, given the annual premium the policyholder would be required to pay to the guaranty association in a liquidation. *See, e.g.*, Ex. RP-56 at 103. Cantilo opined that these are not exceptions; "[t]here are many cases where the raw projection of future benefits less future premium doesn't really tell you what the real value of the policy is." N.T., 5/17/2021, at 177.

Cantilo discussed several different ways to compare the value of the Plan options to what would be available in a liquidation. Using the Intervening Regulators' standard of present value of future benefits less present value of future premiums, 85% of policyholders will have at least one option as favorable in

[10] "Carpenter value" refers to the United States Supreme Court's decision in *Neblett v. Carpenter*, 305 U.S. 297 (1938), which is often cited for the proposition that, in order for a rehabilitation plan to be constitutional, policyholders must fare as well in rehabilitation as they would in a liquidation.

liquidation and 15% will not. Ex. RP-56 at 105. Using the present value of future benefits divided by annual premiums, those numbers are 79% and 21%. *Id*. at 106. Using the maximum policy value divided by annual premium, those numbers are 89% and 11%. *Id*. at 107. Using the maximum policy value less present value of future premiums, those numbers are 96% and 4%. *Id*. at 108. Finally, using the Rehabilitator's preferred standard of maximum policy value, also referred to as the "benefit account value" or "lifetime maximum benefit" in some policies, *id*. at 104, 100% of policyholders will have at least one option in the Plan that offers the same or a better value than in a liquidation. *Id*. at 109.

Cantilo acknowledged that these are actuarial techniques that rely on the exercise of professional judgment. He opined that the maximum policy value is what policyholders use when they purchase an insurance policy, *i.e.,* the maximum daily benefit and the maximum benefit period.

Cantilo offered additional reasons to explain why rehabilitation is preferable to liquidation. First and foremost is the value of policyholder choice. Second, the Second Amended Plan contains features that would not be available to policyholders in liquidation, such as an option to retain their current policy level of coverage, which may exceed the applicable guaranty association cap, by paying the If Knew Premium. Third, there is the enhanced non-forfeiture option that provides reasonable coverage for no additional premium. In a liquidation, the non-forfeiture option would be locked into the policy's present coverages and terms, which may result in a very short period of coverage. Fourth, the Plan reduces or eliminates the subsidies in the current rate structure, which cannot be done in a liquidation.

Finally, Cantilo testified about the likelihood of success of the Second Amended Plan. He opined that the Plan is designed to eliminate the Funding Gap

over three phases. This is not likely to happen in Phase One, but Phase One will materially reduce the Funding Gap.

Cantilo offered an exhibit illustrating the amount of the Funding Gap reduction under 11 hypothetical policyholder election scenarios. In general, the more that policyholders elect to pay the If Knew Premium for their current benefits (Option 4), the worse the outcome for the Funding Gap. For example, in Scenario 1, where 7% elect Option 1, 8% elect Option 2 or 2A, 4% elect Option 3 and 81% elect Option 4, the Funding Gap is reduced by $525 million. Ex. RP-56 at 113. At the other extreme, in Scenario 11, where a very small number of policyholders elect Option 4 and the rest split evenly among Options 1, 2, 2A and 3, the Funding Gap is completely eliminated. *Id*. This underscores how the policyholders will be the masters of the fate of SHIP. No matter how much of the Funding Gap is eliminated in Phase One, SHIP will be in better shape if it eventually has to be liquidated because the discriminatory subsidies in the premium rate structure will be eliminated and the policies will be right-sized.

On examination by the Intervening Health Insurers, Cantilo testified that the SHIP policies contain provisions that allow SHIP to modify the premium rate. Some policies provide that rate increases will require the approval of state regulators, while others specify that rate increases may be sought only where an increase is warranted given the claims experience of the cohort of policyholders covered by the same policy form. Cantilo stated that these provisions are standard in long-term care insurance policies. The Rehabilitator designed the If Knew Premium methodology in the Second Amended Plan to be consistent with the standards for setting long-term care insurance premium rates, which are substantially the same in every state.

b. Marc Lambright

Marc Lambright, an accident and health insurance actuary with Oliver Wyman, testified for the Rehabilitator. Lambright testified that the Pennsylvania Insurance Department engaged Oliver Wyman in early 2017 to conduct a targeted examination of SHIP's reserves and the assumptions used by its actuarial firm, Milliman, to set the reserves. Following its examination, Oliver Wyman submitted a report making several observations: Milliman's cash flow testing assumptions were too optimistic; claim reserves for the past several years were inadequate; and the Beechwood investment program was riskier than assumed in the 2016 cash flow test report. Ex. RP-56 at 53. Oliver Wyman made several recommendations for the ongoing financial monitoring of SHIP. They included using more recent experience to develop morbidity, lapse and termination assumptions. *Id*. Milliman largely rejected Oliver Wyman's recommendations.

In 2018, after SHIP was placed under the supervision of the Insurance Department, Cantilo asked SHIP to devise a corrective action plan.[11] Cantilo also asked Oliver Wyman to continue analyzing SHIP's financial condition. Lambright testified that much of 2018 was spent pressing SHIP to substantiate some of its actuarial assumptions. Lambright testified that the Beechwood investment losses ($176 million) and the premium deficiency reserve booked in 2018 ($347 million) had a significant impact on SHIP's financial picture. N.T., 5/18/2021, at 374. In 2019, Lambright assisted Vincent Bodnar as he built the corrective action plan that would become the rehabilitation plan.

[11] Section 510(a) of Article V authorizes the Insurance Commissioner to "make and serve upon the insurer and any other persons involved, such orders … as are reasonably necessary to correct, eliminate or remedy" the insurer's condition that required the supervision. 40 P.S. §221.10(a).

c. Vincent Bodnar

Vincent Bodnar, an actuary at Oliver Wyman with a specialty in long-term care insurance, testified as an expert witness. Bodnar performed actuarial work for the Rehabilitator and was involved in developing the Second Amended Plan, including the Phase One options to be offered to the policyholders.

Bodnar described the seriatim model as the core of the Second Amended Plan. A seriatim model, which produces actuarial projections for each policy individually, has become the industry standard in the past five years. The input to the seriatim model consists of individual policyholder characteristics such as age, gender, issue age, benefit features of the policy, and the premium charged. Applied to the input file are actuarial assumptions, including morbidity and mortality rates, lapse rates, and exhaustion rates, which Oliver Wyman has developed using SHIP's historical experience. The seriatim model projects future premiums and future claims for each policy on a month-by-month basis. N.T., 5/18/2021, at 397.

Bodnar explained that the If Knew Premium methodology employed in Phase One determines the premium an insurer would charge had it known when the policy was issued what it knows today, *i.e.*, that it would experience lower returns on investments, lower mortality rates, lower lapse rates, and higher claim incidence rates. The If Knew Premium assumes a 60% lifetime loss ratio from inception of a policy, *i.e.,* the use of 60% of expected premium to pay benefits to policyholders. The other 40% of expected premium is used to pay salaries, administrative overhead, premium taxes, federal taxes and profit for the insurer. The goal of the lifetime loss ratio is to establish a premium level that is reasonable in relation to the benefits paid. The 60% lifetime loss ratio is the benchmark required for a premium rate increase in most states. The If Knew Premium methodology employed in Phase One will be

actuarially justified and will not recoup past underpricing losses, although several states allow such recoupment. In the Penn Treaty liquidation, guaranty associations sought premium rate increases from the states based on an If Knew Premium methodology similar to the one employed in Phase One.

Because the Second Amended Plan intends to set premium rates on a seriatim basis, each policyholder will receive an individual premium increase calculated on the benefit features of his policy and the policyholder's characteristics. The model does not consider individual claim experience but, rather, "all the various variants that make up a given assumption" for a risk class. N.T., 5/18/2021, at 412. By contrast, in a traditional rate application process, insurers request state approval of an aggregate premium rate increase, although their models might be developed on a seriatim basis.

Bodnar testified that it is common for an insurer to receive mixed responses to a premium rate increase request from state regulators because each state has its own approach to reviewing rates. Additionally, the rate review process typically takes between 90 days and 2 years. Protracted rate reviews with drastically different outcomes has resulted in some SHIP policyholders paying a premium rate that subsidizes the inadequate premium rates of other SHIP policyholders. The Second Amended Plan seeks to eliminate this inequitable discrimination in premium payments.

Based on his experience with insurance product development and consumer choices, Bodnar testified that, generally, policyholders look at maximum policy value, *i.e.,* the maximum daily benefits, elimination period, and premium rate in choosing an insurance policy. Bodnar considered all these factors in developing the options in the Second Amended Plan. Option 1 allows policyholders to retain

their current premium rates with reduced benefits. Options 2 and 2A provide policyholders with basic policy coverages at corresponding If Knew Premium rates. The basic policy retains the key components of long-term care and reduces or eliminates some features, such as a 4.5% inflation rider, that are not so important to policyholders. The maximum daily benefit, although reduced, would continue to provide meaningful coverage to most policyholders. The policyholders who elect Option 2 or 2A would not be subject to a rate increase in Phase Two, which is an appealing feature. In the Penn Treaty liquidation, policyholders were offered a benefit reduction option similar, but not identical to, Options 1 and 2 or 2A, but Bodnar did not recall how that affected their premium level. N.T., 5/19/2021, at 517, 520. By contrast, the Second Amended Plan proposes to offer policyholders three options by which to reduce their coverages and save premiums.

Option 3 of the Second Amended Plan offers a non-forfeiture option, which allows policyholders to receive up to 2.5 years of coverage and stop paying any additional premium. This is more generous than the standard non-forfeiture option, which caps coverage to the amount of premiums the policyholder has paid from inception. Policyholders in the Penn Treaty liquidation who chose the standard non-forfeiture option received continued coverage for a shorter period of time, sometimes only months. *Id*. at 435.

Option 4 of the Second Amended Plan allows policyholders to keep their current policy benefits and pay the If Knew Premium rate to retain those benefits. The guaranty associations in the Penn Treaty liquidation did not offer an equivalent option to policyholders whose coverages exceeded the statutory limits. Instead, they offered a rate increase option that retained the policy's coverages up to the statutory maximum amount allowed for each resident.

Bodnar explained how the different Phase One options relate to Phase Two of the Plan. Policyholders who elect Options 1 and 4 and have a policy providing coverage in excess of the guaranty association limits will be subject to a rate increase in Phase Two. Phase Two seeks to deploy a self-sustaining premium rate methodology, which will keep the lifetime loss ratio at 60% and thus be actuarially justified. Phase Two is not absolutely necessary under the Second Amended Plan because Phase One could close the Funding Gap, or the assumptions deployed in Phase One could play out differently than projected. Bodnar opined that any meaningful reduction in the Funding Gap during the rehabilitation would be a success.

Bodnar opined that a rehabilitation as proposed in the Second Amended Plan, as opposed to an immediate liquidation, presents policyholders with better options; sets the premium rates to equitable levels; and reduces SHIP's Funding Gap. There is no formulaic method to determine whether policyholders are better off in a rehabilitation or in a liquidation; the so-called "Carpenter test" is not an actuarial test. Policyholders who choose Option 4 will have a policy with a net present value greater than or equal to what they would have in liquidation because it will not be capped at the level set forth in the applicable guaranty association statute. However, Option 4 has the least effect on reducing the Funding Gap. N.T., 5/19/2021, at 512-513.

Bodnar opined that policyholders are likely to consider the maximum policy value/premiums analysis or the maximum policy value analysis in making determinations. The present value analysis, or "Carpenter test," is appropriate for evaluating the impact of the Phase One options on SHIP's liabilities. However, he explained that policyholders do not use a present value analysis when they choose

their long-term care insurance coverage. Nor would they rely solely on the present value analysis to select one of the options offered under the Second Amended Plan.

Upon approval of the Second Amended Plan, Bodnar and the actuarial team at Oliver Wyman will prepare an actuarial memorandum in support of the If Knew Premium rates, similar to what would be submitted to state regulators in a rate increase filing. In developing the Second Amended Plan, Oliver Wyman has prepared an actuarial report describing the If Knew Premium rating methodology and an assumption report, Ex. RP-16 and Ex. RP-17, and has gathered all the information needed for the actuarial memorandum. N.T., 5/19/2021, at 460.

ii. Intervening Regulators' Evidence

a. Frank Edwards

Frank Edwards, the vice president and chief life health actuary of INS Consultants, testified as a fact witness on behalf of the Intervening Regulators. Edwards testified that under the Second Amended Plan, policyholders bear the responsibility for the $1.2 billion Funding Gap through benefit reductions and premium increases. By contrast, in liquidation, policyholders would bear a burden of approximately $397 million, and the guaranty associations would bear a burden of approximately $837 million. This represents the difference between the net amount the guaranty associations would pay to policyholders and the distributions they would receive from the SHIP estate. Because a rehabilitation does not trigger the guaranty associations, these funds will not be available to benefit policyholders under the Second Amended Plan.

Edwards observed that among the four options in the Second Amended Plan for Phase One, Option 4 provides a net present value for approximately 83% of policyholders that is greater than they would receive in a liquidation. The other

options provide policyholders with a net present value that is lower than they would receive in liquidation.

Oliver Wyman presented 10 scenarios to illustrate the potential results of the Second Amended Plan for SHIP's liabilities, each leaving a deficit that ranged from $699 million to $186 million. Ex. RP-16 at 11. Only Scenario 11, later added, eliminates the Funding Gap. Based on the information provided by Oliver Wyman, Edwards calculated a "Best Interest" scenario, which assumed that each policyholder will choose the option that provides the greatest net present value, or "Carpenter value." Ex. SIR 5-4. Option 4 would give 67.13% of the policyholders the greatest net present value, which would reduce SHIP's Funding Gap by $184 million. *Id*.

Edwards addressed a comparison of rehabilitation to liquidation under Phase Two. Edwards calculated the effects of hypothetical Phase Two premium increases on policyholders who selected Option 4 in Phase One. Assuming a premium increase of 50% in Phase Two, the percentage of policyholders receiving a net present value greater than in a liquidation under Option 4 drops to 33.89%. The percentage of policyholders in a rehabilitation, in the aggregate, that would receive a net present value greater than liquidation is 54.57%. Assuming a premium increase of 100% in Phase Two, the percentage of policyholders for whom Option 4 provides a net present value greater than in a liquidation drops to 22.92%. The percentage of all policyholders in a rehabilitation, in the aggregate, that would receive a net present value greater than in a liquidation is 47.21%. Even so, these hypothetical premium increases of 50% and 100% would leave remaining a Funding Gap of approximately $858 million and $676 million, respectively. Ex. SIR 5-5.

Edwards observed that the information presented by Oliver Wyman indicated that the net present value of Option 2 for policies with benefits in excess

of guaranty association limits is typically less than the net present value of the guaranty association limits. Ex. SIR 5-6.

Edwards did not evaluate Oliver Wyman's work. He compared the Second Amended Plan to liquidation using hypotheticals in which policyholders made elections based solely on maximizing the present value of future policy benefits minus the present value of future premiums, or the "Carpenter value."

iii. Intervenor NOLHGA's Evidence

a. Peter Gallanis

Peter Gallanis, the president of NOLHGA, testified as a fact witness. NOLHGA intervened in this proceeding to offer its suggestions on the Second Amended Plan; provide background information on the guaranty association system; and identify and request certain information material to its guaranty association members.

NOLHGA's members are life and health guaranty associations, one for each state and the District of Columbia, which are nonprofit entities created by state statutes to protect policyholders when a life or health insurance company is liquidated. In multi-state insurance insolvencies, the guaranty associations collaborate and coordinate through NOLHGA to fulfill their statutory obligations. NOLHGA has been involved in approximately 100 multi-state insurance receiverships, nine of which involved long-term care insurance. If SHIP goes into liquidation, most NOLHGA member guaranty associations would be activated to provide coverage to SHIP policyholders, subject to the statutory limit on coverage in the member's state, which is generally $300,000 per resident.

Gallanis testified that the Second Amended Plan should emphasize that the options that policyholders select in Phase One will be permanent. The Second

Amended Plan's discussion of SHIP's unfunded liability needs clarification, or it should be eliminated. The subject need not be addressed until a liquidation may occur.

He testified that the Rehabilitator's sample Illustrative Policyholder Guidance Pages on guaranty association coverage and premium rates in liquidation could be misleading. In response, NOLHGA prepared a sample Summary of Policyholder Protection by Guaranty Associations in Liquidations that it believes should be sent to policyholders during Phase One. Ex. N-1. Gallanis believes NOLHGA should review all policyholder communications that refer to liquidation or guaranty associations and be allowed to comment on these communications before they are sent to policyholders.

Gallanis testified that NOLHGA wants more information on SHIP's reinsurance agreements with Transamerica, American Health and Life Insurance Company, and Primerica Life Insurance Company. NOLGHA also seeks more information on SHIP's in-force policies that are not long-term care policies.

Gallanis explained that members of a guaranty association are licensed life and health insurers. If SHIP is placed under an order of liquidation, the guaranty associations will provide resident policyholders with coverage up to the lesser of the maximum benefit level provided in the policy or the statutory limit for guaranty association coverage, which is $300,000 per resident in most states.[12] The guaranty associations may continue coverage under the policy; work with the receiver to transfer the business to a financially solvent insurer; or issue alternative policies. The guaranty associations may seek premium rate increases or offer policyholders

[12] The guaranty association limits range between $100,000 in Puerto Rico, $300,000 in 42 states and the District of Columbia, $500,000 in 6 states, $615,525 in California, and no limit in New Jersey.

modified benefits based on current premium rates, as was recently done in the Penn Treaty liquidation. The guaranty associations generally do not charge premiums to policyholders who have been on premium waiver. The options offered by the guaranty associations in the Penn Treaty liquidation are illustrative of what could be offered in a potential SHIP liquidation.

In a liquidation, the guaranty associations will assess their member insurers, using the methodology set forth in their governing statutes to determine each member insurer's assessment. The member insurers pay the assessments from their general accounts. In some states, the member insurers can offset a portion of the assessment against state premium taxes that the insurers would otherwise owe. Member insurers can also impose surcharges on their policyholders to fund assessments. The guaranty associations are not funded by state revenues.

Gallanis explained that NOLHGA does not endorse or oppose the Second Amended Plan. NOLHGA intends to monitor the rehabilitation if this Court approves the Second Amended Plan, so that the guaranty associations will be prepared if SHIP ultimately is liquidated.

b. Matthew Morton

Matthew Morton, an actuary with the Long Term Care Group and an advisor to NOLHGA, testified as a fact witness about guaranty association coverage and premium rate increases in liquidation. Morton assisted NOLHGA in several long-term care insurer insolvencies, including the Penn Treaty liquidation.

In a liquidation, a policyholder receives a continuation of coverage from a guaranty association. The policy's benefits are paid in full until the policyholder exhausts the maximum benefit amount or maximum coverage period set forth in the policy, or until the payments reach the statutory coverage limit. Many

long-term care policyholders are not affected by the statutory coverage limit because: (1) the policy's maximum benefit amount is less than the statutory coverage limit; (2) the policyholder never goes on claim; or (3) the policyholder does not stay on claim long enough to reach the statutory coverage limit.

In the Penn Treaty liquidation, the guaranty associations implemented a nationwide rate increase program, which resulted in 34 states approving 100% of the requested rate increases; 11 states approving between 80% and 100% of the requested rate increases; and 3 states approving less than 60% of the requested rate increases. No state denied a rate increase request. The majority, 44 states, approved the initial rate increase filing within 15 months. The guaranty associations spent 6 to 12 months preparing and filing the rate increase applications.

The guaranty associations' methodology for calculating premium rate increases in the Penn Treaty liquidation was similar to the If Knew Premium methodology proposed in the Second Amended Plan, with two exceptions. First, the Second Amended Plan proposes to calculate rate increases seriatim, or individually, while Penn Treaty's rate increase applications were developed on a cohort basis, by which policyholders were grouped together by policy form. The cohort basis is the industry standard for an insurer that is a going concern. Second, the Second Amended Plan proposes to calculate rate increases based on the total maximum value of the policy. In Penn Treaty's liquidation, the premium rates were calculated based on benefits being capped at the guaranty association statutory limits.

Morton testified that the premium rate increase methodology used by the guaranty associations in the Penn Treaty liquidation "largely" addressed the inequities in premium rates and the cross-state rate subsidization issue. N.T., 5/20/2021, at 806. When asked on cross-examination to expound on his

understanding of "largely," Morton acknowledged that using a cohort method to adjust premium rates results in some policyholders paying more than the If Knew Premium. *Id*. at 817-18. If a seriatim method is used, all policyholders will pay the If Knew Premium and no more.

In the Penn Treaty liquidation, the default option for policyholders who failed to make elections was to accept the rate increase. Policyholders were offered policy modifications, including lowering daily benefits or the inflation rider; a reduced paid-up policy; or a cash-out option in exchange for termination of the policy. Only one state approved the cash-out option. Approximately 76% of the Penn Treaty policyholders accepted the rate increase, among which "a little bit less than a half" took the option by default; 13% of the policyholders reduced their benefits; 8% of the policyholders elected to cash out; and 3% of the policyholders elected a reduced paid-up policy. *Id*. at 812. The guaranty associations treated Penn Treaty policyholders on premium waiver the same before and after the liquidation by continuing the waiver.

iv. Intervening Agents and Brokers' Evidence

a. Daniel Schmedlen

Daniel Schmedlen, Chief Executive Officer of LTC Global, testified on behalf of the Intervening Agents and Brokers. These agents and brokers are all employed by LTC Global and are paid commissions by SHIP. The commission is set forth in the agency agreement and based on a percentage of premium. The policyholder pays a premium to the insurer, which deducts a certain percentage of the premium and remits it to the agent as a commission. The agent is not obligated to contact the insured after issuance of the policy, although the agent might accept the initial premium payment on behalf of the insurer.

A sample agent agreement was introduced into evidence by the Rehabilitator. It provided that the agent and successors "shall have the vested right to receive all commissions payable under this [a]greement." Ex. RP-10 at 3. Schmedlen understood this language as creating the agent's vested property interest in that part of any premium collected by SHIP that it owed to the agent as a commission. LTC Global expects that its agents will continue to receive commissions during SHIP's rehabilitation, as they did during Penn Treaty's rehabilitation.

The insurer determines the amount of commission payable to the agents. Once a policy is issued and delivered, the agent is paid a commission in accordance with the commission schedule set forth in the agency agreement. The first-year commission is higher than the renewal commission, and the amount of renewal commission changes with time. The commission schedule in the sample agent agreement showed that the first-year commission ranged from 45% to 70% of the first-year premium, depending on the age of the policyholder. After 10 years, the commission is typically reduced to a percentage of premium in the "middle single digits." N.T., 5/20/2021, at 850. If the insurer has to refund any portion of the premium to the insured, the agent returns his commission to the insurer in proportion to the refunded premium. Where there is no premium paid, there is no commission owed to the agent.

v. Intervening Health Insurers' Evidence

Intervening Health Insurers introduced into evidence six sample insurance policies issued by SHIP's predecessors and assumed by SHIP. The policies provided that SHIP may increase premium rates over time without

specifying the methodology to be used in calculating the rate increases. The policies are silent on agent and broker commissions.

vi. Intervening Policyholders' Evidence

a. James Lapinski

Intervenor James Lapinski, a policyholder of SHIP as well as a broker, testified on his own behalf. He expressed concern about the Second Amended Plan's discussion of the impact of the COVID-19 pandemic on the long-term care insurance industry. He requested that the Rehabilitator update the discussion with more recent data. Lapinski presented a three-page excerpt from the Society of Actuaries report, dated September 30, 2020, which indicated that COVID-19 has had an impact on emerging long-term care insurance experience through higher mortality and lower claim incidence. An excerpt of a newsletter produced by Fairfax County, Virginia, suggested that more than 80% of COVID-19 deaths have been adults over 65 years old. Further, 34% of COVID-19 deaths in the United States have been seniors living in long-term care facilities, which accounts for less than 1% of the U.S. population. Lapinski opined that a combination of a decline in claim utilization and increase in lapse or cancellation of policies suggests that SHIP has experienced a major decrease in claims experience due to the pandemic.

Lapinski presented a balance sheet of SHIP showing that the value of SHIP's bond holdings as of December 31, 2020, declined by approximately $500 million from the previous year. SHIP's reported cash on hand and short-term investment income also declined from the previous year by approximately $500,000. This does not correlate with the decrease in the value of the bonds. Lapinski questioned the changes in reserves shown in the balance sheet. Specifically, he requested the Rehabilitator to explain the decline in SHIP's capital and surplus from

approximately $12 million in 2017 to a deficit of $916 million in 2019, as well as the decline in the number of policies in force from 151,000 in 2009 to approximately 39,000 as of the filing of the Second Amended Plan. Observing that the Second Amended Plan contains excerpts from SHIP's unfiled 2019 statutory financial statement and the internal 2020 financial information (*see* Appendix B of the Second Amended Plan), Lapinski requested that SHIP file its 2019 and 2020 statutory financial statements before this Court rules on the Second Amended Plan.

Lapinski and his wife pay annual premiums totaling $9,000 for their three policies. Over the past 25 years, they have paid over $200,000 in premiums. He estimated that skilled nursing facilities cost $500 per day, which they cannot afford without insurance coverage. Lapinski raised concerns with the timing of the rehabilitation and stated his desire for SHIP to avoid the lengthy process that Penn Treaty had gone through prior to liquidation.

b. Rose Marie Knight

Rose Marie Knight, a policyholder, also testified. She agreed with Lapinski's testimony. She has been a policyholder for 22 years and currently pays an annual premium of $1,200. She questioned why SHIP has not raised her premium for the last four or five years. Knight's policy has a lifetime benefit period. She will have to pay a higher premium to retain this maximum coverage period under the Second Amended Plan. Knight expressed concern about her ability to pay a higher premium and becoming a burden on her children. N.T., 5/21/2021, at 935. She noted that the government has recently incurred great debts, which will cause inflation that "is starting to hit." *Id*. at 933-34.

Both Lapinski and Knight expressed concern and confusion as to the Second Amended Plan's proposed policy restructuring, which they interpreted as removing benefits or cancelling guaranty association coverage.

III. Standard of Review

Section 516(b) of Article V authorizes the Rehabilitator to "take such action as [she] deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate the insurer. … [She] shall have full power … to deal with the property and business of the insurer." 40 P.S. §221.16(b). The legislatively stated purpose of Article V, to which the Court must give effect, is "the protection of the interests of insureds, creditors, and the public generally...." and the "equitable apportionment of any unavoidable loss" through, *inter alia*, "improved methods for rehabilitating insurers...." *Grode v. Mutual Fire, Marine and Inland Insurance Co.*, 572 A.2d 798, 803 (Pa. Cmwlth. 1990) (*Mutual Fire I*) (single-judge opinion) (quoting Section 501 of Article V, 40 P.S. §221.1).

The Pennsylvania Supreme Court has explained this Court's role in a rehabilitation as follows:

> In overseeing the course of rehabilitation to check any abuse of discretion by the Commissioner, the Commonwealth Court is authorized to "approve or disapprove the plan [of rehabilitation] proposed, or may modify it and approve it as modified. If it is approved, the rehabilitator shall carry out the plan." 40 P.S. § 221.16(d). Therefore, in order for the Plan to warrant the Commonwealth Court's imprimatur it must be found to be free from any abuse of the Rehabilitator's discretion.

Foster v. Mutual Fire, Marine and Inland Insurance Co., 614 A.2d 1086, 1091 (Pa. 1992) ("*Mutual Fire II*"). Further, "it is not the function of the courts to reassess the

determinations of fact and public policy made by the Rehabilitator." *Id*. Our Supreme Court has explained:

> 'It has been established as an elementary principle of law that courts will not review the actions of governmental bodies or administrative tribunals involving acts of discretion *in the absence of bad faith, fraud, capricious action or abuse of power* .... That the court might have a different opinion or judgment in regard to the action of the agency is not a sufficient ground for interference; *judicial* discretion may not be substituted for *administrative* discretion.'

Id. at 1092 (quoting *Norfolk and Western Railway Co. v. Pennsylvania Public Utility Commission*, 413 A.2d 1037, 1047 (Pa. 1980) (emphasis in original)).

With the above principles in mind, the Court considers whether the Rehabilitator abused her discretion in formulating the Second Amended Plan. The Court is also mindful that "the Rehabilitator is constrained by constitutional mandate[s]." *Mutual Fire I*, 572 A.2d at 804.

IV. Legal Analysis

A. The Second Amended Plan Serves a Rehabilitative Purpose and is within the Discretion of the Rehabilitator

1. Goals of the Plan

There is no fixed goal that every rehabilitation plan must satisfy to obtain this Court's approval. Specifically, the Pennsylvania Supreme Court has stated that a

> rehabilitation, in order to be legitimate, does not have to restore the company to its exact original condition. So long as the rehabilitation properly conserves and equitably administers "the assets of the involved corporation in the interest of investors, the public and others, (with) the main purpose being the public good" the plan of rehabilitation is appropriate.

Mutual Fire II, 614 A.2d at 1094 (quoting 2A COUCH ON INSURANCE 2d §22.10).

The unrefuted testimony of the Rehabilitator's witnesses established two overarching goals of the Second Amended Plan: (i) to reduce or eliminate the Funding Gap and (ii) to eliminate SHIP's inequitable and discriminatory premium rate structure, which is marked by cross-policyholder subsidies. The Plan will meet these goals by setting premium rates for all policyholders pursuant to an actuarially sound methodology, the If Knew Premium rate, which is widely accepted by regulators across the country, and by offering policyholders meaningful options. Instead of being forced to accept rate increases commensurate with their current coverages, policyholders will have the option to reduce coverages, thereby reducing their premiums.

In pursuing these goals, the Second Amended Plan addresses one of the major causes of SHIP's financial distress: policy underpricing. The Plan will address underpricing by (i) resetting premiums, on a prospective basis, to what they would have been without the erroneous actuarial assumptions and (ii) doing so on a seriatim basis, thereby ensuring that the premiums going forward are consistent across the entire pool of policyholders so that similarly situated policyholders will not be paying different premiums. The Plan will give policyholders meaningful choices for coverage in lieu of rate increases, without placing the cost of SHIP's historical policy underpricing upon the public through the guaranty association system. These goals serve the public good. *See Mutual Fire II*, 614 A.2d at 1094, n.4 (determining that the state's interest in "regulat[ing] the fiscal affairs of its insurers for the welfare of the public" is a legitimate and significant public purpose).

2. No Contrary Evidence

The Intervening Regulators, who object to the Second Amended Plan in its totality, did not introduce an expert witness to dispute any of the Rehabilitator's

actuarial projections, including the impact of the various options on policyholders and the Funding Gap, or the Plan's proposed premium rate methodologies. The Intervening Regulators' actuary, Frank Edwards, testified as a fact witness, and he acknowledged that he was not asked to evaluate the Rehabilitator's work.

Edwards' testimony consisted of "mathematical exercises," N.T., 5/19/2021, at 564, that compared the Plan to a liquidation. He assumed that policyholders are "better off" with the "maximum present value" of their policies. *Id*. at 568. Known as the "Carpenter value," maximum present value is future benefits minus future premiums, adjusted to their present value. Edwards acknowledged that he could not opine on policyholder preferences. Cantilo and Bodnar, both qualified experts, testified persuasively that policyholders do not make choices based on the maximum present value of their policies. Rather, policyholders will rely on other metrics, most notably the maximum policy value, such as maximum daily benefit and maximum benefit period, to make choices. Using those metrics provides a better outcome for policyholders than they would experience in liquidation.

B. The Goals of the Plan Could Not Be Achieved in Liquidation

The Rehabilitator's evidence demonstrated that immediate liquidation of SHIP would be improvident for several reasons. First, a liquidation of SHIP will not address the Funding Gap. Second, a liquidation will not address the existing inequitable premium rate structure and cross-policyholder subsidies. Instead, it will perpetuate those problems. Third, a liquidation of SHIP will unnecessarily delay any resolution of SHIP's financial condition. Fourth, the options available to policyholders under the Second Amended Plan are better than what would be offered by guaranty associations in a liquidation.

1. Liquidation Will Not Address the Funding Gap

As noted, the Funding Gap is largely attributable to significant historical underpricing of SHIP's policies. In a liquidation, the entire cost of this shortfall will be shifted to the guaranty association system and, ultimately, to the public. As NOLHGA's Peter Gallanis acknowledged, the guaranty associations will fund the cost of the underpricing by assessing their member companies, which, in turn, fund the assessments from their policyholder generated funds. These insurers will then recoup some portion of the loss through premium tax offsets or by raising rates they charge to their own policyholders. The Rehabilitator concluded that shifting the burden to taxpayers and policyholders of other life and health insurers will not serve the "public good." *Mutual Fire II*, 614 A.2d at 1094. That determination is within her discretion and is entitled to deference. *Id*. at 1091 ("[T]he involvement of the judicial process is limited to the safeguarding of the plan from any potential abuse of the Rehabilitator's discretion.").

2. Liquidation Will Perpetuate the Inequitable Premium Rate Structure

In a liquidation of SHIP, assuming the guaranty associations would seek rate increases as they did in the Penn Treaty liquidation, similarly situated policyholders will continue to pay different rates. NOLHGA's actuary, Matthew Morton, acknowledged that this is attributable to the guaranty associations' practice of seeking rate increases for cohorts of policyholders. Using a cohort method results in some policyholders paying more than the If Knew Premium in liquidation. The Second Amended Plan will adjust premium rates on a seriatim basis, which eliminates the possibility of any policyholder paying more than the If Knew Premium.

Further, the guaranty associations must request rate increases from the state of issue, not the state where the policyholder resides. The experience from the Penn Treaty liquidation showed that states do not act uniformly. For example, Florida (one of Penn Treaty's largest states by premium) granted only 50% of the guaranty associations requested, and actuarially justified, rate increases for policies written in that state. Florida similarly has refused to grant SHIP's requested rate increases, and there is no reason to believe the result would be any different in a liquidation. *See* Ex. RP-53 (showing that since 2009, SHIP has requested approximately $62.6 million in premium rate increases from the Florida Insurance Department, but only $7.6 million has been approved).

The Intervening Regulators' States of Maine, Massachusetts and Washington are illustrative of the problem. Since 2009, only Massachusetts has approved a significant percentage of the rate increases sought by SHIP. *See* Ex. RP-53 (showing a 90% approval ratio in Massachusetts but an 11% approval ratio in Maine and a 63% approval ratio in Washington). The Rehabilitator's evidence demonstrated that a liquidation will not alleviate SHIP's premium rate inequities and cross-policyholder subsidization issues.

3. Liquidation Involves Inherent Delays

At a minimum, a liquidation would cause a material delay in addressing the policy underpricing which lies at the root of SHIP's insolvency. NOLHGA's actuary testified that in the Penn Treaty liquidation it took six months to a year to prepare and file the rate applications on behalf of the guaranty associations. It took an additional 15 months to receive decisions from most of the state insurance regulators, with the final state's approval taking more than 4 years. Bodnar testified that the rate approval process can take anywhere from 90 days to 2 years or more.

Thus, at best, in a liquidation of SHIP it would take nearly two years to prepare, file and receive approvals on rate increase requests, and there would be no certainty that the rates would be approved at the requested actuarially justified level.

By contrast, the Second Amended Plan can be implemented quickly, thereby addressing the causes of SHIP's financial distress, preserving assets, and reserving flexibility for Phase Two and beyond. Cantilo testified that it would take approximately six months to prepare and transmit election packages to policyholders and gather any Issue State Opt-out elections. Upon implementation of the Plan, the Rehabilitator will know within approximately eight months how much of the Funding Gap will be eliminated. The outcome of Phase One will determine whether Phase Two will be necessary and, if so, its scope. While the Self-Sustaining Premium methodology proposed for Phase Two is actuarially justified according to Bodnar's undisputed expert testimony, the Rehabilitator may consider alternatives as necessary depending on the outcome of Phase One. The Rehabilitator will also provide reports to the Court at the appropriate times with her recommendations regarding Phase Two. A liquidation does not offer this kind of flexibility. *See Mutual Fire I*, 572 A.2d at 803 ("[T]he benefits of rehabilitation – its flexibility and avoidance of inherent delays – are preferable to the static and cumbersome procedures of statutory liquidation.").

4. Policyholders Will Have Fewer Choices in Liquidation

In a liquidation of SHIP, policyholders will not be offered the choices provided under the Second Amended Plan. NOLHGA's witnesses acknowledged that the benefit modification offers made by the guaranty associations in the Penn Treaty liquidation, which were the first of their kind in a long-term care insurance liquidation, do not match the options offered under the Plan. Specifically, there was

no equivalent to the basic policy coverages provided in Option 2/2a. There was no enhanced non-forfeiture option similar to Option 3. There was no option similar to Option 4 that could provide coverage above the applicable guaranty association cap. The Plan provides greater flexibility for policyholders than they would have in liquidation by offering meaningful policy modification alternatives that will also alleviate the Funding Gap and inequitable rate structure.

C. The Plan Meets the Legal Standards for Confirmation

1. The Plan's Rate Approval Mechanism and Issue-State Rate Approval Alternative are Permissible Under Pennsylvania Law and the United States Constitution

The Intervening Regulators object to the Second Amended Plan for the stated reason that the Plan proposes to have premium rates set by the Rehabilitator and this Court rather than by state-of-issue regulators. Intervening Regulators' Memorandum of Law, 6/14/2021, at 41. The Intervening Regulators assert that the Rehabilitator's statutory powers under Article V to "direct and manage" the "property and business of the insurer," Section 516(b) of Article V, 40 P.S. §221.16(b), does not include authority to change "SHIP's policies and rates without required regulatory approvals." Intervening Regulators' Memorandum of Law at 44. They also assert that the Plan's deviation from the ordinary state-by-state rate review process violates the Full Faith and Credit Clause of the United States Constitution[13] and is inconsistent with the principle of comity. The Plan's Issue

[13] It states:

> Full Faith and Credit shall be given in each State to the public Acts, Records, and judicial Proceedings of every other State. And the Congress may by general Laws prescribe the Manner in which such Acts, Records and Proceedings shall be proved, and the Effect thereof.

State Rate Approval Option does not cure these infirmities because it is coercive and offers, at most, a "nominal deference" to the state of issue's authority to regulate the premium rates for policies issued in that state. Intervening Regulators' Memorandum of Law at 50, 52.

We begin with a review of Section 516 of Article V, which sets forth the powers and duties of the Rehabilitator. It states, in pertinent part, as follows:

> (b) *The rehabilitator may take such action as he deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate the insurer.* He shall have all the powers of the directors, officers and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator. He shall have full power to direct and manage, to hire and discharge employes subject to any contract rights they may have, and to deal with the property and business of the insurer.
>
> * * *
>
> (d) The rehabilitator may prepare a plan for the reorganization, consolidation, conversion, reinsurance, merger or other transformation of the insurer. Upon application of the rehabilitator for approval of the plan, and after such notice and hearing as the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. If it is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens upon the equities of policyholders of the company, provided that all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for such period and to such an extent as may be necessary.

U.S. CONST. art. IV, §1. A statute is a "public Act" within the meaning of the Full Faith and Credit Clause. *Franchise Tax Board of California v. Hyatt*, 136 S.Ct. 1277, 1281 (2016) (*Hyatt II*) (citing *Carroll v. Lanza*, 349 U.S. 411, 412 (1955)).

40 P.S. §221.16(b)(d) (emphasis added).

The Rehabilitator may "take such action as [she] deems necessary or expedient to correct the condition" that caused the need for rehabilitation, 40 P.S. §221.16(b), and in doing so, she may prepare a rehabilitation plan to "*impair the contractual rights of some policyholders* in order to minimize the potential harm to all of the affected parties." *Consedine v. Penn Treaty Network American Insurance Co.*, 63 A.3d 368, 452 (Pa. Cmwlth. 2012) (*Penn Treaty*) (citing *Mutual Fire II*, 614 A.2d at 1094) (emphasis added). This authority includes a reduction of coverage to match the policyholder's existing premium. It has long been understood that the legislature has vested the Rehabilitator with broad discretion in proposing a rehabilitation plan. *Mutual Fire I*, 572 A.2d at 804, *affirmed*, *Mutual Fire II*, 614 A.2d at 1086 (observing that the insurance commissioner, as statutory rehabilitator of an insurer, is given broader discretion to structure a rehabilitation plan than is given to a statutory liquidator).

In the *Mutual Fire* rehabilitation, the plan amended the policyholders' contractual right to full payment on covered claims by reducing all claim payments by an equal percentage. Here, the Rehabilitator could have done something similar by reducing the coverage of each policy to match the premium being paid. This would equitably address the Funding Gap. However, this would not give policyholders a choice. Further, policyholders whose premium is very inadequate might find themselves with a policy with very limited coverage.

Mutual Fire was a different receivership. There, the policies lapsed during the rehabilitation, and the sole object of the rehabilitation was to pay outstanding claims to the fullest extent possible. By contrast, here, the SHIP policies

are still in force and will remain in force until SHIP emerges from rehabilitation. In this respect, SHIP's rehabilitation is more complex.

A core cause of SHIP's insolvency is policy underpricing, and the Rehabilitator proposes to "correct the condition" through a combination of benefit modifications and premium rate increases. Section 516(b) of Article V, 40 P.S. §221.16(b). Policyholders will be able to decide which of the four options offered under the Second Amended Plan best fits their individual circumstances. The Plan follows the principles of *Mutual Fire I* and *II* and extends them to a different context, as appropriate for a long-term care insurer. The Plan falls within the Rehabilitator's "broad powers … to effectuate equitably the intent of the Rehabilitation statutes." *Mutual Fire II*, 614 A.2d at 1094. The Plan's mechanism for setting actuarially justified rates also falls within the Rehabilitator's broad powers, and they will be reviewed by the Court as part of the rehabilitation proceeding.

Arguably, the only contract "right" given up by the SHIP policyholder is the expectation that the state where the policy was issued will approve the premium rate for each of the four options in Phase One. No policyholder commented on this "right" to state-by-state rate regulation. Policyholder Rose Marie Knight expressed concern about the fact that her premium had not been increased for years. N.T., 5/21/2021, at 933.

The Intervening Regulators assert that the Plan's rate approval provisions "override the insurance laws of other [s]tates" and, thus, violate the Full Faith and Credit Clause of the United States Constitution. Intervening Regulators' Memorandum of Law at 38. Alternatively, the Intervening Regulators contend that this Court should refrain from approving the Plan under the principle of comity because the Plan's "displacement of the rate setting authority of the individual

[s]tates" is a "blatant intrusion" on the sovereignty of other states. Intervening Regulators' Memorandum of Law at 49. The Court finds no merit to these arguments.

Article V empowers this Court to rehabilitate the business of "a domestic insurer or an alien insurer domiciled in this Commonwealth." Section 515(a) of Article V, 40 P.S. §221.15(a). As a general rule, the insolvent insurer's state of domicile "has an overriding interest in assuring that the rehabilitation, if possible, is effectuated." *Matter of Mutual Benefit Life Insurance Co.*, 609 A.2d 768, 777 (N.J. Super. 1992). The court's "decree approving the rehabilitation plan for an insolvent insurer domiciled in its state has a *res judicata* effect upon out-of-state policyholders so as to preclude a subsequent attack upon the plan in another state." 1 COUCH ON INSURANCE 3d §5:31.

Maine, Massachusetts, and Washington have adopted, in substantial part, the Uniform Insurers Liquidation Act (UILA),[14] which was approved by the National Conference of Commissioners on Uniform State Laws in 1939. The UILA addressed the difficulties that arise in the receivership of an insolvent insurer with assets and liabilities located in several states; the UILA provides a "uniform system for the orderly and equitable administration of the assets and liabilities of defunct multistate insurers." *Altman v. Kyler*, 221 A.3d 687, 692 n.6 (Pa. Cmwlth. 2019) (quotations omitted). Pennsylvania, on the other hand, adopted the Insurer's Supervision, Rehabilitation and Liquidation Model Act (Model Act) approved by the National Association of Insurance Commissioners. *See Koken v. Reliance*

[14] *See* 24-A Me. Stat. Ann. §4363; *In re Liquidation of American Mutual Liberty Insurance Company*, 747 N.E.2d 1215, 1225 n.13 (Mass. 2001); and *American Star Insurance Co. v. Grice*, 865 P.2d 507, 509 (Wash. 1994).

Insurance Co., 893 A.2d 70, 76 (Pa. 2006). Following the Model Act, Article V addresses "the problems of interstate rehabilitation and liquidation by facilitating cooperation between states in the liquidation process, and by extending the scope of personal jurisdiction over debtors of the insurer outside this Commonwealth." Section 501(c) of Article V, 40 P.S. §221.1(c).

Given Maine, Massachusetts, and Washington's adoption of the UILA and Pennsylvania's adoption of the similar Model Act, a single, cohesive, uniform handling of SHIP's rehabilitation through a single state is consistent with the underlying policies sought to be served by those laws. Notably, the laws of Maine, Massachusetts and Washington also designate the domiciliary insurance commissioner as the receiver of an insurer undergoing liquidation or rehabilitation.[15] The Intervening Regulators have presented no reason to set aside Pennsylvania's primacy in SHIP's receivership.

Nor does the Full Faith and Credit Clause require this Court to apply the insurance rate regulatory laws of Maine, Massachusetts, and Washington with respect to the establishment of the If Knew Premium rate in the Second Amended Plan. The purpose of the full faith and credit command

> was to alter the status of the several states as independent foreign sovereignties, each free to ignore obligations created under the laws or by the judicial proceedings of the others, and to make them integral parts of a single nation throughout which a remedy upon a just obligation might be demanded as of right, irrespective of the state of its origin.

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

Baker by Thomas v. General Motors Corporation, 522 U.S. 222, 232 (1998) (citation omitted). Congress' Full Faith and Credit Act[16] requires that "all courts ... treat a state court judgment with the same respect that it would receive in the courts of the rendering state." *Standard Chartered Bank v. Ahmad Hamad Al Gosaibi and Brothers Co.*, 99 A.3d 936, 941 (Pa. Super. 2014) (citing *Matsushita Electric Industrial Co. v. Epstein*, 516 U.S. 367, 373 (1996)).

The relevant precedent differentiates between the credit owed to *laws* and the credit owed to *judgments* under the Full Faith and Credit Clause. *Baker*, 522 U.S. at 232. The Full Faith and Credit Clause "does not compel a state to substitute the statutes of other states for its own statutes dealing with a subject matter [] which it is competent to legislate." *Id*. (citation omitted). Instead, "it is frequently the case under the Full Faith and Credit Clause that a court can lawfully apply either the law of one State or the contrary law of another." *Franchise Tax Board of California v. Hyatt*, 538 U.S. 488, 496 (2003) (*Hyatt I*). By contrast, "[a] final judgment in one State, if rendered by a court with adjudicatory authority over the subject matter and persons governed by the judgment, qualifies for recognition throughout the land." *Baker*, 522 U.S. at 233. A court may be guided by the forum state's public policy in determining the law applicable to a controversy,

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[16] It provides:

> Such Acts, records and judicial proceedings or copies thereof, so authenticated, shall have the same full faith and credit in every court within the United States and its Territories and Possessions as they have by law or usage in the courts of such State, Territory or Possession from which they are taken.

28 U.S.C. §1738.

Likewise, the Pennsylvania legislature has enacted the Uniform Enforcement of Foreign Judgments Act, which defines "foreign judgment" as "any judgment, decree, or order of a court of the United States or of any other court requiring the payment of money which is entitled to full faith and credit in this Commonwealth." 42 Pa. C.S. §4306.

but there is no "public policy exception" to the full faith and credit due a court's judgment. *Id*. at 233.

At issue here is whether the Second Amended Plan, if approved by this Court, would give full faith and credit to the insurance laws of Maine, Massachusetts, and Washington. The Court concludes that it would.

In *Carroll v. Lanza*, 349 U.S. 411 (1955), the United States Supreme Court considered a negligence action brought by a Missouri worker against a general contractor in Arkansas, where he sustained injuries. Both Missouri and Arkansas had enacted a workers' compensation law that provided the exclusive remedy of the employee for a work-related injury. The Arkansas law, however, also allowed the injured employee to pursue common-law tort claims against a third party. The Supreme Court held that the Full Faith and Credit Clause did not make Missouri's statute a bar to enforcement of Arkansas' law. Arkansas had sufficient grounds to apply its own law because of its interest in protecting persons injured within its borders and, thus, "opened its courts to negligence suits against prime contractors, refusing to make relief by way of workmen's compensation the exclusive remedy." *Id*. at 412-13. In sum, Missouri law (compared with Arkansas Law) embodied "a conflicting and opposed policy," and Arkansas law did not embody "any policy of hostility to the public Acts of Missouri." *Id.* at 413.

Likewise, in *Hyatt I*, 538 U.S. 488, a former California resident who had moved to Nevada brought tort actions in Nevada state court against the California franchise tax board, alleging negligent misrepresentation, invasion of privacy, fraud, and other torts in connection with the board's assessments and penalties for taxes he allegedly owed. The Nevada Supreme Court applied Nevada law, which gave state agencies immunity for negligence but not for intentional torts.

Accordingly, the Nevada Supreme Court ordered the trial court to dismiss the negligence claim for lack of jurisdiction but allowed the intentional tort claims to proceed to trial. The tax board appealed.

The United States Supreme Court upheld the Nevada Supreme Court's decision. The Court emphasized that the Full Faith and Credit Clause does not require one state to apply another state's law that violates its "own legitimate public policy." *Id.* at 497 (internal quotations omitted). Nevada's choice of law in that case did not "exhibi[t] a policy of hostility to the public Acts of a sister State." *Id.* at 499 (citing *Carroll*, 349 U.S. at 413). Further, Nevada had "sensitively applied principles of comity with a healthy regard for California's sovereign status" by "relying on the contours of Nevada's own sovereign immunity from suit as a benchmark for its analysis." *Id*. at 499.

Following remand, a jury found in the taxpayer's favor and awarded him almost $500 million in damages and fees. The tax board again appealed to the Nevada Supreme Court, arguing that the Full Faith and Credit Clause required Nevada to limit damages to $50,000, the maximum that Nevada law would permit in a similar suit against its own agencies. The Nevada Supreme Court affirmed $1 million of the award. Instead of applying the Nevada statute applicable to suits against Nevada's own agencies, the Nevada Supreme Court applied a special rule for one case. On further appeal, the United States Supreme Court held that this decision of the Nevada Supreme Court violated the Full Faith and Credit Clause because it lacked the "healthy regard for California's sovereign status" and "reflect[ed] a constitutionally impermissible policy of hostility to the public Acts of a sister State." *Franchise Tax Board of California v. Hyatt*, 136 S.Ct. 1277, 1282-83 (2016) (*Hyatt II)* (citation omitted).

In the case *sub judice*, the evidence demonstrated that the Rehabilitator will use the If Knew Premium methodology in the implementation of the Plan. This methodology will assume a 60% lifetime loss ratio, which is the benchmark for a premium rate increase in Pennsylvania and most other states. The If Knew Premium methodology is used by insurance regulators nationwide to set long-term care insurance premium rates. The self-sustaining premium to be implemented in Phase Two of the Plan will likewise use a 60% lifetime loss ratio. *See* 31 Pa. Code §89a.117 ("Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least 60%[.]").

A review of the insurance statutes of Maine, Massachusetts, and Washington shows that these sister states share Pennsylvania's interest in ensuring that long-term care insurance premium rates are not excessive, unfairly discriminatory, or unreasonable in relation to the benefits provided under the policy.[17] This commonly-shared interest will be advanced, rather than impaired, by the Second Amended Plan, which seeks to correct SHIP's discriminatory premium rate structure; sets the premium rates to appropriate levels; and employs the If Knew

[17] The Maine Insurance Code requires that the state insurance regulator determine that the rate filings on health insurance policies comply with "the requirements that rates not be excessive, inadequate or unfairly discriminatory." 24-A Me. Stat. Ann. §2736. The insurance statute in Massachusetts provides that the insurance commissioner may "disapprove such form of policy if the benefits provided therein are unreasonable in relation to the premium charged, or if it contains any provision which is unjust, unfair, inequitable, misleading or deceptive, or which encourages misrepresentation as to such policy[.]" Mass. Gen. Laws Ann. Ch. 175 §108(8)(A). Likewise, the insurance statute in Washington provides that long-term care insurance rate increases are not permitted "if the benefits provided therein are unreasonable in relation to the premium charged." Wash. Rev. Code §48.18.110. These standards are similar to the Pennsylvania standard for adjusting long-term care insurance premium rates. *See* Section 353 of The Insurance Company Law of 1921, Act of May 17, 1921, P.L. 682, *as amended*, *added by* the Act of June 23, 1931, P.L. 904, 40 P.S. §477a.

Premium methodology to establish a premium level that is reasonable in relation to the benefits paid.

Alternatively, under an Issue-State Rate Approval Option, a state may opt out of the rate approval section in the Plan. If a state opts out, the Rehabilitator will file an application to increase rates for policies issued in that state to the If Knew Premium level. The regulator for the opt-out state will render a decision on the Rehabilitator's rate increase application; if it is only partially approved, the Rehabilitator will downgrade the benefits under the affected policies accordingly. Cantilo testified that policyholders in an opt-out state will still have four options, although they are not exactly the same as those offered in the Second Amended Plan. This does not render the Issue-State Rate Approval Option "coercive" or "nominal," as the Intervening Regulators assert; rather, it provides the issue state with a meaningful way to control the mix of benefit reductions and premium rate increases. It prevents the opt-out state from interfering with Pennsylvania's ability to rehabilitate SHIP. In sum, the Second Amended Plan gives a "healthy regard" for the insurance laws of other states by "relying on the contours of [Pennsylvania insurance law] as a benchmark for its analysis." *Hyatt I*, 538 U.S. at 499.

The Second Amended Plan does not follow the ordinary rate review process for a solvent insurer, but it preserves the substantive rights of SHIP's policyholders to have their premium reviewed by a qualified actuary and an insurance regulator to ensure that the rate is actuarially justified and reasonable in relation to the benefits. The Plan changes the forum for the premium determinations to the state responsible for the rehabilitation of SHIP, *i.e.*, Pennsylvania. The conflict between Pennsylvania law and the laws of Maine, Massachusetts, and Washington, if any, is one of procedure, to which this Court owes no deference. *See*

Wilson v. Transport. Ins. Co., 889 A.2d 563, 571 (Pa. Super. 2005) (citation omitted) (the "choice of law" analysis applies only to conflicts of substantive law, which "creates the rights and duties of the parties to a judicial proceeding").

The insistence of the Intervening Regulators that the Rehabilitator submit rate increase applications to 46 states, the District of Columbia, and the U.S. Virgin Islands renders a rehabilitation of SHIP an impossibility. Pennsylvania has a compelling interest in enforcing Article V, which protects "the interests of insureds, creditors, and the public generally" through

> *(i) early detection of any potentially dangerous condition in an insurer, and prompt application of appropriate corrective measures; (ii) improved methods for rehabilitating insurers, involving the cooperation and management expertise of the insurance industry;* (iii) enhanced efficiency and economy of liquidation, through clarification and specification of the law, to minimize legal uncertainty and litigation; *(iv) equitable apportionment of any unavoidable loss;* (v) lessening the problems of interstate rehabilitation and liquidation by facilitating cooperation between states in the liquidation process, and by extending the scope of personal jurisdiction over debtors of the insurer outside this Commonwealth; and (vi) regulation of the insurance business by the impact of the law relating to delinquency procedures and substantive rules on the entire insurance business.

Section 501(c) of Article V, 40 P.S. §221.1(c) (emphasis added).[18] Furthermore, as this Court observed in *Mutual Fire I*,

> the benefits of rehabilitation—its flexibility and avoidance of inherent delays—are preferable to the static and cumbersome procedures of statutory liquidation. The statute's purpose is, in the end, that to which we must give effect. That legislatively

[18] Section 501(b) of Article V states that its provisions "shall be liberally construed to effect the purpose stated in subsection (c)." 40 P.S. §221.1(b).

> stated purpose is "the protection of the interests of insureds, creditors, and the public generally...." and the "equitable apportionment of any unavoidable loss" through, *inter alia*, "improved methods for rehabilitating insurers...." Section 501 of the Act, 40 P.S. §221.1. No interest is served by adding to the delay which has already occurred in this case. On the contrary, the goals of Article V of the Act are better served by a rehabilitation which effectively ensures more distribution in a shorter period of time than would occur in liquidation.

572 A.2d at 803.

Here, the evidence established that the ordinary rate filing process often involves 6 to 12 months of preparation and years of review in some states. "No interest is served by adding to the delay which has already occurred in this case." *Mutual Fire I*, 572 A.2d at 803. Further, a state-by-state rate filing process would not address the inconsistent rate approvals from state insurance regulators, which leave SHIP with less revenue than needed and similarly situated policyholders paying vastly different premiums for the same coverage. Cantilo credibly testified that the Plan's premium rate methodologies and approval mechanisms are necessary to address the inequities in SHIP's current rate structure. The use of the If Knew Premium across all policies will put all policyholders on a level playing field because it is calculated on a seriatim basis.

In sum, under Article V, the Rehabilitator has the authority to propose, and this Court has the authority to approve, the Second Amended Plan's provisions regarding the establishment of premium rates for the four policyholder options in Phase One. The Full Faith and Credit Clause does not require the Rehabilitator to submit these premium rates to 46 states, the District of Columbia, and the U.S. Virgin Islands for their review and approval. This would fracture Pennsylvania's "own legitimate public policy" in the rehabilitation of SHIP, a Pennsylvania-

domiciled insurer. *Hyatt I*, 538 U.S. at 497. In no way does this aspect of the Second Amended Plan reflect "a policy of hostility to the public Acts of a sister State." *Id.* at 499. To the contrary, the interests of Maine, Massachusetts, and Washington in ensuring that long-term care insurance premium rates are not excessive, unfairly discriminatory, or unreasonable to the benefits provided will be advanced, rather than impaired, by the Plan.

Finally, the Court rejects the Intervening Regulators' arguments on comity. Application of comity is "a matter of judicial discretion," and Pennsylvania courts exercise comity "when application of another state's law contradicts no public policy of Pennsylvania and instead furthers a Pennsylvania policy." *Chestnut v. Pediatric Homecare of America, Inc.*, 617 A.2d 347, 350 (Pa. Super. 1992). The Plan has "sensitively applied principles of comity with a healthy regard" for the insurance laws of other states by "relying on the contours of [Pennsylvania insurance law] as a benchmark for its analysis." *Hyatt I*, 538 U.S. at 499.

Once this Court renders a judgment on the Second Amended Plan, it is Maine, Massachusetts, and Washington that owe this Court's judgment full faith and credit. *See Underwriters National Assurance Co. v. North Carolina Life and Accident and Health Insurance Guaranty Association*, 455 U.S. 691 (1982). *See also* 1 COUCH ON INSURANCE 3d §5:31 (discussing state court's violation of Full Faith and Credit Clause by refusing to treat prior judgment of another state's insurance rehabilitation court as *res judicata*).

2. The Plan Satisfies all Constitutional Requirements

The Intervening State Insurance Regulators argue that the Second Amended Plan is unconstitutional because it does not satisfy the standard that "[c]reditors and policyholders must fare at least as well under a rehabilitation plan

as they would under a liquidation." *Koken v. Fidelity Mutual Life Insurance Co.*, 803 A.2d 807, 826 (Pa. Cmwlth. 2002) (citing *Neblett v. Carpenter*, 305 U.S. 297 (1938)). In applying the *Carpenter* standard, this Court is guided by the three-part test adopted in *Mutual Fire II*.[19] The "threshold inquiry" is whether the state action "has operated to substantially impair a contractual relationship" in violation of Article I, Section 10 of the United States Constitution and Article I, Section 17 of the Pennsylvania Constitution.[20] *Mutual Fire II*, 614 A.2d at 1094 n.4. An impairment of contractual rights is not a *per se* violation of law. *Id*. If a particular policyholder is found to be worse off under a rehabilitation plan, the impairment could be considered "substantial," but the Court still needs to determine whether (1) the rehabilitator has acted for a legitimate and significant public purpose and (2) the adjustment of contractual rights is reasonable and of a nature appropriate to that public purpose. *Id*. To that end, the Court must be mindful that Article V is intended to protect "the interests of insureds, creditors, and the public generally[.]" Section 501(c) of Article V, 40 P.S. §221.1(c).

i. The Plan Satisfies Pennsylvania's Interpretation of *Carpenter*

Under the so-called "*Carpenter* test," a rehabilitation plan should be confirmed if creditors will fare at least as well under the plan as they would in liquidation. *Mutual Fire II*, 614 A.2d at 1093-94. As our Supreme Court has

[19] Several of the objectors to the Mutual Fire rehabilitation plan argued that the plan impaired their contractual rights. In analyzing their argument, our Supreme Court expressly adopted the three-part test announced by the United States Supreme Court in *Energy Reserves Group, Inc. v. Kansas Power and Light Co.*, 459 U.S. 400, 411 (1983), for determining when a state law may impair a contractual right. *Mutual Fire II*, 614 A.2d at 1094 n.4. Thus, whether an alleged contractual impairment is caused by a receiver's workout plan or a statute, the analysis is the same.

[20] Article I, Section 10 of the United States Constitution states, in pertinent part: "No State shall … pass any … Law impairing the Obligation of Contracts[.]" U.S. CONST. art. 1, §10. Article I, Section 17 of the Pennsylvania Constitution states: "No … law impairing the obligation of contracts … shall be passed." PA. CONST. art. I, §17.

explained, this does not mean that every single policyholder must satisfy that test. *See id*. at 1102 ("individual interests might have to be sacrificed or compromised in order to preserve the ultimate goal of [the rehabilitation] process[.]"); *see also Penn Treaty*, 63 A.3d at 453 ("[*Carpenter*] did not establish the broad principle that a rehabilitation plan is *per se* invalid unless every policyholder will fare as well in rehabilitation as in liquidation."). Instead, the Court is guided by the three-part test established by *Mutual Fire II*. *Penn Treaty*, 63 A.3d at 453.

Under that test, if a particular policyholder is found to be worse off under a rehabilitation plan than in liquidation, and that impairment is "substantial," the Court should confirm the plan so long as the Rehabilitator has acted for a legitimate and significant public purpose and the contractual modification is reasonable and appropriate to that public purpose. *Id.* In this regard, "[t]he Court must consider the greater good, including the consequences to the larger class of policyholders and the taxpaying public." *Id.* (citing *Vickodil v. Insurance Department*, 559 A.2d 1010, 1013 (Pa. Cmwlth. 1989)).

The Second Amended Plan meets that test. Even assuming, *arguendo*, that the Plan substantially impairs policies, it serves a legitimate and significant public purpose, and the policy modifications are reasonable and appropriate to that purpose. At the hearing, Special Deputy Rehabilitator Cantilo aptly observed:

> And the question that we were debating [was], is it reasonable, if a policyholder has been paying a quarter for a dollar's worth of insurance for decades, to adopt, as the workout plan, a plan in which the taxpayers step up to pay their remaining 75 cents.
>
> And what we concluded is that we could right size the policy, and we could create a set of options for policyholders that would enable them to get fundamental [long term care] coverage but pay reasonable rates like the rest of the country for that coverage and not shift all that burden to the taxpayers.

N.T., 5/17/2021, at 78-79. In short, the Plan narrows the Funding Gap, promotes fairness and equity among policyholders, and appropriately balances the interests of the policyholders and the broader taxpaying public.

ii. The Intervening Regulators' Interpretation of *Carpenter* is Flawed

The Intervening Regulators urge a rigid application of *Carpenter*, *i.e.*, that all policyholders must fare as well in rehabilitation as they would in liquidation. To that end, the Intervening Regulators compared the net present value of the benefits policyholders will receive under the Second Amended Plan with the net present value of the benefits they can expect to receive in a liquidation. Notably, the Court in *Carpenter* was comparing the cash payment to policyholders under a rehabilitation plan with the cash payment they would receive in a liquidation, at a time when there was no guaranty association protection for policyholders. Here, the alternatives are not cash payments but continued insurance coverage. The value comparison of coverage to SHIP policyholders in a rehabilitation as compared to a liquidation cannot be reduced to dollar amounts.

The Intervening Regulators' metric is one not actually used by policyholders when making the decision to purchase long-term care insurance. As testimony from Cantilo and Bodnar established, consumers choose their policy benefits and limits according to their personal circumstances. For example, a policyholder may wish to protect his estate against dissipation by an extended stay in a nursing home. Each policyholder will have different goals and different financial situations that will affect the type and amount of coverage they purchase. Not a single witness testified that the liquidation value of a policy figures into this analysis. Cantilo and Bodnar opined that the comparison methodology policyholders use is the maximum policy value, not the *Carpenter* value. Cantilo

provided compelling examples of actual SHIP policyholders whose *Carpenter* value, using the Intervening Regulators' proposed net present value metric, would, in fact, produce a poor option for that policyholder. *See* Ex. RP-56 at 102-03. The Court credits Cantilo's statement that "[t]here are many cases where the raw projection of future benefits less future premiums [doesn't] really tell you what the real value of the policy is." N.T., 5/17/2021, at 177.

In any event, even under the Intervening Regulators' metric, 85% of SHIP policyholders will be offered one option with a value equal to or higher than the value of the policy they will have in liquidation. Several other metrics produced even higher percentages of policyholders who will fare at least as well under the Plan as in liquidation.

3. The Plan is Feasible to the Extent Required by Pennsylvania Law

The Intervening Regulators argue that the Second Amended Plan is not feasible because it is unlikely to eliminate the Funding Gap and restore SHIP to solvency. To begin, there is no statutory requirement in Pennsylvania that a rehabilitation plan must be "feasible" in order to be approved, nor has that standard been adopted in our decisional law. The only reference to feasibility anywhere in Pennsylvania law occurred in the Mutual Fire receivership during the implementation of an already approved rehabilitation plan. *Mutual Fire II*, 614 A.2d 1086. The Intervening Regulators have not cited any other case in which "feasibility" appears. Notably, in *Mutual Fire*, the rehabilitator raised "feasibility" to support a request to modify the Court-approved rehabilitation plan. *Id*. at 1090. The Intervening Regulators' attempt to read a non-existent pre-approval "feasibility" requirement into Article V has no support in *Mutual Fire II*.

The Intervening Regulators argue that a "feasible" rehabilitation plan must be "reasonably likely to succeed in restoring the company to solvency" in order to be approved. Intervening Regulators' Post-Hearing Memorandum at 5.

First, the Court notes that the meaning of "company solvency" is context specific. The peak of SHIP's activity in the insurance marketplace was in the late 1990s, when it had more than 300,000 policies in force. N.T., 5/17/2021, at 40; Ex. RP-56 at 18. By 2003, when SHIP discontinued writing new business and went into run-off, the number of policies in force was already in a steep decline. N.T., 5/17/2021, at 40; Ex. RP-56 at 18. The Second Amended Plan, if successful, will restore SHIP to what it was pre-receivership, *i.e.*, an insurer winding down its long-term care insurance business and able, as a going concern, to continue coverage and pay the claims of its existing policies. The Court rejects the Intervening Regulators' suggestion that a return to solvency by SHIP requires more than a return to its pre-receivership status. SHIP had long ceased being an active and growing presence in the insurance marketplace.

Second, the Pennsylvania Supreme Court has stated that "[s]o long as the rehabilitation properly conserves and equitably administers 'the assets of the involved [insurer] in the interest of investors, the public and others, (with) the main purpose being the public good' the plan … is appropriate." *Mutual Fire II*, 614 A.2d at 1094 (quoting 2A COUCH ON INSURANCE 2d §22.10). Simply, the Court rejected the notion that a rehabilitation plan must contemplate a resuscitation of the insolvent insurer's operations.

Under any outcome, the Second Amended Plan will materially reduce the Funding Gap and significantly improve SHIP's financial condition. The Intervening Regulators offered no substantive evidence to overcome the

Rehabilitator's evidence on this issue. The Intervening Regulators correctly point out that the ultimate goal of the Mutual Fire rehabilitation plan was to restore the company to solvency. The Second Amended Plan has, as its ultimate goal, SHIP's return to solvency. It "does not have to restore the company to its exact original condition." *Mutual Fire II*, 614 A.2d at 1094.

Further, as a matter of public policy the rehabilitation of an insurer, where possible, is the preferred course. *Penn Treaty*, 63 A.3d at 440 (recognizing liquidation as a remedy of last resort); *Koken v. Legion Insurance Co.*, 831 A.2d 1196, 1230 (Pa. Cmwlth. 2003) (same); and *Mutual Fire II*, 614 A.2d at 1094 (same). As this Court explained, "a liquidation, no matter how 'successful,' is certain to cause harm to the policyholders, creditors and taxpaying public[.]" *Penn Treaty*, 63 A.3d at 461.

In summary, Article V does not require the Second Amended Plan be "feasible" in order to be approved, and the Intervening Regulators' arguments to the contrary simply voice a disagreement with the Rehabilitator's exercise of discretion. The Plan will eliminate or reduce the Funding Gap, which is a legitimate purpose. The ultimate goal of the Second Amended Plan is to return SHIP to the level of solvency needed to run-off its long-term care insurance business.

4. The Plan is Fair and Equitable

As stated, SHIP's current premium rate structure is unfairly discriminatory because policyholders with substantially similar coverage are not paying the same premium, thereby burdening some policyholders with subsidizing the premium payments of other policyholders. This Court has recognized that eliminating these unfair "subsidies between policyholders in different states and

between different groups of policyholders" is itself a legitimate goal of rehabilitation. *Penn Treaty*, 63 A.3d at 443, 460.

The Intervening Regulators argue that unless the Plan maintains SHIP's current unequal treatment of policyholders on a state-by-state basis, then the Plan is unlawful. The Intervening Regulators' position fails for several reasons.

First, the Intervening Regulators lack standing to assert the claim that the Plan treats "policyholders in different States differently." Intervening Regulators' Post-Hearing Memorandum at 32. They expressly disavowed that they were appearing in a *parens patriae* or other representative capacity for policyholders in their states. N.T., 5/19/2021, at 541-47. Even so, the Intervening Regulators failed to present any evidence showing how policyholders in their respective states would be unfairly treated by the Plan's proposal to eliminate unfair subsidies between groups of policyholders.

Second, the Plan will end the existing unequal treatment of similarly situated policyholders. The Intervening Regulators strain to characterize some policyholders as receiving "more" by "suffering smaller benefit cuts" when compared to other policyholders receiving "less" by "suffering greater benefit cuts." Intervening Regulators' Post-Hearing Memorandum at 38. This is a function of the fact that many policyholders presently pay an inadequate premium. The Court rejects the Intervening Regulators' characterization of right sizing premium to policy coverage as itself an act of unequal treatment.

To eliminate the unfair subsidies between policyholders, the change in rates or coverages will have a greater impact on the more underpriced (and over-subsidized) policies that have benefited at the expense of other policyholders. The Plan will require similarly situated policyholders to pay the same premium coverage.

The Plan's elimination of unfair subsidies between policyholders aligns with this Court's precedent in the Penn Treaty receivership, which recognized that a rehabilitation plan may properly eliminate such subsidies. *Penn Treaty*, 63 A.3d at 443, 460.

Third, the Intervening Regulators improperly invoke Section 544(b) of Article V, 40 P.S. §221.44(b), which states that no subclasses may be created within the policyholder class in a liquidation. As a threshold matter, this is a rehabilitation, not a liquidation. More fundamentally, the Plan does not give "some policyholders greater consideration than others." Intervening Regulators' Post-Hearing Memorandum at 35. To the contrary, the Second Amended Plan treats similarly situated policyholders the same regardless of the state in which their policy was issued.

D. Other Concerns and Objections Raised at the Hearing are Overruled or Have Been Adequately Addressed

1. Intervening Regulators' Application for Reconsideration

At the close of the hearing on May 21, 2021, this Court granted the Rehabilitator's oral motion "for judgment in the nature of a directed verdict" against the Intervening Regulators regarding the Issue State Rate Approval Option in the Second Amended Plan. N.T., 5/21/2021, at 981. The Rehabilitator argued that the Intervening Regulators did not present any evidence that their interests would be harmed by the Issue State Rate Approval Option, and as such, their objection to the Issue State Rate Approval Option cannot serve as a basis for this Court to disapprove the Plan. *Id*. at 986-88.

On June 1, 2021, the Intervening Regulators filed an application for reconsideration for the stated reason that the Rehabilitator's motion was vague, was made without notice and lacked support in the applicable court rules. More

specifically, the Intervening Regulators contend that the term "[I]ssue [S]tate [R]ate [A]pproval [O]ption" is not "meaningful," as "it is impossible to tell" whether it was referring to the "opt-out" provision under the Second Amended Plan. Application for Reconsideration at 7. They also contend that a motion for a directed verdict can be filed only in a "jury case" or an "adversarial proceeding," which is not the case here. *Id*. at 8, 12. Even so, to grant a motion for a directed verdict requires this Court to consider "all of the evidence before it in the light most favorable to the [Intervening] Regulators." *Id.* at 14. They assert that the Rehabilitator's motion "[f]ails on the [r]ecord" because Cantilo and Bodnar testified that the Plan seeks to "supersede the existing state rate approval system," which would impact state regulators and policyholders. *Id*. at 14-15. The Intervening Regulators' arguments are not persuasive.

To begin, the Rehabilitator's motion for a directed verdict was not vague. In moving for a directed verdict, the Rehabilitator's counsel stated that "the [Intervening Regulators] have failed to put on any evidence which would or could support an interest they purport to represent with respect to the issue[] state rate approval option." N.T., 5/21/2021, at 981-82. Counsel went on to assert that "absent any testimony as to the ways in which a regulator is constrained or harmed by that option, the [Intervening Regulators] here have no argument to present which would show that [the option] does not sufficiently address the concerns that they have raised at some earlier stage in these proceedings." *Id*. at 986. The Intervening Regulators objected to the motion for the reason that granting a directed verdict would be improper under the circumstances as the case presents "significant open legal issues." *Id*. 989. The Rehabilitator's counsel responded:

> To be clear, we're only seeking the directed verdict on the [I]ssue [S]tate [R]ate [A]pproval [O]ption issue. I don't have here where

> it was raised in the memorandum. We're not seeking a directed verdict as to, generally, the questions of whether the [P]lan is fair and equitable or the exercise of the [R]ehabilitator's discretion generally. This is a narrow motion, Your Honor, on the [I]ssue [S]tate [R]ate [A]pproval [O]ption and the opt-out offer thereunder[.]

Id. at 991.

After hearing arguments from both parties, the Court granted the motion. It stated that "there is an opt-out option that preserves the right of the [] … state of issue to pursue a state rate approval powers and [Intervening Regulators'] witness did not address why the [P]lan was deficient … in that way." *Id*. at 994. In short, the motion was not vague.

This Court also rejects the Intervening Regulators' argument that the Rehabilitator's motion for a directed verdict lacked due notice. The Intervening Regulators do not cite, and this Court did not find, any legal authority which would have required such notice. The Rehabilitator did not need to disclose her litigation strategy at the hearing with the Intervening Regulators. In any event, the Intervening Regulators were given an opportunity to file with this Court an application for reconsideration, which they did on June 1, 2021.

Nor did the Intervening Regulators cite any legal authority to support their proposition that a directed verdict can only be entered in a jury trial. Notably, the Intervening Regulators' proposition is at odds with their earlier position that this Court should have ruled on the legal issues before holding an evidentiary hearing on the Second Amended Plan.

Pennsylvania Rule of Appellate Procedure 106 provides:

> Unless otherwise prescribed by these rules the practice and procedure in matters brought before an appellate court within its original jurisdiction shall be in accordance with the appropriate

> general rules applicable to practice and procedure in the courts of common pleas, so far as they may be applied.

PA. R.A.P. 106. However, the Intervening Regulators point to Pennsylvania Rule of Appellate Procedure 3783(b), which provides that "[t]he Pennsylvania Rules of Civil Procedure shall apply to adversarial proceedings."[21] PA. R.A.P. 3783(b). Because an action to rehabilitate an insurer pursuant to Article V is a "formal proceeding," not an "adversarial proceeding," PA. R.A.P. 3772(f), the Intervening Regulators argue that it is not subject to the Rules of Civil Procedure.

The Intervening Regulators overlook the precept that the Court has discretion to conduct a statutory proceeding as is expedient and appropriate to move the case to a conclusion in a methodical fashion. *See, e.g., In re Tax Sale Held September 10, 2003 by Tax Claim Bureau of County of Lackawanna*, 859 A.2d 15, 18 (Pa. Cmwlth. 2004) (recognizing that while a trial court is not required to use the Pennsylvania Rules of Civil Procedure in tax sale proceedings, it has discretion to use the Rules of Civil Procedure where appropriate).

Here, the Rehabilitator seeks approval of the Second Amended Plan in this Court's original jurisdiction.[22] Pennsylvania Rule of Civil Procedure 226(b)

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[21] Rule 3772(c) defines "adversarial proceeding" as

> [a]ny action (1) initiated by the rehabilitator or liquidator against persons other than the insurer, (2) asserting a right or interest afforded by Article V and for which neither Article V nor prior orders of the Court provide an avenue for redress, and (3) that the Court determines shall be governed by Pa. R.A.P. 3783 (adversarial proceedings) as an adversarial proceeding.

PA. R.A.P. 3772(c). Pennsylvania Rules of Appellate Procedure 3771 to 3784 (Summary and Formal Proceedings Against Insurers) apply to all actions in the Commonwealth Court arising under Article V. PA. R.A.P. 3771-3784.

[22] 42 Pa. C.S. §761(a)(3) (This Court has "original jurisdiction of all civil actions or proceedings … [a]rising under Article V of the act of May 17, 1921 (P.L. 789, No. 285), known as 'The Insurance Department Act of 1921.'").

provides that a trial court may, "[a]t the close of all the evidence … direct a verdict upon the oral or written motion of any party." PA. R.C.P. No. 226(b). This Court has affirmed the entry of a directed verdict following a single-judge bench trial. *See, e.g., Geschwindt v. Wagner*, 1 A.3d 970 (Pa. Cmwlth. 2010) (affirming directed verdict entered by trial court following bench trial). This Court has entered directed verdicts in matters brought within its original jurisdiction. *See, e.g., Pennsylvania Human Relations Commission v. School District of Philadelphia*, 651 A.2d 177 (Pa. Cmwlth. 1993) (granting a school district's motion for a directed verdict by treating it as a motion for a compulsory nonsuit[23] against the Pennsylvania Human Relations Commission on the ground that it had failed to demonstrate that mandatory desegregation measures were feasible).

> A directed verdict can be entered in one of two circumstances:
>
> > one, the movant is entitled to judgment as a matter of law and/or two, the evidence is such that no two reasonable minds could disagree that the outcome should have been rendered in favor of the movant. With the first, the court reviews the record and concludes that, even with all factual inferences decided adverse to the movant, the law nonetheless requires a verdict in his favor. Whereas with the second, the court reviews the evidentiary record and concludes that the evidence was such that a verdict for the movant was beyond peradventure.

Hall v. Episcopal Long Term Care, 54 A.3d 381, 395 (Pa. Super. 2012) (quoting *Campisi v. Acme Markets, Inc.*, 915 A.2d 117, 119 (Pa. Super. 2006)).

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[23] While the trial court may, "[*a*]*t the close of all the evidence* … direct a verdict upon the oral or written motion of any party," PA. R.C.P. No. 226 (emphasis added), "the court, on oral motion of the defendant, may enter a nonsuit on any and all causes of action if, *at the close of the plaintiff's case on liability*, the plaintiff has failed to establish a right to relief." PA. R.C.P. No. 230.1(a)(1) (emphasis added).

The issue raised in the Rehabilitator's motion for a directed verdict is a narrow one: whether the Issue State Rate Approval Option is unlawful as the Intervening Regulators alleged. This is a mixed question of law and fact. The Intervening Regulators assert that the Issue State Rate Approval Option is coercive and provides them with no meaningful review of the rate filings. In their application for reconsideration, the Intervening Regulators contend that the "opt-out" provision cannot be "separated from the larger concern over superseding [s]tate rate approval statutes[.]" Application for Reconsideration at 7.

The Intervening Regulators did not present any evidence to support their challenge to the opt-out provision of the Plan. Cantilo credibly testified that if a state chooses to exercise the Issue State Rate Approval Option, the Rehabilitator will file an application on a seriatim basis to increase rates for policies issued in that state. The Intervening Regulators assert that the requirement that opt-out states act within 60 days and review the rate filings on a seriatim basis is "inconsistent" with "state practices." Application for Reconsideration at 16. However, no evidence in the record supports this claim.

In sum, the Intervening Regulators did not show that the Issue State Rate Approval Option is unconstitutional or otherwise is harmful to their interests. Collectively, those interests involve approximately 2,000 of the 39,000 policyholders affected by the Plan. Ex. RP-22 at 2. This Court properly entered a directed verdict on the Intervening Regulators' objection to the Issue State Rate Approval Option. However, this Court disagrees with the Rehabilitator's proposition that the Intervening Regulators should be dismissed from the rehabilitation proceeding. The Rehabilitator's motion was a narrow one, as was this Court's order granting the motion.

For the foregoing reasons, this Court denies the Intervening Regulators' application for reconsideration.

2. Policy Restructuring

NOLHGA and Lapinski raised concerns about the policy restructuring provisions in the Second Amended Plan that impact SHIP's tax liability. The restructuring will address potential taxable income owed by SHIP for cancellation of indebtedness and will bifurcate policy liabilities into funded and unfunded portions. This policy restructuring will not affect coverage for policyholders either now or in the event of a liquidation. Cantilo testified that the restructuring does not affect policyholder choices and will not be performed on a seriatim basis. N.T., 5/17/2021, at 143.

As a result of the concerns raised at the hearing, the Rehabilitator will file a separate application with this Court to address the restructuring and tax issues. N.T., 5/21/2021, at 996. All parties will have an opportunity at that point to raise objections.

3. Policyholder Communications

NOLHGA raised concerns regarding policyholder communications, especially with respect to information related to guaranty associations and their coverage limit. However, NOLHGA's president and fact witness, Peter Gallanis, acknowledged that the Rehabilitator has not refused to engage with NOLHGA regarding its concerns with the Plan or consider NOLHGA's proposed changes. N.T., 5/20/2021, at 686. NOLHGA is free to propose modifications to the Plan and continue to communicate with the Rehabilitator, as NOLHGA has done to date. Gallanis acknowledged that the Rehabilitator is a "capable commissioner" who understands the "important aspects" of the guaranty association system. *Id.* at 680.

4. COVID-19 Pandemic

Policyholder James Lapinski raised concerns regarding the impact of COVID-19 on long-term care insurance experience through higher mortality and lower claim incidence. With regard to this issue, Cantilo credibly testified that SHIP has experienced a moderate increase in mortality since the beginning of the pandemic in 2020, which generated a moderate increase in lapses of policies. The pandemic also caused a small increase in morbidity and adversely affected SHIP's expected yield on invested assets. However, the actuarial report prepared by Oliver Wyman shows that the aggregate effects of the pandemic had a moderate impact on SHIP's financial condition and are not material to the implementation of the Second Amended Plan. N.T., 5/17/2021, at 26; N.T., 5/21/2021, at 944.

Lapinski requested that the Second Amended Plan's discussion on COVID-19 be updated with more recent data. Oliver Wyman's actuarial report noted the evolving nature of COVID-19's impact and stated that while certain assumptions "were developed based on claims data predating the effects of COVID-19[,] [the actuarial team] will consider the effects of COVID-19 when [they] update [their] actuarial assumptions in 2021." Ex. RP-16 at 28. As Bodnar testified, upon approval of the Plan, Oliver Wyman will prepare an actuarial memorandum in support of the If Knew Premium rates, similar to one that would ordinarily be submitted to state regulators in a rate increase filing. All parties will have an opportunity at that point to raise objections.

5. Funding Gap and SHIP's Balance Sheet

Lapinski questioned the size of SHIP's Funding Gap and the decline of SHIP's capital and surplus and value of its bond holdings as reflected in its balance sheet ending December 31, 2020. In that regard, Cantilo provided extensive

testimony on SHIP's hazardous financial condition, the causes of SHIP's insolvency, and the actions taken by the Pennsylvania Insurance Department prior to rehabilitation. The evidence that the Second Amended Plan will substantially reduce the Funding Gap and address SHIP's inequitable rate structure was extensive. As for the decline in the value of SHIP's bond holdings, Cantilo credibly explained that it was due to a decline in yield in the markets in which SHIP's bonds were invested, which added to SHIP's deficit from 2019 to 2020. N.T., 5/21/2021, at 950-51.

6. Timing

Finally, Lapinski raised concerns with the timing of the rehabilitation proceeding and stated his desire for SHIP to avoid the lengthy process that Penn Treaty went through prior to liquidation. This Court shares Mr. Lapinski's desire to address SHIP's financial condition swiftly, as does the Rehabilitator. Cantilo testified that the Plan can be implemented quickly: within eight months of approval, the Rehabilitator anticipates receiving policyholder elections, which will enable her to measure the precise impact of Phase One on SHIP's Funding Gap. N.T., 5/18/2021, at 339-40.

V. Conclusions of Law

1. The Rehabilitator is authorized to "take such action as he deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate the insurer." Section 516(b) of Article V, 40 P.S. §221.16(b). This includes preparing "a plan for the reorganization, consolidation, conversion, reinsurance, merger or other transformation of the insurer." Section 516(d) of Article V, 40 P.S. §221.16(d).

2. Upon application of the Rehabilitator for approval of a plan of rehabilitation, and after notice and a hearing thereon, "the court may either approve

or disapprove the plan proposed, or may modify it and approve it as modified. If it is approved, the rehabilitator shall carry out the plan." Section 516(d) of Article V, 40 P.S. §221.16(d).

3. "[I]t is not the function of the courts to reassess the determinations of fact and public policy made by the Rehabilitator[]" in formulating a plan of rehabilitation. *Mutual Fire II*, 614 A.2d at 1091. "Rather, the involvement of the judicial process is limited to the safeguarding of the plan from any potential abuse of the Rehabilitator's discretion." *Id*.

4. The Rehabilitator's evidence established that the Second Amended Plan will conserve and equitably administer the assets of SHIP in the interest of policyholders, creditors and the public, "with the main purpose being the public good." *Id*. at 1094. The Plan is designed to return SHIP to its pre-receivership status as a run-off company able to meet its obligations as they come due.

5. The Rehabilitator's evidence established that the Second Amended Plan will reduce or eliminate the Funding Gap and eliminate SHIP's inequitable and discriminatory premium rate structure by offering policyholders meaningful choices to modify their long-term care insurance policies.

6. The Rehabilitator's evidence established that policyholders will fare as well or better under the Second Amended Plan than they would in liquidation. The Plan will provide the benefits of rehabilitation, such as flexibility and the accelerated disposition of claims, which is preferable to the static procedures of liquidation.

7. The Rehabilitator is authorized under Article V to establish actuarially sound premium rates for SHIP policyholders, as needed to rehabilitate

SHIP, and without the additional approval of the state insurance department where the policy was initially issued.

8. The Rehabilitator did not abuse her discretion in formulating the Second Amended Plan.

VI. Conclusion

The Rehabilitator has made a compelling case in support of her Second Amended Plan of Rehabilitation. Indeed, her evidence was not contradicted on any material fact. The Intervening Regulators suggest that they would have exercised their discretion differently, but this is not a basis for the Court to disapprove the Plan.

The opposition of the Intervening Regulators is based upon their belief that the state-by-state regulation of premium rates must be the starting point of any plan to rehabilitate an insolvent insurer. The Court has several responses.

First, the standard for an appropriate premium rate is substantially the same in every state: the premium must be reasonable in relation to the coverage provided in the policy. The evidence presented at the hearing demonstrated that the premium rates used in the four options in Phase One of the Second Amended Plan will satisfy that standard. The Rehabilitator will be tasked with proving satisfaction of that standard in her actuarial memorandum. The Intervening Regulators presented no evidence that she cannot or will not be able to do so.

Second, the Issue State Rate Approval Option preserves the state-by-state procedure for those states that share the concerns of the Intervening Regulators. To the extent a state does not believe that the Rehabilitator, and this Court, should be solely responsible for the task of establishing the seriatim premiums used for the four policyholder options in Phase One, the state can assume responsibility to do so by opting out of this aspect of the Second Amended Plan.

Neither SHIP's policies nor state rate regulatory statutes insulate policyholders from paying a reasonable premium for their coverage. To the contrary, they require the opposite. The Second Amended Plan will advance, not undermine, a reasonable and non-discriminatory premium rate structure, which is the point of rate regulation.

Essentially, the Intervening Regulators exalt the process by which insurance premium rates are set over the rehabilitation of an insolvent insurer whose condition was caused by an inadequate and discriminatory premium structure. As was established by the Rehabilitator's evidence, a rehabilitation of SHIP cannot be accomplished by placing the correction of the company's premium rates into the hands of 46 states.

In all respects, the Second Amended Plan satisfies applicable constitutional requirements. Neither the Full Faith and Credit Clause nor principles of comity require this Court to apply the insurance rate regulatory laws of other states when considering a plan to rehabilitate SHIP, a Pennsylvania domiciled insurer in receivership. Nevertheless, the Seconded 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

Appendix B

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

O R D E R

AND NOW this 24th day of August, the Court hereby ORDERS as follows:

1. The Application for Approval of the Plan of Rehabilitation for Senior Health Insurance Company of Pennsylvania (SHIP) filed by Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as Statutory Rehabilitator of SHIP, is GRANTED. The Second Amended Plan of Rehabilitation, filed on May 3, 2021, is APPROVED, with the exception of Section VI.N of the Plan (relating to suspension of agent and broker commissions).

2. The Court defers resolution of the Joint Application for Approval of Settlement Agreement, filed by the Rehabilitator and Intervenors ACSIA Long Term Care, Inc., Global Commission Funding LLC, LifeCare Health Insurance Plans, Inc, Senior Commission Funding LLC, Senior Health Care Insurance Services, Ltd., LLP, and United Insurance Group Agency, Inc., pending a hearing to be scheduled by separate order. The Rehabilitator shall continue paying commissions until Phase One of the Second Amended Plan of Rehabilitation is implemented.

3. The Rehabilitator shall promptly submit an actuarial memorandum in support of the If Known Premium rates to be used in Phase One of the Second Amended Plan of Rehabilitation to the Pennsylvania Insurance Department for its review and approval.

4. The Rehabilitator, in her capacity as Insurance Commissioner, shall designate an appropriate deputy insurance commissioner to review the actuarial memorandum submitted to the Insurance Department. Thereafter, the Rehabilitator shall submit the approved actuarial memorandum to the Court.

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

Order Exit
08/25/2021

Appendix C

IN THE COMMONWEALTH OF PENNSYLVANIA

- - -

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

- - -

Friday, May 21, 2021

Day Five/Afternoon Session

Pages 976-1003

- - -

Proceeding in the above-captioned matter held before THE HONORABLE MARY HANNAH LEAVITT, at the Commonwealth Court of Pennsylvania, 601 Commonwealth Avenue, Harrisburg, Pennsylvania, commencing at 12:49 p.m., on the above date, by Melissa Bartman, RPR.

* * *

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insurers have nothing further for the record.

JUDGE LEAVITT: All right. Thank you.

The record is closed.

MR. BROADBENT: Thank you, Your Honor.

So at this time, Your Honor, the rehabilitator would respectfully apply to this Court for judgment in the nature of a directed verdict on the issue of the rehabilitator's right to effect policy modifications otherwise known as the issue state rate approval option.

It's the rehabilitator's view that the record and the evidence clearly and unambiguously supports judgment in the rehabilitators favor on that issue.

State insurance regulators are the only party which have raised it in this Court, and in their intervention papers, in fact, they sought no relief but in their prehearing memoranda they asked that the Court disapprove the plan. And one basis on one which they requested that disapproval was on this issue state of rate approval option.

But the fact remains, Your Honor, we've come to the end of this hearing and the state insurance regulators have failed to put on any evidence which would or could support an interest they purport to

represent with respect to the issues state rate approval option.

This Court directly asked Mr. Leslie to identify the interest of the regulators. And he first stated, quote, the plan affects policyholders across the United States not just in Pennsylvania, closed quote.

Now, I don't really understand, frankly, what basis Mr. Leslie or his clients would have for purporting to represent policyholders outside of their own states and, in fact, I would assume that many of those policyholders would object to the state insurance regulators of Maine, Massachusetts, and Washington purporting to speak for them.

But putting that aside, the Court went on to ask Mr. Leslie if they were here in a parens patriae capacity. And I believe Mr. Leslie said the regulators were not.

The Court further asked Mr. Leslie to identify the harm suffered by the state insurance regulators and he could not do so.

The Court further asked Mr. Leslie to identify whether the state insurance regulators believe that their authority was being usurped, and he did not say that it was. And we have the transcript if that would be helpful. But I will continue unless the Court

wants to see it.

Ultimately, in that exchange with the Court, Mr. Leslie did not in any way reference the issue state rate approval option. In fact, the issue identified as being most critical, in his words, were that the plan is a bad deal for policyholders and hurts policyholders all over the United States, and we want to be able to talk about that.

So the adverse effect of policyholders which may, in fact, be adverse effect on policyholders in the final but principally promises to be here. I think that was on page 534.

Mr. Leslie did raise the issue of whether the rehabilitator would argue that the plan was res judicata, which, of course, we will. But Mr. Leslie clarified his clients were here because they believed the plan was unconstitutional and unlawful, and bad for policyholders.

But, now, Your Honor, at the end of a week, the only testimony or evidence we've heard in that respect from the regulators came from Mr. Edwards who purported to do some mathematical calculations showing that on a net present value basis, certain policyholders had a greater net present value liquidation than rehab. But that may or may not be true depending on how you

look at his numbers. But that's not the -- well, frankly that's not the test in our view nor is it the only data on which the rehabilitator might rely.

But more importantly, Your Honor, none of that testimony went to whether the states and their regulators were harmed by the -- by the issue state rate approval option.

And there are four key points there I'd like to make, and I'll only need a few more minutes of the Court's time.

First, as to the rates themselves, there's been no testimony from any actuarial or regulatory witness that the -- if the new methodology proposed by the regulator violates any state statute or regulation in Maine, Massachusetts, or Washington. There's been no testimony that any premium which is tied to a lifetime loss ratio of 60 percent, as if knew does, would violate state laws of those states.

There's been no testimony from any regulatory witness that the state insurance regulators would disapprove of a new fee rate as the rehabilitator proposes to be done on a seriatim basis here.

And really they can't because there's no objection to that from a policyholder basis or from a regulator basis because the end result is that

individual policyholders pay an if knew premium. They don't pay on the basis of an average, which could result in some policyholders underpaying and some policyholders overpaying subsidized their coverage.

Second point is there's been no testimony from the regulators of those states, or any other state for that matter, that the state regulators reject the options themselves as unlawful.

And the regulators and their witnesses focused -- their witness, Mr. Edwards, focused on the impact of the options on policyholders as opposed to liquidation. But there's been no evidence showing that those options are illegal under those states' laws or that the regulators would not allow them.

Third, I've not heard testimony from any of the state insurance regulators that any policyholder whose premiums would otherwise be governed by Maine, Massachusetts, or Washington law suffered any harm. There's no policyholder from those states that's here in this Court to assert that he or she has no option that he or she wants them in the plan.

No policyholder has asserted that he or she would be harmed by the rehabilitator of this Court as opposed to the state insurance regulators of Maine, Massachusetts, and Washington reviewing and approving

the rates under an actuarially justified standard as Mr. Bodnar and Mr. Cantilo testified.

That's likely true, Your Honor, because no such policyholders would exist. There's no absolute or inviolate right of those policyholders to have the regulators of the issue state decide what their premiums should be either as a matter of statute or as a matter of the policy terms.

Finally, Your Honor, it's important for the rehabilitator to note that no witness has explained how the issue of the issue state rate approval opt-out process does not hand control to the regulators in the way that Mr. Cantilo has explained and as is set out in the plan.

In our view, absent any testimony as to the ways in which a regulator is constrained or harmed by that option, the regulators here have no argument to present which would show that it does not sufficiently address the concerns that they have raised at some earlier stake in these proceedings. Although it may be that they have abandoned those issues had they not raised them here in Court.

Now, I imagine Mr. Leslie will have something to say about this, and I'll just preemptively note that this is not a purely legal issue in the way he

may seek to suggest. Without actual evidence from the state insurance regulators on the impact of the plan with respect to their ability to regulate, and that is without factual testimony, showing the regulators could not control the rates or that the regulators would reject the options available to opt-out state policyholders, there's no basis for argument the plan is unlawful.

In closing, Your Honor, it's become clear to me over the last week that the intervener state insurance regulators are here as a resource. While they purport to be opponents of the plan, Mr. Leslie stated and this will be 530, page 530, of the transcript, the quote, we are not seeking to impose our views. All we can do is offer our views and the Court will decide what's best. On that issue, Mr. Leslie and I, in fact, agree.

So with the idea that the regulators are a resource to the rehabilitator in the Court, we thank them for their opinions. But we respectfully reject them. And we continue to seek approval of the plan.

And of course, the issue of the remaining questions under the plan and the rehabilitator's discretion will be taken up by the Court in its opinion.

At this time, Your Honor, we respectfully request that the Court enter judgment in the nature of a directed verdict on the issue of the issue state rate approval option, and deny that that issue could form a basis on which the plan may not be approved. Thank you.

JUDGE LEAVITT: Thank you. Mr. Leslie.

MR. LESLIE: Your Honor, you'll be unsurprised to know that I was -- of course, the first I've heard of this. Much like when I was about to begin my opening statement, I first heard the objection to our witness, notwithstanding the fact that we had identified that witness in our April filings including his exhibits. Notwithstanding that no objection had been raised at the prehearing conference. And obviously, that was a speaking motion, and I responded to it as best I could at the time.

I believe I preserved all of the legal arguments that we had raised in our briefs -- in our prehearing memoranda.

This has been an evidentiary hearing. There are important legal questions that have to be addressed that are foundational. This is a -- the rehabilitation plan proposed in this case is unique. Nothing like this has ever been done in the United

States with regard to a rehabilitation.

To take a $1.2 billion deficiency and address it as the rehabilitator proposes is extraordinary. It's unique. It's unusual for state regulators to object to other -- another state regulator's decision.

It's only because of the extraordinary nature of this, because of the precedential effect that it has, it matters. It matters nationally and it matters to my clients.

I appear here on behalf of them in their official capacity. I appear here on behalf of the attorneys general of Washington and Massachusetts in the furtherance of the public rights and interests of those regulators. And, honestly, I am shocked that the Pennsylvania Commissioner of Insurance would seek to prevent her sister commissioners from being heard on this issue of such critical significance.

So summing up on the legal issue, there are significant open legal issues. This case is not ripe to be decided on a directed verdict. Our witness testified directly to the question of constitutional compliance does this plan comply with the constitutional standard set forth in Neblett. It doesn't.

Our witness provided testimony and

raised the question of fact as to whether, in fact, using the very methodology that the rehabilitator chose to use in its comparison file, using that data provided by Oliver Wyman, offered by the rehabilitator to explain why the plan met the constitutional standard. He offered testimony as to how it didn't.

He offered testimony as to why option two does not afford guarantee association benefits. He offered testimony as to why those options as they play out, particularly option four, are an illusion.

And that illusion is particularly true in the case of Mr. Cantilo's testimony that this rehabilitation plan is most likely not going to solve the insolvency of SHIP. Those are factual questions and it's appropriate for those factual questions to be addressed with the findings of fact and conclusions of law that the Court expects from the parties who have been granted intervention in this case, including us.

These are questions the Court should consider, these are questions that the Court should consider after briefing, and a directed verdict, Your Honor, is not justified under these circumstances.

JUDGE LEAVITT: Thank you. Just to clarify, Mr. Leslie, Mr. Edwards was not qualified as an expert, correct?

MR. LESLIE: No, he was called as a fact witness, Your Honor.

JUDGE LEAVITT: All right.

MR. BROADBENT: Your Honor, may I take just two minutes?

JUDGE LEAVITT: Yes.

MR. BROADBENT: It seems Mr. Leslie is confused about what I'm doing.

To be clear, we're only seeking the directed verdict on the issue state rate approval option 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 plan is fair and equitable or the exercise of the rehabilitator's discretion generally.

This is a narrow motion, Your Honor, on the issue state rate approval option and the opt-out offer thereunder.

The only other two items to raise -- and frankly, Your Honor, Mr. Edwards didn't testify to that and Mr. Leslie didn't identify any.

Two final points. Mr. Leslie mentioned attorneys general. I think he misspoke. But that may be worth clarifying because the attorneys general are

not parties here in this proceeding.

And second, ultimately, Your Honor, the question is this, if there is no harm to the state regulators, how can there be relief that is offered to them and how can they have an objection?

And that's, again, focused on that narrow issue of the issue state rate approval option rather than the entire plan. I just want to make sure that was clear in terms of what we were seeking.

Thank you.

JUDGE LEAVITT: Mr. Leslie?

MR. LESLIE: The rate review and approval question is a legal question. It's not a factual question. And it's an open question because it hasn't been fully briefed. So this is a legal question and not addressing it with factual testimony during this hearing doesn't mean that that legal question is waived, Your Honor.

It's a legal question the Court needs to address as part of its ruling on the proposed plan. That's what I have to say on that, Your Honor. Thank you.

JUDGE LEAVITT: Do you believe that you preserved the issue notwithstanding the fact that you informed the Court that that was not why you were

presenting evidence?

MR. LESLIE: Your Honor, I was explaining why Mr. Edward's testimony was being offered.

JUDGE LEAVITT: No.

MR. LESLIE: At the time.

JUDGE LEAVITT: Well --

MR. LESLIE: And the Court asked me a number of questions about our issues.

JUDGE LEAVITT: Well, because we had an objection to Mr. Edwards.

MR. LESLIE: Yes, and I responded to those questions, Your Honor, by saying all of the legal questions that were -- that were addressed in our memoranda were on the table.

JUDGE LEAVITT: And so --

MR. LESLIE: And the question of approval of rates is a legal question, and it's still on the table.

Your Honor, I also think it's extremely unfair to take a highly technical view of what is said in response to a speaking motion that was never discussed in advance and to use that in a way to try to preclude government officials from being heard on the question.

This is an important point. And it's a

legal point. And I don't think it's fair, Your Honor, to parse through those words said without any advanced notice, without any opportunity to consider the issue. And I did the very best, I think appropriately, to preserve those issues through that colloquy I had with you, Your Honor.

JUDGE LEAVITT: Yes, the question is -- well, nevertheless, there is an opt-out option that preserves the right of the issue -- state of issue to pursue a state rate approval powers and your witness did not address why the plan was deficient in some way on that -- in that way.

MR. LESLIE: Your Honor, we addressed the issue of state rate, the opt-out in our prehearing memoranda.

It's a legal question. It's not a factual question. It's a question of the interpretation of that language. That opt-out language by the language itself, it's a legal question, provides meaningless, meaningless benefits to state regulators.

Mr. Cantilo himself testified as to the consequences of opt-out and how it will, in fact, benefit the estate by reducing the amount of assets -- of liabilities otherwise available should any regulator choose to follow that opt-out.

There's a factual record based on the testimony offered by the rehabilitator in this case on that question and it can be looked at within the context of the legal question in interpreting that provision.

It is primarily a legal question. It should be reserved and dealt with in the briefing. It is not a question that we -- we certainly did not waive it. There are many other provisions of the plan we did not address during this evidentiary hearing.

This was not a hearing to deal with the legal questions. Your Honor will recall that I had proposed that we deal with the legal questions first. The Court preferred to deal with the factual questions. We understood that, and we played within the ground rules that were established for that purpose.

This hearing was a hearing on factual and evidentiary issues. It's now closed. This is a legal question. And it's been preserved and it should be able to be addressed as part of the briefing.

JUDGE LEAVITT: All right. Thank you.

MR. LESLIE: Thank you.

JUDGE LEAVITT: The Court is going to grant the motion. Mr. Leslie, on behalf of your clients, you may make your case in your post-hearing filing on why the Court should reconsider that motion

grant.

Anything else, Mr. Broadbent?

MR. BROADBENT: One item not yet on Your Honor's to-do list would be just to remind the Court because we did hear some testimony from the policyholder witnesses today with regard to the restructuring application, I just wanted to make sure it was clear that the rehabilitator intended to file an application addressed to the restructuring issues.

There was some confusion, I think inaccurate and misunderstandings on the policyholders. But when we file the application for restructuring, which I know Your Honor understands what's involved there, we will file an application and will, in part, explain that issue more broadly to everybody.

JUDGE LEAVITT: And that will be an amended -- amendment to the second amended plan?

MR. BROADBENT: No, it's a second application. We had hoped to have it done. Perhaps part of the plan, we will file a separate application to address the restructuring issue.

JUDGE LEAVITT: All right.

MR. BROADBENT: And finally, Your Honor, although I'd be happy to allow Your Honor to be the one to drive this conversation, yesterday, Your Honor, you

Appendix D

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

ORDER

AND NOW this 25th day of August, 2021, Intervenor State Insurance Regulators' Application to Reconsider Order Granting the Rehabilitator's Oral Motion Regarding Issue State Rate Approval Option is DENIED for the reasons set forth in the Court's Memorandum Opinion and Order filed August 24, 2021.

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

Order Exit
08/25/2021

Received 9/21/2021 5:40:39 PM Commonwealth Court of Pennsylvania

Filed 9/21/2021 5:40:39 PM Commonwealth Court of Pennsylvania
1 SHP 2020

PROOF OF SERVICE

I, Stephen G. Harvey, hereby certify that on September 21, 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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EXHIBIT 7

Filed 10/1/2021 11:16:00 AM Commonwealth Court of Pennsylvania
1 SHP 2020

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

STATE INSURANCE REGULATORS' APPLICATION FOR STAY PENDING APPEAL

Pursuant to Pa. R.A.P. 123 and 1732(a), 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 ("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 Intervenors' 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.

Praecipe 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 CASED 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 <u>permanently</u> 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 follows, 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* Praecipe 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 reversable 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* Praecipe 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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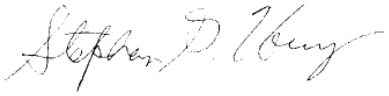
PUBLIC ACCESS POLICY CERTIFICATE OF COMPLIANCE

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.

Respectfully submitted,



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Received 10/1/2021 11:16:04 AM Commonwealth Court of Pennsylvania

Exhibit A

Filed 10/1/2021 11:16:00 AM Commonwealth Court of Pennsylvania
1 SHP 2020

From: [redacted]
Sent: Monday, September 20, 2021 10:57 AM
To: [redacted]
Subject: NAIC: Commissioners and Receivership Contacts regarding SHIP

CAUTION: This email originated from a sender outside of the Commonwealth of Massachusetts mail system. Do not click on links or open attachments unless you recognize the sender and know the content is safe.

On behalf of the Pennsylvania Insurance Department, this message is delivered to the Commissioners & Assistants distribution list.

Good morning.
We have received questions concerning the timing of the SHIP Rehabilitation. States will have at least until November 15, 2021 to decide about the opt-out provision of the SHIP Rehabilitation Plan. A letter is coming in the next few weeks explaining the opt-out procedure, including a robust Frequently Asked Questions document for your use in making a decision. Additionally, we remain available to answer any of your questions at any time. You may reach out to me at: [redacted] or [redacted] with questions or to set up a call. We will send further communication regarding the timeline as soon as it is available. However, you will not need to make a decision on opt-out prior to November 15 in any circumstance.

Warm regards,
Laura

Laura Lyon Slaymaker, Esquire| Deputy Insurance Commissioner
Pennsylvania Insurance Department | Office of Liquidations, Rehabilitations and Special Funds
Capitol Associates Building | 901 N. 7th Street Harrisburg PA 17102
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Received 10/1/2021 11:16:04 AM Commonwealth Court of Pennsylvania

Exhibit B

Filed 10/1/2021 11:16:00 AM Commonwealth Court of Pennsylvania
1 SHP 2020

pennsylvania
INSURANCE DEPARTMENT

August 26, 2021

Via E-Mail

Re: Senior Health Insurance Company of Pennsylvania, In Rehabilitation

Dear Commissioner,

As you know, we have sent you several communications in addition to the numerous conversations we have had regarding the Rehabilitation proceeding for Senior Health Insurance Company of Pennsylvania (SHIP). In October 2020, and again in March of this year, we wrote you about our inclusion in the Proposed Rehabilitation Plan of a new "Issue-state Rate Approval" section that would permit states to opt out of the Plan's premium rate approval process. Most recently we wrote to notify you that on May 3, 2021, we filed the Second Amended Rehabilitation Plan just before the hearing on the Plan commenced in the Commonwealth Court of Pennsylvania (the Court) on May 17, 2021. That amendment remains available on SHIP's website, www.shipltc.com.

I write you now to advise you that, on August 25, 2021, the Court entered its Order Approving the Rehabilitation Plan (Approval Order), which, subject to certain specified modifications, approved the Second Amended Rehabilitation Plan (the "Approved Plan"). The Approval Order is also available on SHIP's website. The issue-state rate approval section remains in the Approved Plan, unchanged from the Second Amended Rehabilitation Plan.

As provided in that section, in the next few weeks we expect to send you formal notice of each state's opportunity to opt out of the rate approval provisions of the Approved Plan. That notice will advise you of the "Opt-out Deadline" and the precise method by which you must advise the Rehabilitator if you elect to opt out of the rate approval provisions of the Approved Plan with respect to the SHIP long-term care (LTC) insurance policies issued in your state. States that do not properly elect to opt-out by the Opt-out Deadline will be deemed to have opted into that section of the Approved Plan.

We believe strongly that the Approved Plan, including its premium rate adjustment provisions, is reasonable and fair and is in the best interest of SHIP LTC policyholders. As you are probably aware, the Approved Plan is the product of extensive analysis and actuarial modeling and of careful thought and balancing of difficult competing interests. It is our view that opting out of the rate approval provisions of the Approved Plan may not be in the best interest of the affected policyholders. We encourage every Commissioner, Director, or Superintendent to evaluate

this matter carefully, including the possible disadvantages of opting out. This matter is discussed at length in Section V. beginning at page 108 of the Approved Plan.

We thought it would be helpful to give you advance notice that you will soon be required to make that decision. Of course, you will not need to do anything if you do not wish to opt out of the rate approval provisions of the Approved Plan. We would be happy to discuss this matter with you in more detail if that would be of value. To do that, please send an email to Deputy Commissioner Laura Lyon Slaymaker at [redacted]. Moreover, we can provide you an updated seriatim file for LTC policies issued in your state with the projected if knew premium. Please let Special Deputy Rehabilitator Patrick Cantilo [redacted] know if you would like such a file.

In closing, let me confirm that I am very pleased that the Commonwealth Court has approved the rehabilitation plan. Arriving at the Plan was a challenging process that required many difficult decisions. This Plan represents what we and our team of experts think is the best solution to a problem that is not likely to go away soon. I am extremely grateful for all the support that we have received from so many of you and your staff along the way.

With warm regards,

Jessica K. Altman
Pennsylvania Insurance Commissioner

Received 10/1/2021 11:16:04 AM Commonwealth Court of Pennsylvania

Filed 10/1/2021 11:16:00 AM Commonwealth Court of Pennsylvania
1 SHP 2020

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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EXHIBIT 8

Filed 11/8/2021 12:14:00 PM Supreme Court Middle District
71 MAP 2021

IN THE
SUPREME COURT OF PENNSYLVANIA

IN RE: SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)	**:**	**No. 71 MAP 2021**

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

STATE INSURANCE REGULATORS' APPLICATION FOR STAY PENDING APPEAL

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Pursuant to Pa. R.A.P. 123 and 1732(a), the Appellants/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 ("State Insurance Regulators"), hereby move for a stay pending appeal of the trial court's 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") for SHIP, as well as the related 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 of that ruling (the "Orders").

The Orders approve the Plan and overrule objections to the Plan. The State Insurance Regulators filed their appeal from the Orders on September 21, 2021.

The Orders and the Memorandum Opinion re Application for Approval of the Plan of Rehabilitation for SHIP issued by the single Judge of the Commonwealth Court (the "Court" or "trial court")[1] are attached to the State Insurance Regulators' Jurisdictional Statement filed September 21, 2021.

[1] The Commonwealth Court has original jurisdiction of proceedings for the rehabilitation or liquidation of insurance companies under 42 Pa. C.S. § 761(a)(3).

Background

1. Application to the Trial Court for Stay Pending Appeal

As required by Pa. R.A.P. 1732(a), the State Insurance Regulators applied for a stay pending appeal in the first instance from the trial court. The State Insurance Regulators filed their Application for Stay Pending Appeal with the Court on October 1, 2021. The Rehabilitator filed her opposition on October 15, 2021, as did the Intervenor Health Insurers.

On November 2, 2021, the State Insurance Regulators filed an Application for Expedited Ruling on Application for Stay Pending Appeal in light of the upcoming November 15, 2021 "opt-out" deadline.

On November 4, 2021, the trial court issued a Memorandum Opinion and Order denying the State Insurance Regulator's Application for Stay ("Stay Op."). Also on November 4, 2021, the Court issued an Amendment Order amending the August 24, 2021 Memorandum Opinion and an Order designating the amended Memorandum Opinion as an Opinion ("Op.") for publication.

The Appendix to the State Insurance Regulators' Application to Stay Pending Appeal ("SIR Appendix" or "SIR App.") filed herewith includes (1) the State Insurance Regulators' Application for Stay Pending Appeal (SIR App. 314), (2) the Rehabilitator's Opposition (SIR App. 351), (3) the Health Insurers' Response (SIR App. 394), (4) the Application for Expedited Ruling (SIR App.

428), (5) the Memorandum Opinion and Order denying the Application for Stay (SIR App. 433), and (6) the November 4, 2021 Opinion (SIR App. 446).

2. Overview

This appeal 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 own comparison analysis, the policyholders would only bear a loss of $400 million, as insurance guaranty associations would provide over $800 million of additional support. The Plan also supersedes the authority of insurance regulators in States other than Pennsylvania to review rates for policies issued in their States.

The Court approved the Plan over the objections of the Intervenor State Insurance Regulators. It disagreed with the Intervenors' 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 (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 present several fundamental issues. First, they 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. Second, 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. Third, 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.[2]

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 may permanently reduce the contract rights of policyholders so that they will have less protection from insurance guaranty associations when SHIP is inevitably

[2] 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.

liquidated. It will also require insurance regulators to decide whether to "opt-out" of the Plan to the detriment of policyholders in their States.

3. Schedule for Implementation of the Plan

The Rehabilitator is now moving to implement the Plan, which involves three basic steps. First, state insurance regulators must make so-called "opt out" decisions concerning whether the Rehabilitator should apply for approval of rates in their states (subject to the restrictions, limitations and consequences imposed by the Plan). The Rehabilitator has established a November 15, 2021 deadline for state insurance regulators to make these so-called "opt-out" decisions. *See* the Special Deputy Rehabilitator's letter of September 30, 2021 (SIR App. 9). Second, the Rehabilitator is to send election packages to SHIP's policyholders so they may make elections regarding permanent "adjustments" (benefit cuts and premium increases) to their policies under the Plan. The election packages are to be sent out around year-end 2021. Third, the Rehabilitator will make the adjustments effective in April 2022. As the Rehabilitator has advised:

> 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.

Notice of Filing of Approved Plan, Ex. A, p. 19 (Sept. 24, 2021) (SIR App. 7).[3]

Standard for Stay Pending Appeal

> 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)).

SUMMARY OF ARGUMENT

The State Insurance Regulators have a compelling 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

[3] Exhibit A to the Notice is the Approved Plan of Rehabilitation as substituted in accordance with the Court's Order of October 28, 2021 regarding the Praecipe to Substitute Approved Plan of Rehabilitation (September 30, 2021). The Approved Plan is the Second Amended Plan (Ex. RP-55). *See* SIR App. 28, 531.

exceeds statutory authority and violates the Full Faith and Credit Clause in superseding the regulatory authority of other States over rates. The State Insurance Regulators are properly present here to protect the interests of elderly policyholders, who relied on SHIP insurance policies to protect them in the last stages of their lives, against a plan that seeks to unnecessarily cut their benefits and exclude state insurance regulators.

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 that were correct, 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.

The interests of policyholders should be the central concern, and it would be a potentially disastrous result for policyholders for the Plan to be implemented and evade appellate review. The Plan requires policyholders to absorb $800 million in losses that should be borne by insurance guaranty associations because the Rehabilitator and trial court concluded in hindsight that the policies were underpriced and then chose not to trigger the guaranty associations. The Plan fails

to satisfy the constitutional requirement that policyholders be treated at least as well in rehabilitation as in liquidation.

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 by the settlement approved by the Court on 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.

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 contends 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. 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.

Facts Relied Upon

This appeal arises from the Rehabilitator's application for approval of a plan of rehabilitation for SHIP. The Second Amended Plan of Rehabilitation (the "Plan", Ex. RP-55) provides an overview. Ex. RP-55 at 81-82, 86-87 (SIR App. 108-109, 113-114). *See also* Op. at 2-5. In brief, SHIP wrote long term care ("LTC") insurance policies. It stopped writing policies in 2003 and has been in run-off paying claims since that time. Its remaining policyholders have an average age of 86, and the policyholders on claim have an average age of 89. SHIP is insolvent. It was placed in rehabilitation proceedings and the Pennsylvania Insurance Commissioner was appointed Rehabilitator on January 29, 2020.

On April 22, 2020, the Rehabilitator applied for approval of a plan of rehabilitation. The Court issued a case management order regarding the application. In accordance with that order, the State Insurance Regulators applied to intervene in the proceedings concerning the proposed plan by application filed July 31, 2020 and joinder filed September 15, 2020 (SIR App. 534, 555). The Court allowed the State Insurance Regulators to intervene by orders entered September 15 and 18, 2020 (SIR App. 568, 569).

A hearing on the Plan was held on May 17-21, 2021. After post-hearing briefing, the Court issued its Memorandum Opinion and approved the Plan in the Orders on August 24 and 25, 2021.

While the matter is complex, the essential facts are as follows.

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 (SIR App. 271-273, 275).

2. SHIP is insolvent, with a deficit or "funding gap" of approximately $1.2 billion. Ex. RP-55 (the Plan) at 87 (SIR App. 114). *See* Op. 13 (referring to "SHIP's insolvency").

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 (SIR App. 277-279; 129-130). The Plan seeks to reduce the funding gap by reducing policy benefits and increasing premiums. Ex. RP-55 at 10, 102-103 (SIR App. 37, 129-130).

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 (SIR App. 50-51; 244-245). Policyholders who choose Option 4 in Phase One face the possibility of additional substantial rate increases or benefit reductions in Phase Two. Ex. RP-55 at 15 ("[P]olicyholders selecting

Option Four would face the possibility of additional substantial rate increases or benefit reductions in Phase Two of the Plan."), 58 (SIR App. 42, 85).

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 (SIR App. 120).

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 (SIR App. 224; 304). 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 (SIR App. 224; 310-311). 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. (SIR App. 119).[4]

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

[4] The State Insurance Regulators' exhibits were admitted into evidence at the hearing (Tr. 550-553) (SIR App. 300-303), and the Court summarized the testimony of Frank Edwards on these points (Tr. 560-566) (SIR App. 305-311) in its opinion. Op. 31.

will apply will be the policies as modified as a result of the elections. Ex. RP-55 at 14, 92; Tr. 300-301, 313 (SIR App. 41, 119; 282-283, 286). As stated in the Plan:

> Policyholder Elections under the Plan will be permanent. This means that if the Plan does not succeed in rehabilitating SHIP fully and the Company has to be placed in liquidation, the policies to which guaranty association coverage and limits . . . will apply will be those as modified as a result of the Policyholder Elections.

Ex. RP-55 at 14 (SIR App. 41).

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 (SIR App. 237, 284). In all likelihood, the Plan will not eliminate the deficit, just reduce it materially. Tr. 189-190 (SIR App. 266-267).

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 – the "Carpenter value") 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 (SIR App. 226; 262, 264, 296, 298). This 85% rests principally on Option 4. Tr. 510, 512-513, 572; Ex. SIR 5-2 (SIR App. 296, 298-299, 313; 225). 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 (SIR App. 274, 299; 41).

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 (SIR App. 249, 251). Each state has its own approach to reviewing rates. Tr. 413-414 (SIR App. 290-291). The Plan does not follow this issue state rate approval process. Ex. RP-55 at 33-34, 96; Tr. 158-159 (SIR App. 60-61, 123; 252-253). It removes state insurance regulators from their role in reviewing rates, which is "unprecedented." Ex. RP-55 at 33-34; Tr. 82 (SIR App. 60-61; 239). 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 (SIR App. 60-61, 123).

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 (SIR App. 135). 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 (SIR App. 138). 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 (SIR App. 136, 143; 257-258). *See* Special Deputy Liquidator's September 30, 2021 Letter at Frequently Asked Questions Response

"Q9" (opting out "is generally expected to be disadvantageous to affected policyholders") (SIR App. 16).

ARGUMENT

I. THE STATE INSURANCE REGULATORS HAVE A COMPELLING 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).

As an initial matter, the State Insurance Regulator may properly raise policyholder interests. In its ruling, the Court held that the State Insurance Regulators lack standing to "assert claims" on behalf of policyholders, adding that it granted limited intervention based on their interests as regulators, not as representatives for policyholders. Stay Op. at 4-5. This cramped view disregards the essential purpose of our nation's state-based insurance regulatory system and its regulators – to protect policyholders.

The State Insurance Regulators are public officials seeking to protect policyholders in furtherance of their public responsibilities. They are long-serving chief insurance regulators, one the longest serving in the United States and another being a past president of the National Association of Insurance Commissioners, and do not take this step lightly. They are not asserting "claims" for policyholders but contending in their regulatory capacity that the Plan unlawfully impairs policyholder interests. As stated in the applications to intervene, the State Insurance Regulators are charged with enforcing state insurance laws and regulating insurers,[5] and they have "a regulatory interest in seeing that contract rights of [the State's] policyholders are respected and that the standards and protections of the statutory rate-setting process are honored." Joint Application for Intervention of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance at 11 ((July 31, 2020) (emphasis added); Joinder of the Washington Insurance Commissioner at 6 (Sept. 15, 2020) (SIR App. 544, 560).

The Court's Orders of September 15 and 18, 2021 granting intervention did not limit the interests the State Insurance Regulators could protect or restrict them to addressing rate review. The State Insurance Regulators sought intervention "for the limited purpose of participating in the proceedings concerning and potentially

[5] *See, e.g.,* 24-A Me. Rev. Stat. § 211; Mass. G.L. c. 175, § 3A; Wash. Rev. Code §§ 48.01.020, 48.02.060.

opposing" the Rehabilitator's Application for Approval of the Plan. Joint Application at 14; Washington Joinder at 8 (SIR App. 547, 562).[6] The Court granted that intervention without qualification (SIR App. 568, 569).

The Court's erroneous reliance on standing serves to prevent this Court's scrutiny of the impact of the Plan on policyholders. It avoids discussion of the undisputed facts that (1) in a present liquidation the guaranty associations would provide over $800 million in support of policy benefits, so that the burden of SHIP's insolvency on its very elderly policyholders would be about $400 million, while under the Plan those policyholders will bear the full $1.2 billion deficit; and (2) the policyholder elections under the Plan are permanent so that policyholder recoveries from guaranty associations in the future liquidation will be limited to the reduced benefits instead of the benefits under the original policies.

These core issues should have been addressed squarely given the Court's supervisory role. This is not private party litigation but a proceeding pursuant to statute for rehabilitation of an insurer with a Plan that will affect the rights of thousands of policyholders across the country. "[T]o warrant the Commonwealth Court's imprimatur," a rehabilitation plan must be found to be free from any abuse of the Rehabilitator's discretion. *Mutual Fire II*, 614 A.2d at 1091. This means

[6] The applications sought "limited" intervention because the State Insurance Regulators did not seek to intervene in the rehabilitation proceeding generally but only as to the application for approval of the proposed plan of rehabilitation.

that the Plan must not violate statutory or constitutional requirements. If, as the State Insurance Regulators contend, the Plan is based on an error of law, it constitutes an abuse of that discretion. *See Taylor*, 230 A.3d at 1072; *Bedford Downs Mgt. Corp. v. State Harness Racing Com'n*, 926 A.2d 908, 916 (Pa. 2007). The issues raised by the State Insurance Regulators in their official capacities were properly before the Court, worthy of consideration, and are now ripe for appellate review.

A. The Court Erred In Holding That There Is No Feasibility Requirement And That The Plan Was Feasible In The Absence of Evidence It Is Likely 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) (SIR App. 22-23). At the hearing, however, the Special Deputy Rehabilitator conceded that "it is not likely that we will magically restore SHIP to solvency." Tr. 80 (SIR App. 237). The Court seemed to acknowledge this (Op. 14, 24-25), but it later said that the Plan "will reduce or eliminate" the funding gap (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 (SIR App. 267). 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 (SIR App. 284). As the Court implicitly acknowledged, the most that can be said is that the Plan will "materially reduce" the funding gap. *See* Op. 66-67.[7] That the Plan may be intended or designed to eliminate the funding gap is irrelevant. Where the Plan is expected only to materially reduce the funding gap, it is not feasible, as 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 actually likely to do so.

[7] The Court asserted that the State Insurance Regulators did not offer evidence on this point (Stay Op. at 5), suggesting they were obligated to present a witness. That is incorrect. The Special Deputy Rehabilitator testified on direct examination and the State Insurance Regulators elicited clarifying testimony on cross as described above. The record is clear that the Plan is not expected to restore SHIP to solvency.

Feasibility is a well-recognized requirement. *See* 1 *Couch on Ins. 3d* § 5:24 (2021) ("Above all, the rehabilitation plan must be feasible . . . ."). Contrary to the Opinion (Op. 65), feasibility has been recognized as a requirement in Pennsylvania. *See Sheppard v. Old Heritage Mut. Ins. Co.*, 425 A.2d 304, 310 (Pa. 1980) ("It is clear that [the company] has the burden of showing that rehabilitation is feasible.") (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 (SIR App. 241). 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 (SIR App. 41, 119). 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.

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

The Court refashioned feasibility, holding that it means "properly conserving and equitably administering the assets of the involved insurer." Op. 66. This deprives feasibility of any meaning. The quoted language from *Mutual Fire II* did not describe the purpose of rehabilitation but only that a plan need not restore the insurer "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.[8]

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

[8] 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.

likely to avoid liquidation, and not just serve as a means to reduce policyholders' contract rights on the way to liquidation.

B. The Plan 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 theory that the policies were historically "underpriced." 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, taxpayers. Op. 45, 63, 81. The Court also relied on its view that the state-based rate approval system resulted in "discriminatory" rates contrary to the public good. Op. 45, 68-69, 80-81.

The Court's approval of the Plan on these policy grounds 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)). Contrary to the Court's assertion that this is a question of discretion (Stay Op. 6), it is a matter of law. The Court improperly disregarded the statutory mandates to advance its policy views at the expense of policyholders.

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. Ex. SIR-5-1; Tr. 564-566 (SIR App. 224; 309-310). While the Court acknowledged this (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. 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. Intentionally Placing the Burden of Insolvency Solely 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* Op. 42-44 (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 that 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 *Grode v. Mutual Fire, Marine and Inland Ins. Co.*, 572 A.2d 798, 807 (Pa. Commw. 1990) ("*Mutual Fire I*") (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 (SIR App. 235, 242). This may leave SHIP as an entity in "better shape" (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. Op. 43, 45, 63, 81. This rationale is legally erroneous. The Court's view that it "serves the public good" (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 have been established around the country to protect policyholders by fulfilling the insolvent insurer's contractual obligations (subject to statutory limits). For instance, the Pennsylvania guaranty association 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. *See Pennsylvania Life and Health Ins. Guar. Assn. v. Pennsylvania Ins. Dept.*, 218 A.3d 9, 14 (Pa. Commw. Ct. 2019); *cf. Illinois Ins.*

Guar. Fund v. Reliance Ins. Co. in Liquidation, 88 A.3d 313, 317 (Pa. Commw. Ct. 2014) (referring to "the primary policy objective of the [property/casualty guaranty association] Act to protect innocent policyholders whose insurance carriers have become insolvent"). 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 Court's opinion (Op. 62-64), this fundamental standard was recognized by the Supreme Court in *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").[9]

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

[9] The Commonwealth Court 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*.

EXHIBIT 1

(PART 3)

Supreme Court in *Mutual Fire II* did not replace the *Neblett* standard with the three-part test of *Energy Reserves Grp., Inc. v. Kansas 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 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. 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 in Phase Two, and that premium increases alone can bring the percentage of policyholders with net present value in excess of liquidation value below 50%. 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. Op. 65. This does not comport with *Neblett*. The United States Supreme Court there 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 expected value of a policyholder's claim at the time of the breach, which is the policy's net present value, not its policy limit. As stated in a leading treatise:

> The measure of damages adopted must be that which will, as nearly as possible, put the policyholders in as good a financial position as they would have been in if there had been no breach, which has been calculated as the present value of the benefits that would have been payable if there had been no insolvency, less the present value of the gross premiums which would have become payable upon the policies.

1 *Couch on Ins. 3d* § 6:1 (2021) (footnotes omitted) (citing *Commissioner of Ins. v. Massachusetts Acc. Co.*, 50 N.E.2d 801, 808-809 (Mass. 1943)).

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) (SIR App. 153). It is an "outer boundary" (Tr. 468) (SIR App. 293) that does not consider the likely amount (projected value) of a claim or the cost (projected premiums) of the policy. RP-55 at 126 (SIR App. 153). Maximum policy value is not an 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 Rehabilitator's authority under 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.[10]

This presents an important question of first impression. The Rehabilitator acknowledges that this aspect of the Plan is "unprecedented," Tr. 82 (SIR App. 239), and the State Insurance Regulators are not aware of any plan of rehabilitation that has purported to supersede state regulation and set rates payable by

[10] Contrary to the Court's assertion (Stay Op. at 7), the statutory basis for state rate regulation was cited in the State Insurance Regulators' Application at 23 (SIR App. 336).

policyholders in other states without review and approval by the insurance regulators of those states.

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

The Court's expansive view of the Rehabilitator's powers (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.[11]

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" (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

[11] 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).

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 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 States' Regulation Over Rates.

Finally, the State Insurance Regulators have compelling arguments that the Court's ruling concerning the Full Faith and Credit Clause is erroneous. 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 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. *See* page 31 above. 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" (Op. 58), and the Court's assertion that the rate setting statutes are all essentially alike (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 (SIR App. 115; 290-291). *See* Op. 14, 28. A Pennsylvania court cannot dictate to other States what rates are to be applied to policies issued in those States, nor can it require that they "surrender[]" (Tr. 169) (SIR App. 257) their authority and substitute itself (or the Pennsylvania Commissioner) for the officials designated to review rates.

The Court's decision reflects hostility to state-based rate setting and the different rates that may result from it. *See* 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 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. Op. 61-62. 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 (SIR App. 138; 287-291). 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" (Op. 58). This disregards the evidence. The Plan itself acknowledges that the options are likely to be worse, Ex. RP-55 at 109 (SIR App. 136), and the Special Deputy Rehabilitator testified that "[i]n terms of policyholders, we think that [states opting out] will be harmful." Tr. 170 (SIR

App. 258).[12] 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 (SIR App. 20). *See also* Special Deputy Rehabilitator's Letter to Commissioners dated September 30, 2021 at 6 (Q1), 7-8 (Q8, Q9) (SIR App. 14, 15-16).

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, REGULATORS AND POLICYHOLDERS WILL SUFFER IRREPARABLE INJURY.

The Rehabilitator is moving to implement the Plan. *See* Notice of Filing of Approved Plan, Ex. A at 19; Special Deputy Rehabilitator's September 30 Letter (SIR App. 7; 9). This is likely to irreparably harm both policyholders and regulators because they will be forced to make decisions that may not be reversable even if the Court's decision is reversed. (The Court's narrow focus on the State Insurance Regulators, *see* Stay Op. 8, allowed it to avoid addressing the impact of the Plan and the denial of a stay on policyholders. This is anomalous.

[12] The Court asserts that the State Insurance Regulators did not offer evidence concerning the "opt out" provision (Stay Op. 8), implicitly suggesting that the State Insurance Regulators were obligated to call a witness. That is incorrect. As discussed above, the Plan and the testimony (direct and cross) of the Rehabilitator's witnesses provides all the necessary evidentiary record for the State Insurance Regulators' position.

Policyholders should be the central consideration in rehabilitation plan proceedings.)

First, most imminently, state insurance regulators face the November 15, 2021 "opt-out" deadline. By that date, the State Insurance Regulators and other regulators across the country will be required to decide whether or not to "opt-out" of the Plan's rate approval provision. 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 (SIR App. 136-137).

This requires insurance regulators to decide whether to nominally retain the appearance of rate review under their states' laws at the expense of policyholders in the State. As noted above, if an "opt-out" regulator does anything other than approve the Rehabilitator's rate proposal in full within 60 days (*see* Ex. RP-55 at 111) (SIR App. 138), the policyholders in the State will be disadvantaged by being left with options that are worse than those available in other states. This is spelled out in the Plan (Ex. RP-55 at 109) (SIR App. 136) and in the Frequently Asked Questions attachment to the Special Deputy Rehabilitator's September 30, 2021 Letter at 6, 7-8 (SIR App. 14, 15-16).[13]

[13] FAQ Responses "Q1" and "Q8" note that "opt-out policyholders" in opt-out states will not have the same options as "opt-in policyholders" in that three options will not be available to them. Response "Q1" notes that in certain circumstances, opt-out policyholders may end up paying a higher premium than they would if the state had not opted out. Response "Q9" states

The Plan thus requires insurance regulators to act on behalf of the policyholders whose policies were issued in their states. It positions regulators to either acquiesce in the Rehabilitator's and Court's usurpation of their role in reviewing rates or to approve the rates in full within sixty days on pain of placing policyholders in their states in a worse position than policyholders in other states.

Second, starting around year-end 2021 and through March 2022, 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 (SIR App. 41, 119). This reduces their rights not only against SHIP but also against guaranty associations. As stated in the Plan:

> Policyholder Elections under the Plan will be permanent. This means that if the Plan does not succeed in rehabilitating SHIP fully and the Company has to be placed in liquidation, the policies to which guaranty association coverage and limits . . . will apply will be those as modified as a result of the Policyholder Elections.

Ex. RP-55 at 14 (SIR App. 41). Options 1 through 3 under the Plan reduce policy benefits, so policyholders who elect those options will be placed in a worse position in the event SHIP is liquidated after Phase One. As discussed above in connection with feasibility, it appears that liquidation is inevitable.

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that opting out "is generally expected to be disadvantageous to affected policyholders." (Emphasis added).

The Rehabilitator has contended that the $800 million in guaranty association support will still be available if SHIP is liquidated after the Plan is implemented. This is erroneous. The $800 million in guaranty association support is calculated based on the existing SHIP policy obligations. If those obligations are reduced by policyholders selecting options under the Plan, then the contribution of guaranty associations in a liquidation will also be reduced. Policyholder elections that reduce policyholders' contract benefits reduce their rights as against SHIP and also against guaranty associations in the liquidation that will inevitably follow, potentially by hundreds of millions of dollars.

Thus, absent a stay, the Plan will impair the contract rights of the 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 be "effective" sometime around April 2022, at which point the policyholders will begin receiving reduced benefits and paying revised premiums in accordance with the Plan. *See* Notice of Approved Plan, Ex. A at 19 (SIR App. 7).

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 the

policyholders and regulators to undo those steps. A stay preserving the *status quo* would prevent such problems.

The Rehabilitator contended, with respect to state rate approval, that the harm to the State Insurance Regulators is reparable if the Plan is reversed. Rehabilitator's Opposition at 31. The Court agreed. Stay Op. 8. However, neither the Rehabilitator nor the Court clearly contended that the harm to policyholders is reparable. The State Insurance Regulators expressed concern that the Rehabilitator may later 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). The Rehabilitator responded by carefully noting that the doctrine rests on equitable considerations and expressly taking "no position" on its potential applicability. Rehabilitator's Opposition at 31-32. The Court also declined to express any view on potential equitable mootness. Stay Op. 9, n.7.

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, as 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 contended that SHIP's insolvency will increase during the appeal, and that this will reduce amounts that can be paid to policyholders. The Court agreed. Stay Op. 9-10. However, this reflects the intended working of the Plan, which places the entire burden of SHIP's insolvency on policyholders through benefits cuts and premium increases and specifically avoids triggering guaranty associations. *See* Op. 45, 63. The State Insurance Regulators' appeal, by contrast, seeks to protect policyholders by triggering guaranty associations.

The Court responded to this by citing an abstract preference for rehabilitation. *See* Stay Op. 10. But that fails to address the concrete harm from the Plan, which places the burden of insolvency on the policyholders. By contrast, 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* 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 contends that delaying benefit cuts and premium increases under the Plan will increase SHIP's insolvency and thus 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 Supreme Court issue an order staying the trial court's Orders approving the Plan pending appeal.

November 8, 2021

Respectfully submitted,

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IN THE
SUPREME COURT OF PENNSYLVANIA

IN RE: SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)	**:**	**No. 71 MAP 2021**

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

STATE INSURANCE REGULATORS' APPENDIX REGARDING APPLICATION FOR STAY PENDING APPEAL INCLUDING BRIEFS USED IN THE TRIAL COURT

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No.	Material Cited in SIR Application for Stay Pending Appeal	SIR App. Page
1	Notice of Filing of Approved Plan of Rehabilitation (September 24, 2021) with page 19 from Exhibit A (the Approved Plan as substituted by Praecipe to Substitute Approved Plan of Rehabilitation (September 30, 2021) and directed by Order dated October 28, 2021)	4
2	Special Deputy Liquidator's Letter to Commissioners dated September 30, 2021 (Exhibit 1 to State Insurance Regulators' Application for Expedited Ruling on Application for Stay (November 2, 2021))	8
3	Rehabilitator's Email to Commissioners dated September 20, 2021 (Exhibit A to State Insurance Regulators' Application for Stay Pending Appeal (October 1, 2021))	19
4	Rehabilitator's Letter to Commissioners dated August 26, 2021 (Exhibit B to State Insurance Regulators' Application for Stay Pending Appeal (October 1, 2021))	20
5	Rehabilitator's Application for Approval of Plan of Rehabilitation (April 22, 2020), without exhibit	22
6	Hearing Ex. RP-55 (the Second Amended Plan of Rehabilitation)	28
7	Hearing Ex. SIR 5-1	224
8	Hearing Ex. SIR 5-2	225
9	Hearing Ex. RP-7	226
10	Excerpts from Transcript of Hearing held May 17-21, 2021	228
11	State Insurance Regulators' Application for Stay Pending Appeal (October 1, 2021) (Exhibits omitted, see above)	314
12	Rehabilitator's Answer and Brief in Opposition to the Intervenor State Insurance Regulators' Application for Stay Pending Appeal (October 15, 2021)	351

13	The Health Insurers' Response to the Intervening Regulators' Application for Stay Pending Appeal (October 15, 2021)	394
14	State Insurance Regulators' Application for Expedited Ruling on Application for Stay Pending Appeal (November 2, 2021)	428
15	Memorandum Opinion and Order Denying State Insurance Regulators' Application for Stay Pending Appeal (November 4, 2021)	433
16	Order Amending Memorandum Opinion Filed August 24, 2021 (November 4, 2021)	445
17	Amended Opinion and Order (November 4, 2021)	446
18	Order Designating Amended Memorandum Opinion as Opinion (November 4, 2021)	533
19	Joint Application for Intervention of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance (July 31, 2020)	534
20	Joinder of the Washington Insurance Commissioner in the Joint Application for Intervention of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance (September 15, 2020)	555
21	Order Granting Application for Intervention of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance (September 15, 2020)	568
22	Order Granting Joinder of the Washington Insurance Commissioner in the Joint Application for Intervention of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance (September 18, 2020)	569
23	Verification of Robert A. Wake (November 5, 2021)	570

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1 SHP 2020

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

NOTICE OF FILING OF APPROVED REHABILITATION PLAN

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 provides notice to all interested parties that she is filing with the Court the Approved Rehabilitation Plan for SHIP ("Approved Plan," attached hereto as Exhibit A).

The Second Amended Plan filed on May 3, 2021, was approved by this Court's Memorandum Opinion and Order docketed August 25, 2021. In the September 13, 2021, Memorandum Opinion and Order approving the Settlement Agreement between the Rehabilitator and Intervening Agents and Brokers (the "Settlement Approval Order"), the Court directed the Rehabilitator to file with the Court an amended rehabilitation plan containing the modification approved therein. The Rehabilitator hereby files that amended plan as the Approved Plan. The Approved Plan will be posted to SHIP's court documents website at https://www.shipltc.com/court-documents.

In addition to the amendment required by the Settlement Approval Order, the Approved Plan includes edits made by the Rehabilitator to the Second Amended Plan of Rehabilitation to convert it from a proposed plan to an approved plan and to cure some ambiguities and errors. None of these edits constitutes a material change in the Plan. The Rehabilitator also submits with this notice a version of the Approved Plan "redlined" to reflect the changes from the Second Amended Plan. (Redline attached as Exhibit B.) The redline omits the illustrations contained at pages 69 to 80 of the Approved Plan for administrative convenience. The illustrations have not changed.

Dated: September 24, 2021

Respectfully submitted,

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1 SHP 2020

EXHIBIT A

could have aggravated substantially SHIP's financial difficulties. Some regulatory agencies had requested or required that insurers (including SHIP) accommodate some premium deferrals, but many or most of these deferrals are also expiring or will soon expire. The net effect of the delays, therefore are also not expected to be material. Continued non-payment of premium beyond the expiration of the deferral period is expected to result in an increased number of policy terminations. The Rehabilitator has already observed a slight increase in the number of policy terminations that appear not to be the result of increased insured mortality. However, in the aggregate they are not expected to be material to the Plan.

D. TIMELINE

The order placing SHIP in rehabilitation required the Rehabilitator to submit to the Court a preliminary plan for SHIP's rehabilitation by April 22, 2020, and a subsequent case management order provided for policyholders and other interested parties to comment on the Plan through September 15, 2020. Over 100 people have submitted comments, some formal but most informal, and a few parties have also been admitted as intervenors. The Approved Rehabilitation Plan reflects the analysis of those comments and continuing work by the rehabilitation team.

At page 35 is a sequence of past and expected events in the presentation and implementation of the Plan. While it is difficult to predict future events in a matter of this complexity and under the current exceptional circumstances, a hearing on the Plan was held beginning on May 17, 2021. On August 25, 2021, The Court filed a Memorandum Opinion and Order approving the Second Amended Rehabilitation Plan with the exception of Section VI.N. relating to the suspension of agents' commissions, which was addressed in a separate hearing on September 8, 2021, and approved on September 13, 2021, along with a settlement between certain intervening agents and the Rehabilitator. Implementation of the Plan commenced following the entry of the Court's Memorandum Opinion and Order. We anticipate that most policyholders will be sent Policyholder Election Packages around year-end and be asked to make their elections by around mid March, 2022, becoming effective in April of next year. The details of options available to some policyholders and these dates may differ because of changes in their circumstances (see Subsection II.L.3, page 37) or decisions made by the senior insurance regulator of the states in which their policies were issued (see Section VI.V, page 108). It is also possible that changes in circumstances generally may result in changes in these dates. This matter is complex and delays in this timetable remain possible.

E. RATIONALE FOR THE PLAN

The Plan hinges on two essential assumptions: (1) in order to maximize policyholder protection, the Plan must strive to reduce the Funding Gap by increasing revenue and reducing liabilities; and (2) while premium rate increases can increase revenue by some increment, elimination by policyholders of long-term care coverage they may not truly need or be able to afford, especially at adequate premium rates, will go much further in remedying the Company's dire financial situation. The Rehabilitator believes that the Plan structure, which is the product of extended analysis by industry experts, offers a reasonable prospect of success based on sound principles.

EXHIBIT 9

Filed 12/22/2021 Supreme Court Middle District

IN THE SUPREME COURT OF PENNSYLVANIA

No. 71 MAP 2021

In Re: Senior Health Insurance Company of 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

Appeal from the Order of the Commonwealth Court Entered on August 24, 2021, in 1 SHP 2020

BRIEF OF AMICI CURIAE INSURANCE REGULATORS IN SUPPORT OF APPELLANTS' APPEAL OF THE ORDER OF THE PENNSYLVANIA COMMONWEALTH COURT

December 21, 2021

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INTRODUCTION

The 27 Departments of Insurance of the Amici Curiae Insurance Regulators (Amici Curiae) through their chief insurance regulatory officials respectfully submit this Brief as *amici curiae* in support of the appeal 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). The Amici Curiae adopt and incorporate by reference from the brief of the SIR Appellants the following: (1) Statement of Jurisdiction; (2) Order in Question; (3) Statement of the Scope of Review and the Standard of Review; (4) Statement of the Questions Involved; and (5) Statement of the Case.

STATEMENT OF INTEREST

The 27 Amici Curiae are the statutory insurance regulators in their respective jurisdictions charged with enforcing the insurance laws and regulations affecting policyholders within their respective jurisdictions. Each has a duty and is empowered to protect and, where necessary, represent the interests of policyholders and consumers within their jurisdiction and has a vital interest in this matter. Each Amici Curiae either issued a certificate of authority to Senior Health Insurance Company of Pennsylvania (SHIP) or its predecessor to transact insurance business within its respective jurisdiction, has policyholders whose

policies are governed by the laws of such jurisdiction, or objects to the precedent that would be established by the Plan of Rehabilitation.

This brief was prepared by counsel for the insurance regulators of the Departments of Insurance for the States of South Carolina and Louisiana, was paid for the by 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), Amici Curiae affirm that no other person or entity has paid for the preparation of or authored this brief in whole or in part.

SUMMARY OF ARGUMENT

It is a well-established principle of law that the authority to approve insurance policy rates and forms and the jurisdiction over the insurance contract is vested in the insurance regulators of the state of policy issuance.[1] The Second Amended SHIP Rehabilitation Plan (Plan) violates the rate and form regulation statutes of the Amici Curiae States as well as the comprehensive receivership and guaranty fund statutes enacted by state legislatures for the protection of policyholders and creditors. The Plan usurps 1) the authority conferred upon and reserved to all states to regulate the business of insurance by both state and federal

[1] Attached as Exhibit 1 is a chart of each of the prior regulatory approval statutes for each Amici

laws, including the McCarran-Ferguson Act[2] and 2) the police power exercised by each jurisdiction's legislature for the protection of its citizens. The Order approving the Plan confers authority beyond the statutory responsibilities of the Rehabilitator and the Court. As such, it is an unconstitutional exercise of authority and an abuse of discretion that should be reversed.

Amici Curiae file this brief to protect policyholders from the unconstitutional exercise of authority and extraterritorial overreach by the Rehabilitator and strongly oppose her unconstitutional actions. The Plan is directly contrary to the Rehabilitator's statutory authority, the laws of the Amici Curiae, and is wholly unsupported by any law or prior legal precedent. The Plan imposes a result that places policyholders in a worse position than if SHIP were liquidated.

Amici Curiae have a substantial and real interest in this appeal because it involves novel issues that affect state-based insurance regulation. This Court's decision will affect the rights of policyholders of insolvent insurers and the future interpretation and application of state receivership and guaranty association statutes nationwide in derogation of the laws of Amici Curiae. Amici Curiae are in the best position to emphasizing the national and regulatory implications of the Plan.

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[2] 15 U.S.C.§1011-1012, reinforced by the Gramm-Leach-Bliley Act, 15 U.S.C. §67-1 *et seq.*

ARGUMENT FOR AMICI CURIAE

A. THE COMMONWEALTH COURT'S ORDER SHOULD BE REVERSED BECAUSE THE PLAN CONTRAVENES THE AUTHORITY OF AMICI AND IS AN ABUSE OF DISCRETION BY THE REHABILITATOR AND THE COURT.

1. The Commonwealth Court Erred in Approving an Infeasible Plan of Rehabilitation that violates the laws of Pennsylvania and the Amici States.

a. The Plan violates the basic principles of state-based insurance regulation.

State-based regulation of insurance exists to protect insurance consumers. "The primary state insurance regulatory functions remain as they have been since the enactment of [the] McCarran-Ferguson [Act]. This allows . . . states to perform solvency oversight of the U.S. insurance industry and to regulate insurer behavior in the marketplace…State legislatures are the public policymakers that establish broad policy for the regulation of insurance by enacting legislation providing the framework under which insurance regulators operate. They establish laws which grant regulatory authority to regulators and oversee state insurance departments and approve regulatory budgets…State insurance regulatory systems are accessible and accountable to the public and sensitive to local social and economic conditions. State regulation has proven that it effectively protects consumers and ensures that promises made by insurers are kept. Insurance regulation is structured around several key functions, including insurer licensing, producer licensing, product regulation (review and approval of rates (including benefits) and forms),

market conduct, financial regulation and consumer services...State regulators protect consumers by ensuring that insurance policy provisions comply with state law, are reasonable and fair, and do not contain major gaps in coverage that might be misunderstood by consumers and leave them unprotected. The nature of the regulatory reviews of rates, rating rules and policy forms varies somewhat among the states depending on their laws and regulations."[3]

b. The Plan violates the comprehensive statutory system for the receivership of insolvent insurers enacted by states and jurisdictions for the protection of policyholders and creditors.

One of the fundamental principles of insurance regulation is to ensure that companies fulfill and honor their policyholder obligations. Insurance regulators protect policyholders through solvency monitoring and financial analysis; and when companies fail, through the receivership and guaranty association laws enacted by states.

State legislatures enacted receivership laws and established guaranty associations to protect policyholders and equitably and broadly spread the losses from insurance company failures rather than impose such losses on individual policyholders. Receivership laws provide for a uniform, orderly and equitable method of claim adjudication and a fair procedure for distribution of the assets of

[3] *State Insurance Regulation*, National Association of Insurance Commissioners (NAIC), Center for Insurance Policy and Research (CIPR) (2011).

the insolvent insurer to policyholders and creditors. Guaranty association laws complement and are instrumental to the protections afforded by the receivership process.

Guaranty associations were created to ensure policyholders receive substantially the contractual benefits for which they paid. "GA coverage provides a level of policyholder protection unavailable in any scenario where the GAs are not triggered to provide protection. The Order of the Commonwealth Court reveals certain misapprehensions as to (a) the status of the GAs as creditors of the failed insurer; (b) the rights and obligations of GAs in their relationships with policyholders; and (c) the level of protection provided to policyholders in the event of liquidation."[4]

"Funding for the guaranty associations comes from assessments on solvent insurers. These assessments are not open-ended, but subject to certain annual limitations. The NAIC Life and Health Insurance Guaranty Association Model Act permits life/health insurers to consider the amount reasonably necessary to meet their assessment obligations in the determination of the premiums they charge" and also allows life/health insurers to recoup assessments via premium tax

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https://www.naic.org/documents/topics_white_paper_hist_ins_reg.pdf. Reference is also made to the text of the statutes cited in Exhibit 1.

credits.[5] Thus, the insurer's insolvency is not imposed fully and only on the policyholder as the SHIP Plan does, but is spread throughout the United States at a minimal cost to individual taxpayers.

The Plan abandons the receivership and guaranty association safety net for policyholders thus supplanting the laws and the protections enacted by the legislature of each jurisdiction. The Plan does this by altering the allocation of loss at the behest of the Rehabilitator and some members of the industry. In doing so, it places the interests of the impaired insurer and insurance industry over policyholders and disregards the legislative enactments of the Amici Curiae jurisdictions.

2. By law, the Rehabilitator only has those powers conferred by statute.

In Pennsylvania, an insurance commissioner acting as a rehabilitator "'can only exercise those powers which have been conferred upon it by the Legislature in clear and unmistakable language.'" *Aetna Cas. and Sur. Co. v. Com., Ins. Dept.*, 638 A.2d 194 (Pa. 1994) (quoting *Commonwealth, Human Relations Commission v. Transit Casualty Insurance Company*, 478 Pa. 430, 438, 387 A.2d 58, 62 (1978). *See also Koken v. Legion Ins. Co.*, 831 A.2d 1196 (Pa. Commw.

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[4] Brief of Amici Curiae Pennsylvania Health and Life Guaranty Association, et al., *In re: Penn Treaty Network America Insurance Company in Rehabilitation,* 2013 WL 9743966 (Pa.), 5.

[5] https://content.naic.org/cipr_topics/topic_guaranty_associationsfunds.htm

Ct. 2003), *aff'd sub nom. Koken v. Villanova Ins. Co.*, 878 A.2d 51 (Pa. 2005). The Rehabilitator has only those powers conferred by 40 Pa. Stat. Ann. §§ 221.1 *et seq.*, which are circumscribed to those of new management. Insurers in rehabilitation are required to comply with the insurance laws of each jurisdiction in which they conduct the business of insurance. Nowhere in the rehabilitation statutes is there "clear and unmistakable language" permitting a statutory rehabilitator (i.e., company management) to displace rate regulatory authority in other jurisdictions and substantially modify policy terms without the requisite regulatory approvals. Rehabilitators must comply with the law and do not have the authority to rewrite state laws because of a disagreement with regulatory policy. Indeed, even to continue the runoff of its policies SHIP must maintain its licensing requirements in each jurisdiction which includes approval of rates and forms. Callous and erroneous disregard for existing and well-established law does not fall within the Rehabilitator's discretion; it constitutes an abuse of it.[6]

a. The Plan violates state laws by bypassing the rate review process enacted by state legislatures and authorizes the Rehabilitator, in her capacity, as Insurance Commissioner to set rates nationally.

The Order issued by the Commonwealth Court seeks to conflate the role of commissioner and rehabilitator. Specifically, it provides that the Rehabilitator ***in***

[6] *Commonwealth v. Taylor*, 230 A.3d 1050, 1072 (Pa. 2021), and cases cited therein.

her capacity as Insurance Commissioner shall designate a deputy commissioner to review the actuarial memorandum as described in the Plan by which the Rehabilitator will only seek approval from the Commonwealth Court for rates to be imposed on a seriatim basis nationwide. Thereafter, the Rehabilitator shall submit the approved actuarial memorandum to the Court.[7] Thus, the Rehabilitator is allowed to step out of her Rehabilitator role and into the role of a foreign state insurance regulator *vis-à-vis* the Amici jurisdictions, and then in her role as Pennsylvania Insurance Commissioner determine rates for SHIP policyholders in every jurisdiction nationwide.

This is unconstitutional. Nothing in the Plan (or in any law) provides that "[T]he Rehabilitator, *in her capacity as Insurance Commissioner*" would (or could) be the rate-setter or approver for SHIP's 30,000 remaining policyholders nationwide, bypassing Amici's prior regulatory approval statutes. The Commonwealth Court's order allows the Pennsylvania Commissioner to arrogate to herself the position of "national rate maker," "rate enforcer," and "benefit downgrader" under a plan that she, as "Rehabilitator," prepared. Amici Curiae are unaware of any provision of any law – in Pennsylvania or elsewhere – that empowers the Pennsylvania Commissioner *qua* Commissioner (or otherwise) with

[7] *See* Record 3115a, Memorandum Opinion and Order, p. 85, para. 4 (August 24, 2021.)

extraterritorial rate-setting authority.

The rate increases under the Plan are extreme, in some cases more than double the amount of the current premium. This can be expected to force unnecessary policy lapses for elderly policyholders who have paid premiums for many years in contemplation of the need for long term care. Policyholders may be able to avoid some of the increases, but only if they agree to lower their contractually guaranteed benefits resulting in many cases of benefit reductions beyond what would otherwise be covered by guaranty associations.

3. The Plan violates the goals and purposes of the rehabilitation process.

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. *See Foster v. Mutual Fire, Marine and Inland Ins. Co.*, 531 Pa. 598, 614 A.2d 1086 (1992). The Rehabilitator must conduct the company's business in compliance with the law. The Rehabilitation Order did not alter SHIP's status as an insurer in each of the jurisdictions in which it operates. Accordingly, the Rehabilitator, in her capacity as SHIP's management, must comply with the laws of each state in which SHIP transacts business.

The Rehabilitator also has a duty to act with a broad view toward minimizing financial harm to all policyholders, creditors, and the general public.[8] The Plan fails to minimize the harm to policyholders, and it certainly appears that the Rehabilitator's goal is solely to reduce SHIP's deficit before it is placed into liquidation which is wholly inconsistent with the goals and purposes of the rehabilitation process.

B. THE COMMONWEALTH COURT ERRED AS A MATTER OF LAW IN APPROVING THE PLAN.

This Court's review of the Commonwealth Court's actions is based on an abuse of discretion standard. *See Foster v. Mutual Fire, Marine and Inland Ins. Co.*, 531 Pa. 598, 614 A.2d 1086 (1992). "An abuse of discretion ... requires a manifest unreasonableness, or partiality, prejudice, bias or ill-will or such a lack of support as to be clearly erroneous."[9] The role of the Court is to safeguard the Plan from any potential abuse and that includes abuse of the Rehabilitator's discretion. *See Mills v. Florida Asset Fin. Corp,* 31 A.3d 849, 850, 818 N.Y.S.2d 333 (3d Dept. 2006). It is clear from the Record in this Case that the Commonwealth Court exceeded its statutory authority when it approved this Plan. Instead of preventing an abuse of discretion, the Commonwealth Court approved a Plan that frustrates

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[8] *Vickodil v. Com., Ins. Dept.,* 126 Pa. Commw. Ct. 390, 559 A.2d 1010 (1989).

[9] *Parr v. Ford Motor Co.*, 109 A.3d 682, 690–91 (Pa. Super. 2014) (*quoting Grady v. Frito–Lay, Inc.*, 839 A.2d 1038, 1046 (Pa. 2003); *Keystone Dedicated Logistics, LLC v. JGB Enterprises, Inc.*, 77 A.3d 1, 11 (Pa. Super. 2013)

the purpose of the rehabilitation process (which is to safeguard the rights of policyholders) and exceeds the statutory authority of the Rehabilitator.

Deference to the Rehabilitator's discretion does not require the Court to accede to or embolden the misuse of the receivership or rate review processes. *See* 40 P.S. § 221.18(a); *Koken v. Villanova*, 583 Pa. 400, 878 A.2d 51 (2005); *State ex rel Flowers v. Universal Care of Tenn.*, 2007 WL 3072776 (Tenn. Ct. App. 2007).

C. THE ORDER MUST BE REVERSED BECAUSE THE PLAN IS NOT DESIGNED TO BE FAIR AND EQUITABLE TO ALL POLICYHOLDERS.

1. The Court's Order must be reversed because the Plan is not feasible or fair and equitable to all policyholders.

a. The Plan is not fair and equitable to all policyholders.

The Plan improperly discriminates between policies in the same class and policyholders in different jurisdictions. In a liquidation, policyholders must receive equal percentage distributions.[10] This is also true in a rehabilitation.[11] The disparate treatment of policyholders does not bear any reasonable relationship to the public interest in *rehabilitating* the insurer and is not necessary to preserve the rights of

[10] 40 P.S. § 221.44 and 221.61(a).

[11] "Article V does not authorize giving some policyholders greater consideration than others." *Koken*, 831 A.2d at 1246.

all policyholders.[12] There is no basis in law for the variability in treatment of policyholders.

b. SHIP Policyholders will not fare better under this Plan than in liquidation.

The record does not support the Rehabilitator's contention that SHIP policyholders will fare better under this Plan than in liquidation. This Plan requires policyholders to give up benefits they would be able to keep in liquidation. For example, some policyholders have lifetime benefits. Under the Plan, those policyholders must pay the If-Knew premium to keep those benefits or receive a benefit reduction that would reduce the maximum length of the contract to four years depending on the option selected. In liquidation, the policyholders' benefits would not change substantially. They would be able to keep that benefit subject to guaranty association limits.

Under the Plan, policyholders on claim who are not paying the If-Knew premium must pay the premium differential to keep their premium waivers.[13] In liquidation, the guaranty associations would likely honor the policyholder's

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[12] *See Commercial National Bank v. Superior Court*, 14 Cal App.4th 393, 17 Cal. Rptr. 2d 393 (1993) (court set aside order that established a two-tier valuation system the improperly discriminated between substantially identical policies in the same class).

[13] It is not a premium waiver if the policyholder must pay for it.

premium waiver. Detailed explanations of the options and benefit downgrades proposed are set forth in the Plan.

Some policyholders will make the difficult choices proposed by the Plan possibly believing that it will help SHIP because it is in "rehabilitation." They will likely act based on the Rehabilitator's representation that "[i]n the event SHIP would be ordered to be liquidated, it is probable that policyholders will retain benefits in excess of the guaranty fund limits"[14] and the approval of the Plan by the Commonwealth Court while not understanding that SHIP's liquidation is inevitable and any preservation of benefits is short-lived. The option s presented to policyholders in the various Plan phases are designed to coerce policyholders into paying higher premiums for the same or substantially less coverage and to coerce them into selecting significant benefit downgrades for the same cost or to select a nonforfeiture option.

The Plan does not minimize the financial harm to SHIP policyholders; it forces policyholders to reduce or drop coverage. Its purpose is ***not*** to honor policyholder contractual obligations but rather to reduce SHIP's liabilities before it goes into liquidation. The Rehabilitator acknowledges that the Plan places additional burdens on policyholders and is intended to decrease SHIP's deficit by

[14]https://www.shipltc.com/_files/ugd/630dfc_30441fe77fd7464ba4d7da30983450ba.pdf at FAQ 12.

increasing premium revenue and reducing policyholder benefits.[15] The Special Deputy Rehabilitator admitted at hearing that, "it is not likely that we will magically restore SHIP to solvency, but it is likely that the plan ...would substantially reduce the deficit."[16]

The Special Deputy Rehabilitator also admitted at the hearing that the purpose of the Plan is to transfer the burden of insolvency from legislatively-crafted guaranty associations and their member insurers to the policyholders because the Rehabilitator does not believe policyholders who paid the premiums set by law paid enough.[17] Guaranty associations are future creditors (to be considered in the liquidation process) and only the present creditors and policyholders are to be considered in a rehabilitation proceeding. The Commonwealth Court erred in approving a Plan that placed liquidation considerations over the rehabilitation process.

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[15] Transcript May 17, 2021 Record 1631a-1814a (transcript p. 80, 289-292).

[16] Transcript May 17, 2021 Record 1631a-1814a (transcript p. 80).

[17]The Rehabilitator attributes SHIP's insolvency to inadequate rates. However, t significant contributors to SHIP's insolvency include the erroneous actuarial assumptions, declines in its investments and poor investment decisions by its management. Transcript May 17, 2021 Record 1631a-1814a (transcript p. 46, 49, 51.)

c. State receivership laws, including Pennsylvania's, require rehabilitation plans to be feasible to be approved.

The Plan does not comply with the feasibility standard articulated under Pennsylvania law. *Sheppard v. Old Heritage Mut. Ins. Co.*, 492 Pa. 581, 594, 425 A.2d 304, 310 (1984) (company [through the Rehabilitator] has the burden of demonstrating the feasibility of the Plan). The evidence presented at the hearing shows the Plan frustrates the goals of the rehabilitation process. The weight of the evidence presented at the hearing does not demonstrate that the Plan is feasible or that SHIP can bridge the $1.2 billion funding gap and avoid liquidation.

Instead of restoring SHIP to solvency the Plan is designed to run-off SHIP's remaining 30,000 policyholders. The Plan enables the insurer to use the insolvency process to avoid or repudiate its policyholder obligations for products it did not properly price from inception. The Plan shifts the burden of its insolvency to its policyholders contrary to the laws enacted to protect insurance consumers in the Amici jurisdictions.

D. EXTRATERRITORIAL ENFORCEMENT OF THE PLAN IS UNCONSTITUTIONAL.

Finally, and of utmost interest to Amici Curiae, it is respectfully submitted that enforcement of any final order of this Court in another jurisdiction violates the law of each jurisdiction and is unconstitutional. Before a court or State is bound by the judgment rendered in another State, it may inquire into the jurisdictional basis

of the foreign judgment court's decree. If that court did not have jurisdiction over the subject matter or the relevant parties, full faith and credit need not be given. "[T]he Full Faith and Credit Clause does not require a State to apply another State's law in violation of its own legitimate public policy." *Nevada v. Hall*, 440 U.S. 410, 421, 99 S.Ct. 1182, 1188, 1189, 59 L.Ed.2d 416 (1979). *See also Ferrelli v. Commonwealth of Pennsylvania,* 783 A. 2d 891 (Pa. Cmwlth. 2001). States are precluded from "adopt[ing] any policy of hostility to the public Acts" of other states. *Franchise Tax Board of California v. Hyatt,* 139 S. Ct. 1485, 1497. Under the circumstances, Amici Curiae respectfully contend that allowing the Pennsylvania Commissioner of Insurance to set the premium rates for policies governed by the law of other states violates the law and public policy of each Amici jurisdiction, if not all other jurisdictions with SHIP policyholders.

E. CONCLUSION

The Plan abrogates the power expressly reserved to each Amici insurance regulator to approve rates and policy forms for insurers within their jurisdiction and disregards long-standing federal and state laws. The Plan is not feasible, is wholly inconsistent with the goals and purposes of a rehabilitation proceeding, circumvents state laws, and improperly shifts the burden of filling the deficit from the statutorily enacted receivership and guaranty association process to SHIP's elderly policyholders.

The Amici join Appellants in urging this Court to reverse the Order of the Commonwealth Court. The requested relief is necessary to preserve the laws and regulatory principles of the system of state-based insurance regulation and to prevent irreparable harm to SHIP policyholders.

Respectfully Submitted,

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AMICI INSURANCE REGULATORS EXHIBIT 1
PRIOR RATE APPROVAL AUTHORITY STATUTES

State	Statutory Citation
Arizona	Arizona Revised Statutes 20-1691.08
Arkansas	Ark. Code Ann. § 23-79-109 and Ark Code Ann. § 23-79-110
District of Columbia	D.C. Off.Code § 31-4712(a) and under 26-A DCMR §§ 2600 et seq.
Connecticut	Conn. Gen. Stat §§ 38a-501 and 38a-528
Idaho	§41IDSTAT 41:Ch.18§41:1812; 41:Ch.46: §41-4608; IDAPA 18.04, 11.024, 11.025
Indiana	IC 27-8-5-1; 27-8-5-1.5; 760 IAC 2-13-1
Iowa	IA Code ch. 514G. Iowa Code § 514G.111; Admin. Code rule 191-39.28
Louisiana	LA. Rev.Stat. 22:12,1095,1181-1191; LAC 37:46.19.1901 *et seq.*
Maryland	Md. Code Ann., Ins. Art. § 11-703(c)(2), § 18-116(b); § 18-116.1; § 12-203(b)(1); Code of MD. Reg. 31.14.01.36
Mississippi	Miss. Code Ann. §83-9-1; and 9-3(5-6), 9-5 (7) (Supp. 2020)
Montana	Mont. Code Ann. §33-16-203-211
New Hampshire	NH RSA 415:1 and NH RSA 415-D:11, Admin Rule Ins. 3601.19
New Jersey	N.J.S.A.17B:27E-10 and N.J.S.A.17B:27E-11
New Mexico	NMSA 1978 ch.59A, articles 18, 44, 46,47; NMAC 13.10.15.34
North Carolina	NCGS §58-51-95 (2021)
North Dakota	N.D.C.C. § 26.1-30-19
Ohio	Ohio Rev. Code §§ 3901.011, 3923.45, 3923.46, 3923.47; Ohio Adm.Code 3901-4-01
Oklahoma	36_O.S. §332, 902, 2028, 3610, 3611, 3648, 4426(F), 4430, 6002, 7004; OAC 365:10-5-47.1, 10-5-48, 10-5-54, 10-5-46, 10-5-48.6
Rhode Island	R.I. Gen. Laws § 27-18-8; R.I. R.I. Gen. Laws Chapter 27-34.2
South Carolina	§38-3-110(1) (2019);38-3-110(1) (2019); § 38-72-75 (2019); § 38-61-10 (2015)
South Dakota	SDCL 58-6-1, 58-1-5, 58-6-46, 58-17-4.1 et seq., SDCL Ch. 58-18, SDCL 58-18B, and ARSD Ch. 20:06:21
Utah	UT Code §§ 31A-2-201.1; 31A-21-201; 31A-22-602; 31A-22-1404(24); Rule R590-148-24 and R590-220
Vermont	8 Vt. Stat. Ann. § 3541; 8 Vt. Stat. Ann. Ch. 154; LTC Rule H-2009-01; Ins. Bulletin No. 216
West Virginia	W.Va. Code §§ 33-6-8 and 33-6-9.; § 33-15A-1, et seq., *Long-Term Care Insurance Act;* State Rules Title 114, Series 32
Wisconsin	Wis.Stat. ch. 625 and 632.20, Wis.Adm.Code Ins. 3.455(9)(9m)
Wyoming	W.S. 26-15-110; 26-38-101 - 26-38-106 and 26-38-110; 26-38-105(r); Reg. Ch. 37

THE SIGNATURES ON THE ATTACHED PAGES ON BEHALF OF THE AMICI CURIAE ARE INCLUDED DUE TO A PRIOR REQUEST FROM THE CLERK OF COURT AND DO NOT CONSTITUTE AN APPEARANCE OTHER THAN TO REPRESENT THE AUTHORITY OF EACH REGULATOR TO BE AN AMICI CURIAE

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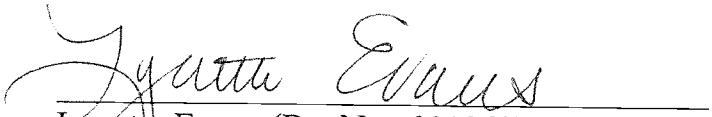

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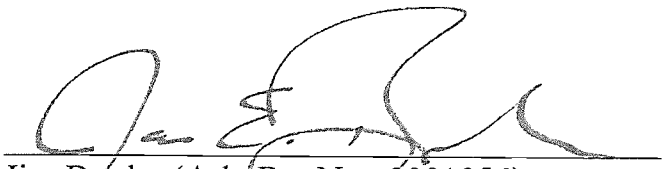

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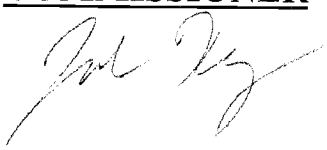

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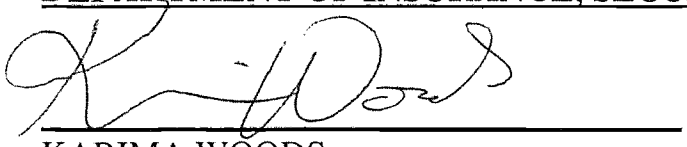

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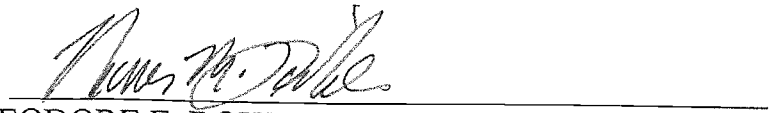
By: 

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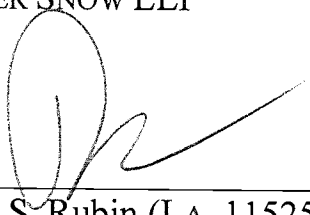

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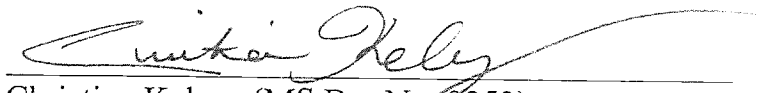

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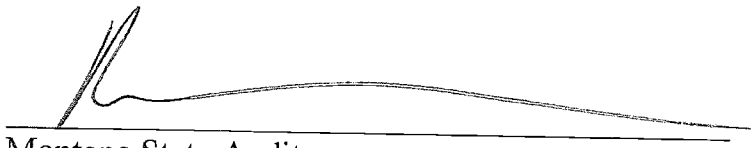

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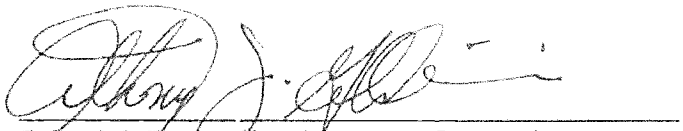

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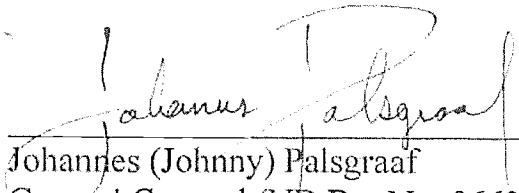

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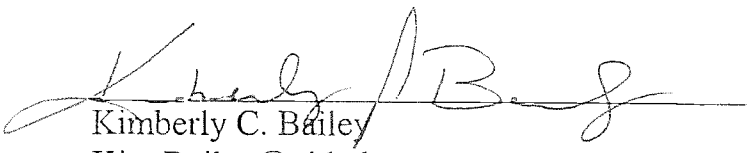

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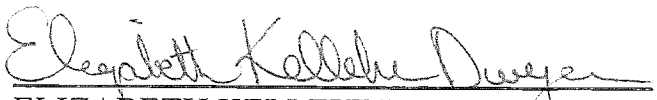

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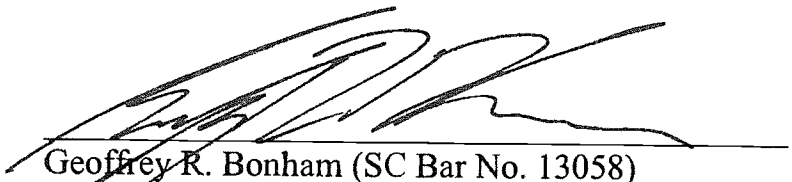

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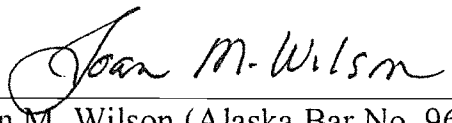
By: 

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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.

I further certify that pursuant to Pa. R. App. P 531(b)(3) that this Brief contains no more than 5534 words which is less than the allowable 7000 words.

December 21, 2021.

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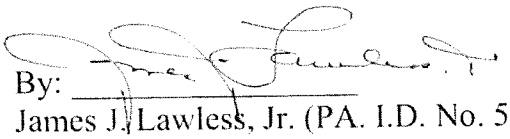

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EXHIBIT 10

IN THE SUPREME COURT OF PENNSYLVANIA
MIDDLE DISTRICT

IN RE: SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)	:	No. 71 MAP 2021
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	:	

ORDER

PER CURIAM

AND NOW, this 31st day of January, 2022, the Application for Leave to Supplement is **GRANTED**, and the Application for Stay Pending Appeal is **DENIED**. The "Motion for Leave to File Briefs as Amici Curiae (in Support of Application for Stay Pending Appeal)" is **DISMISSED** as moot.

A True Copy Elizabeth E. Zisk
As Of 01/31/2022

Attest: Elizabeth Zisk
Chief Clerk
Supreme Court of Pennsylvania

EXHIBIT 11

SHIP
SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
(IN REHABILITATION)
P.O. Box 64675, St. Paul MN 55164-0675

1

Action Required By: February 28, 2022

John J. Sample
123 Main Street
Apt. B
Carmel, IN 46032

IMMEDIATE ACTION REQUIRED

Dear Mr. Sample:

I'm writing today with important information about your long-term care insurance from Senior Health Insurance Company of Pennsylvania (In Rehabilitation) ("SHIP") and to thank you for your patience and understanding as we guide the company through the rehabilitation process.

As part of this process, you have a very important decision to make at this time. A number of new coverage options are available to you. You are required to select only one option by February 28, 2022.

To get started, please refer to the enclosed "Step-by-Step Guide for Policyholders" and follow these simple steps:

Step 1: Review your personalized options.

Step 2: Learn more about each option.

Step 3: Indicate your choice on the attached Coverage Election Form, detach and mail the completed form to SHIP in the enclosed postage-paid return envelope as soon as possible.

You'll find more details in the "Important Information for Policyholders" booklet and "Summary of Current Coverage" document provided. To watch our informational video series and learn more, visit us online at **shipltc.com**. Please know we are here to help you. We understand you have a lot invested in your current policy and you want to make sure you will have protection when you need it. Just call us at (833) 894-8577.

Sincerely,

Patrick H. Cantilo

Patrick H. Cantilo
Special Deputy Rehabilitator

P.S. **Please note that your Coverage Election Form must be postmarked by February 28, 2022.**

▶ Tear Here ◀

Coverage Election Form

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)

POLICYHOLDER NAME: John J. Sample

POLICY NUMBER: 8321

ELECTION EFFECTIVE DATE: 4/20/2022

IMPORTANT: This form must be signed and postmarked by February 28, 2022.

Best way to reach you, if we have questions.

Phone:

Email:

Select the option that best suits your needs.

Policy Feature	Your Current Policy	Option 1 Downgrade Your Policy	DEFAULT Option 2 Convert to a Basic Policy	Option 2a Convert to an Enhanced Basic Policy	Option 3 Convert to an Enhanced Paid-Up Policy	Option 4 Keep Your Current Coverage
Billable Annual Premium	$2,887	$2,887	$1,188	$1,248	$0	$3,362
Annual Premium	$2,887	$2,887	$1,188	$1,248	$0	$3,362
Annual Premium Change (%)	N/A	0%	-58.85%	-56.77%	-100%	16.45%
Maximum Lifetime Benefit	Unlimited	Unlimited	$394,644	$493,305	$246,652	Unlimited
Maximum Lifetime Benefit Change (%)	N/A	0%	-60.54%	-50.67%	-75.33%	0%
Phase Two Rate Increase/Benefit Reduction Possible	N/A	Yes	No	No	No	Yes
SELECT ONE ▶	☐	☐	☐	☐	☐	☐

Sign below.

I understand the election I have made above and acknowledge that I have made the election voluntarily. I agree that the changes I have requested will become effective April 20,2022 and cannot be reversed after February 28, 2022.

I understand that if I do not clearly mark only one election, or if I do not return this signed form postmarked by February 28, 2022, I will receive Option 2 by default.

Signature:

Date: / / (Month / Day / Year)

Print name here:

Signatory authority: ☐ Power of Attorney ☐ Conservator ☐ Other:

Return this form in the postage-paid envelope postmarked by February 28, 2022.
Questions? Call **(833) 894-8577**, Monday through Friday, 8:00 a.m. to 6:00 p.m. EST.

UNV045%PL407081TPM

PO Box 64675, St. Paul, MN 55164-0675

SHIP-EP-LTREF-0122

SHIP
SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
(IN REHABILITATION)

Choosing the Right Coverage Option

A Step-by-Step Guide for Policyholders

Step One: Review Your Personalized Options

Prepared For John J. Sample
Policy Number: 8321

This chart shows the options currently available to you. Use it to compare the details most important to you.

Policy Feature	Option 1 Downgrade Your Policy	DEFAULT Option 2 Convert to a Basic Policy	Option 2a Convert to an Enhanced Basic Policy	Option 3 Convert to an Enhanced Paid-Up Policy	Option 4 Keep Your Current Coverage
Maximum Benefit Period	Unlimited	1,460 Days	1,825 Days	913 Days	Unlimited
Maximum Daily Benefit	NH: $358.86 ALF: $298.71 HHC: $199.14	NH: $270.30 ALF: $225.00 HHC: $150.00	NH: $270.30 ALF: $225.00 HHC: $150.00	NH: $270.30 ALF: $225.00 HHC: $150.00	NH: $337.88 ALF: $337.88 HHC: $337.88
Maximum Lifetime Benefit	Unlimited	$394,644	$493,305	$246,652	Unlimited
Benefit Account Value (Pool of Money)	No	Yes	Yes	Yes	No
Elimination Period	100 Days	100 Days	100 Days	100 Days	100 Days
Reimbursement Type	Reimbursement	Indemnity	Indemnity	Indemnity	Indemnity
Inflation Benefit	No Inflation	No Inflation	No Inflation	No Inflation	No Inflation
Extension of Benefits	Not Included	Not Included	Not Included	Not Included	Not Included
Restoration of Benefits	Not Included	Not Included	Not Included	Not Included	Included
Return of Premium Benefit	Not Included	Not Included	Not Included	Not Included	Not Included
Waiver of Premium Benefit	Included	Not Included	Not Included	Not Included	Included
Billable Annual Premium	$2,887	$1,188	$1,248	$0	$3,362
Annual Premium	$2,887	$1,188	$1,248	$0	$3,362
Rehabilitation Plan Required Benefit Eligibility	Yes	Yes	Yes	Yes	No
Phase Two Rate Increase/Benefit Reduction Possible	Yes	No	No	No	Yes

Note: If you do not return your Coverage Election Form on time, the Option identified as "Default" will be deemed to be your choice. Annual Premium is the cost of coverage for policy features listed under each option. Billable Annual Premium is that amount minus any premium that is currently being waived.

In the event the Company is placed in liquidation in the future, available benefits may be reduced below those identified in Your Personalized Options, except for Option 3.

SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)

Step Two: Learn More About Each Option

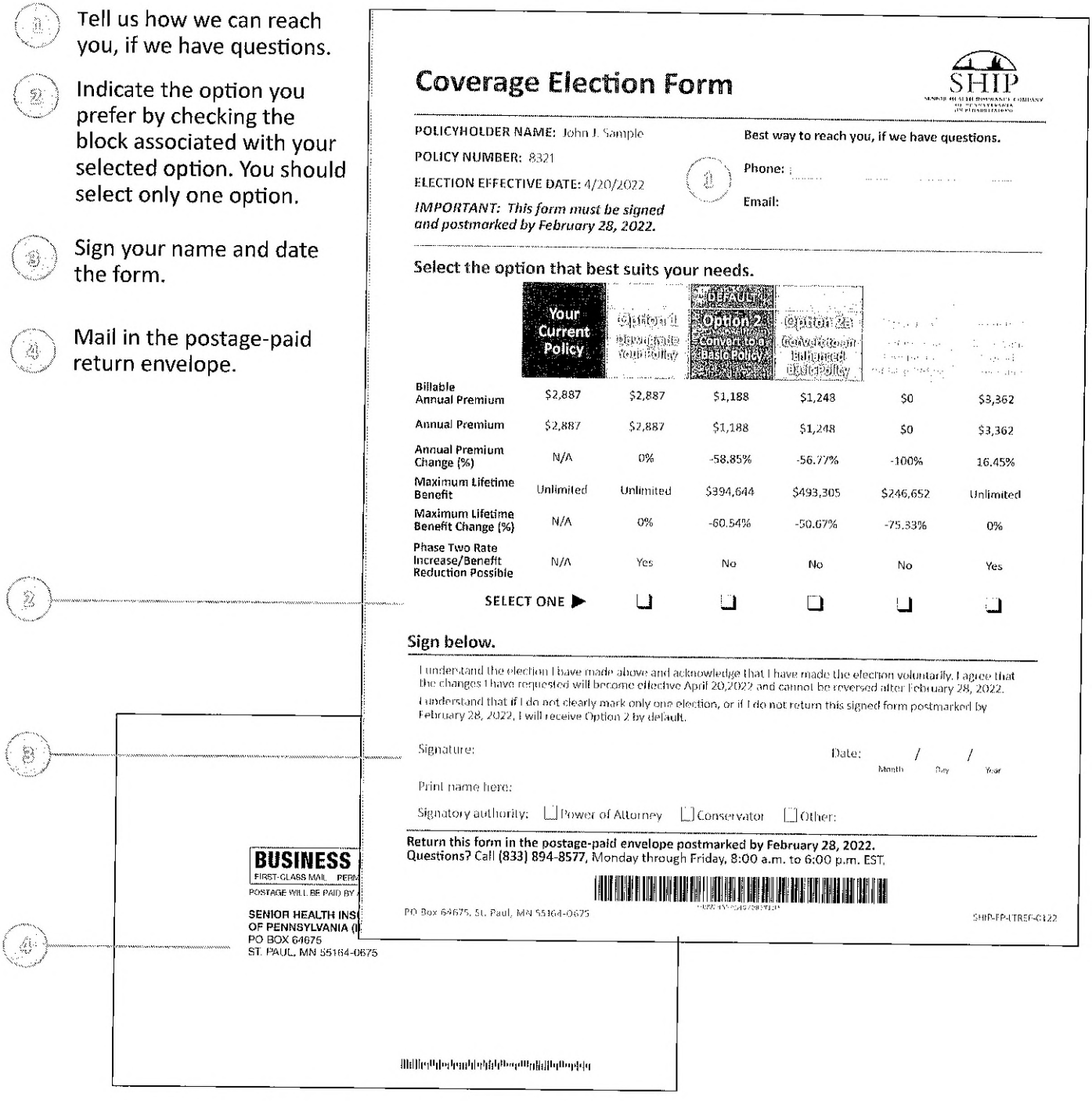
We understand that no two policyholders are alike. To help you navigate through the process of making your election decision, we've outlined several preferences to consider that may be important for you to think about. **Please review the policy features outlined in your Personalized Options chart on page two of this guide. Some options may not apply to all policies. Options that do not apply to you will appear on your Personalized Options chart with a designation of N/A (Not Applicable) per the policy features.**

If your preference is to...	Consider these options	A bit about the options...
Maintain your current premium (recognizing that benefits may be reduced in Phase Two of the Rehabilitation Plan)	**Option 1** (Downgrade Your Policy)	• This option offers reduced benefits while allowing your premium to remain the same. • Your benefits will be reduced as shown on your Personalized Options chart on page two of this guide. • The premium rates and benefits associated with this option are not guaranteed and may change significantly in Phase Two of the Rehabilitation Plan.
Adjust your premium <u>and</u> benefits (designed to balance premium and benefits)	**Option 2** (Convert to a Basic Policy) **Option 2a** (Convert to an Enhanced Basic Policy)	• These options offer benefits available on a new Basic Policy (Option 2) or a new Enhanced Basic Policy (Option 2a). Option 2a may offer a longer benefit period and more inflation protection. For some policyholders Option 2 may provide the same coverage as Option 2a. • The new premium for this new policy will correspond to the benefits displayed on your Personalized Options chart on page two of this guide. • These options aim to strike a balance between Option 1 and Option 4, but with two significant benefits: 1. You are protected from mandatory future premium rate increases or benefit reductions in Phase Two of the Rehabilitation Plan. 2. There is an added safety net where your benefits will not be reduced below coverage levels provided in liquidation.
Stop paying premium altogether (while maintaining a basic level of coverage)	**Option 3** (Convert to an Enhanced Paid-Up Policy)	• This option offers a paid up insurance policy with benefits displayed on your Personalized Options chart on page two of this guide. This means you will no longer have to pay premium, and coverage will terminate when the Maximum Lifetime Benefit is exhausted. • The benefits associated with this option are generally richer than those offered as part of a traditional (non-Rehabilitation) nonforfeiture option. • This option will not be subject to premium rate increases or benefit reductions in Phase Two of the Rehabilitation Plan.
Preserve your current benefits (recognizing that premium may be increased in Phase Two of the Rehabilitation Plan)	**Option 4** (Keep Your Current Coverage)	• This option offers continuation of current coverage at a potentially higher premium rate. • You will have the same level of protection you have now at the premium amount displayed on your Personalized Option chart on page two of this guide. • The premium rates and benefits associated with this option are not guaranteed and may change significantly in Phase Two of the Rehabilitation Plan.
Have certainty (with respect to the premium you will pay and the benefits you will receive throughout the Rehabilitation process)	**Option 2** (Convert to a Basic Policy) **Option 2a** (Convert to an Enhanced Basic Policy) **Option 3** (Convert to an Enhanced Paid-Up Policy)	• All 3 of these options offer certainty that you will not be subject to mandatory premium rate increases or benefit reductions in Phase Two of the Rehabilitation Plan.

Step Three: Indicate Your Choice On The Enclosed Form

Your Coverage Election Form must be signed and postmarked by February 28, 2022

1. Tell us how we can reach you, if we have questions.
2. Indicate the option you prefer by checking the block associated with your selected option. You should select only one option.
3. Sign your name and date the form.
4. Mail in the postage-paid return envelope.



Coverage Election Form

SHIP

POLICYHOLDER NAME: John J. Sample
POLICY NUMBER: 8321
ELECTION EFFECTIVE DATE: 4/20/2022
IMPORTANT: This form must be signed and postmarked by February 28, 2022.

Best way to reach you, if we have questions.
Phone:
Email:

Select the option that best suits your needs.

	Your Current Policy	Option 1 Upgrade Your Policy	DEFAULT Option 2: Convert to a Basic Policy	Option 3: Convert to a Balanced Basic Policy		
Billable Annual Premium	$2,887	$2,887	$1,188	$1,248	$0	$3,362
Annual Premium	$2,887	$2,887	$1,188	$1,248	$0	$3,362
Annual Premium Change (%)	N/A	0%	-58.85%	-56.77%	-100%	16.45%
Maximum Lifetime Benefit	Unlimited	Unlimited	$394,644	$493,305	$246,652	Unlimited
Maximum Lifetime Benefit Change (%)	N/A	0%	-60.54%	-50.67%	-75.33%	0%
Phase Two Rate Increase/Benefit Reduction Possible	N/A	Yes	No	No	No	Yes
SELECT ONE ▶		☐	☐	☐	☐	☐

Sign below.

I understand the election I have made above and acknowledge that I have made the election voluntarily. I agree that the changes I have requested will become effective April 20,2022 and cannot be reversed after February 28, 2022.

I understand that if I do not clearly mark only one election, or if I do not return this signed form postmarked by February 28, 2022, I will receive Option 2 by default.

Signature: Date: / / Month Day Year

Print name here:

Signatory authority: ☐ Power of Attorney ☐ Conservator ☐ Other:

Return this form in the postage-paid envelope postmarked by February 28, 2022.
Questions? Call (833) 894-8577, Monday through Friday, 8:00 a.m. to 6:00 p.m. EST.

PO Box 64675, St. Paul, MN 55164-0675

SHIP-FP-LTREF-0122

BUSINESS
FIRST-CLASS MAIL PERM
POSTAGE WILL BE PAID BY
SENIOR HEALTH INS
OF PENNSYLVANIA (
PO BOX 64675
ST. PAUL, MN 55164-0675

IF YOU DON'T RETURN YOUR COVERAGE ELECTION FORM ON TIME, YOU WILL AUTOMATICALLY RECEIVE THE DEFAULT OPTION IDENTIFIED ON YOUR PERSONALIZED OPTIONS CHART AND ON YOUR COVERAGE ELECTION FORM.

Understanding the Policy Features in Your Personalized Options chart.

The information provided in Step One of the guide was customized just for you. It details the options available to you and provides cost and benefit information for each option. We encourage you to carefully evaluate the benefits, premium, and possibility of future rate increases/benefit reductions in light of your personal situation with a family member or trusted advisor. Maximum Lifetime Benefit and Annual Premium have been provided to enable you and your advisor to compare the maximum lifetime benefits to annual cost for each option.

Policy Feature	Description
Maximum Benefit Period[1,2]	The maximum length of time your policy pays benefits.
Maximum Daily Benefit[3]	The most you can collect each day for each type of care: Nursing Home (NH), Assisted Living Facility (ALF), Home Health Care (HHC). Your policy may include certain additional benefits. If your policy includes additional benefits that are based on your NH, ALF, or HHC benefit amount(s), the maximum daily benefit amount for the additional benefits will change based on the option you choose. To learn more about additional benefits please refer to the Glossary of Terms in your Important Information for Policyholders brochure.
Maximum Lifetime Benefit[1]	The maximum benefit amount you can collect from your policy assuming benefit payments begin now. This benefit amount may not include eligible Restoration of Benefits associated with the policy.
Benefit Account Value (Pool of Money)	"Yes" means policy benefits are measured by the total dollar amount paid. "No" means they are measured by the number of days benefits are paid.
Elimination Period[1,4]	The length of time you must wait after becoming eligible for benefits before you are eligible to receive benefit payments.
Reimbursement Type[2, 5]	Reimbursement means you're covered for actual expenses up to the applicable limit. Indemnity means you'll be paid the full daily amount, regardless of expenses incurred.
Inflation Benefit	A rider or policy provision that increases your coverage at regular intervals to guard against inflation.
Extension of Benefits	A policy provision that allows claim payments to continue, even if your policy lapses for non-payment.
Restoration of Benefits	A policy provision that restores your benefits to the original maximum level, if no claims are filed for an extended period of time, such as 180 days.
Return of Premium Benefit	This policy provision or rider provides for return of some or all of the policy premium paid if you do not have claims during a given time frame (such as ten years or the time your policy was in force).
Waiver of Premium Benefit[4]	With this policy provision, you are not required to pay premiums under certain specified circumstances such as while you are on claim.
Rehabilitation Plan Required Benefit Eligibility[4]	"Yes" means the benefit eligibility requirements outlined in the SHIP Rehabilitation Plan will apply to your policy if you select this option. Rehabilitation Plan Benefit Eligibility requires that you 1) be expected to require care for at least 90 days, and be unable to perform two or more Activities of Daily Living (i.e., eating, dressing, bathing, transferring, toileting, and continence) without substantial hands-on or standby assistance; or 2) for at least 90 days, need substantial assistance due to a severe cognitive impairment. In either case a licensed healthcare professional must certify a plan of care. "No" means the benefit eligibility requirements outlined in the SHIP Rehabilitation Plan do not apply. The benefit eligibility requirements of your policy do not change.

1. Your Maximum Benefit Period, Maximum Lifetime Benefit, and Elimination Period may be lower than what is shown if you are currently receiving benefits or have received benefits in the past.
2. Maximum Benefit Period and Reimbursement Type are shown for the highest level of care covered by the policy.
3. Some policies may have Monthly or Weekly benefits instead of Daily benefits.
4. If these features change under an option and benefit eligibility for a claim has been approved prior to the Effective Date, these modifications will only apply to future claims.
5. Under Option 1, if your Reimbursement Type changes from Indemnity to Reimbursement and benefit eligibility for a claim has been approved prior to the Effective Date, this Policy Feature modification will only apply to future claims.

Note: Refer to the Glossary of Terms in the "Important Information for Policyholders" booklet for a more detailed description of each Policy Feature.

Questions About Your Options?

Q1. When will my new coverage or premium go into effect?

Your new coverage or premium will go into effect on the Election Effective Date listed on your Coverage Election Form.

Q2. Can I change my decision once I return the Coverage Election Form?

You can change your decision until the deadline indicated on your Coverage Election Form. Coverage Election Forms post-marked after this date will not be accepted. It is important to submit your Form on time.

Q3. What happens if I do not return my Coverage Election Form?

If you do not return your Coverage Election Form, the Option identified as "Default" on your Personalized Options chart (on page two of this guide) and on your Coverage Election Form will be deemed to be your choice. Please be sure to make an election and return your completed Coverage Election Form on time.

Q4. What happens if I return my Coverage Election Form without a signature or if I do not select only one option?

Under these circumstances, your Coverage Election Form will be considered invalid. The Option identified as "Default" on your Personalized Options chart (on page two of the guide) and on your Coverage Election Form will be deemed to be your choice. Please be sure to submit a properly completed and signed form.

Q5. What happens if I cannot find my Coverage Election Form?

If you have misplaced your Coverage Election Form, please contact (833) 894-8577. We will promptly send you a new Coverage Election Form.

Q6. Do I need to send any money with my completed Coverage Election Form?

No. You do not need to send any money with your completed Coverage Election Form. You will continue to be billed in the same way you are billed now. If you have not paid premium recently and premium becomes due, a premium notice will be mailed to the address on file.

Q7. Can my premiums increase in Phase Two of the Rehabilitation Plan?

If you elect Option 1 or Option 4, your policy may be subject to additional rate increases in Phase Two of the Rehabilitation Plan. You would be notified in advance of any required premium increase. Similar to Phase One, customized options would be prepared and fully explained to you.

Q8. Can my benefits be reduced in Phase Two of the Rehabilitation Plan?

If you elect Option 1 or Option 4, your policy may be subject to additional benefit reductions in Phase Two of the Rehabilitation Plan. You would be notified in advance of any required benefit reduction. Similar to Phase One, customized options would be prepared and fully explained to you.

Q9. What happens if I cancel or lapse my coverage, instead of making a coverage decision?

If you cancel or lapse your policy *before* your Option becomes effective, your coverage will be converted to a standard paid-up policy. Coverage provided by a standard paid-up policy equals the total premium paid by you since the issue date of your policy, reduced by the sum of any claim payments and any returned premium payments made to you since the issue date of your policy.

If you cancel or lapse your policy *after* your Option becomes effective, your coverage will be converted to the Enhanced Paid-Up Policy as described under Option 3 on your Personalized Options chart on page two of this guide.

Q10. I am currently receiving benefits under my long-term care policy. Do I still have to return the Coverage Election Form?

Yes. You must return your completed Coverage Election Form even if you are currently receiving claim benefit payments. Your benefits may change, depending on the Option you select. If you choose an Option that changes your benefits, your new benefits will start on the date your Option becomes effective. If you do not return your Coverage Election Form, the Option identified as "Default" will be deemed to be your choice.

Q11. What is the difference between Annual Premium and Billable Annual Premium?

Annual Premium is the cost of coverage for policy features listed under each option on your Personalized Options chart. Billable Annual Premium is that amount minus any premium that is currently being waived.

If you currently pay the full premium amount, your Annual Premium and Billable Annual Premium are the same. If your premiums are currently being waived, and your new Annual Premium is greater than the waived premium amount, you will be billed the Annual Billable Premium when your new option becomes effective.

Q12. I currently do not have to pay premium because my policy is on waiver of premium. Do I still have to return the Coverage Election Form?

Yes. You must return your completed Coverage Election Form even if you are currently not paying premium.

More Questions? Call (833) 894-8577. Monday through Friday, 8:00 a.m. to 6:00 p.m. EST.

EXHIBIT 12

STATE OF CONNECTICUT

INSURANCE DEPARTMENT

IN THE MATTER OF:	)	
	)	
	)	Docket No. LH 22-13
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)	)	
	)	
Respondent	)	

CEASE AND DESIST ORDER

The Insurance Commissioner of the State of Connecticut (hereinafter "the Commissioner") has cause to believe that the acts, practices, transactions, and course of business engaged in by Senior Health Insurance Company of Pennsylvania (In Rehabilitation) (hereinafter "SHIP") may be conducted in an illegal and improper way and that irreparable harm may be caused to the citizens of the State of Connecticut. As a result, the issuance of the following Cease and Desist Order appears warranted:

FINDINGS OF FACT

1. SHIP is a life and health insurance company that administers a closed block of long-term care insurance policies and is organized pursuant to the laws of the Commonwealth of Pennsylvania and has its principal place of business at 550 Congressional Boulevard, Suite 200, Carmel, Indiana 46032. SHIP is domiciled in Pennsylvania.

2. SHIP is licensed in approximately forty-six (46) states as well as the District of Columbia and the United States Virgin Islands; however, SHIP does not currently hold, nor has it ever held, an insurance license issued by the Connecticut Insurance Department ("Department").

3. Despite not holding an insurance license issued by the Department, at present SHIP insures approximately twenty-five (25) in-force individual long-term care insurance policies that were issued in Connecticut by a predecessor of SHIP from 1990 through 1994. SHIP insures approximately fifty-seven (57) other in-force individual long-term care insurance policies for policyholders residing in Connecticut but with polices issued in other states.

4. SHIP has been insolvent since at least December 31, 2018, when it reported a deficit of approximately a half-billion dollars. On January 29, 2020, upon the application of the Insurance Commissioner of Pennsylvania ("Rehabilitator"), the Commonwealth Court of Pennsylvania, entered an Order of Rehabilitation placing SHIP into rehabilitation in accordance with the provisions of Pennsylvania law.

5. Patrick H. Cantilo ("Special Deputy Rehabilitator") was appointed by the Rehabilitator as Special Deputy Rehabilitator of SHIP generally having the power to act on behalf of the Rehabilitator, subject to the control and direction of the Rehabilitator.

6. On April 22, 2020, the Rehabilitator filed her Application for Approval of the Plan of Rehabilitation for SHIP along with a proposed Rehabilitation Plan and subsequently filed a Second Amended Rehabilitation Plan on May 3, 2021. Such Rehabilitation Plan was approved by a Memorandum Opinion and Order of the Commonwealth Court of Pennsylvania on August 24, 2021.

7. On or about August 26, 2021, the Department received a letter from the Rehabilitator concerning information for states about opting-out of the rate approval provisions of the Rehabilitation Plan. On September 30, 2021, the Department received formal notice which indicated an "opt-out deadline" of November 15, 2021.

8. On November 15, 2021, the Commissioner forwarded correspondence to the Rehabilitator and Special Deputy Rehabilitator of SHIP that the Department would withdraw from the premium rate increase approval provision of the Rehabilitation Plan for

all of the in force long-term care insurance policies currently held by SHIP and first issued by SHIP or its predecessors in Connecticut. Such correspondence stated that any application and rate request made by SHIP must be filed with the Department pursuant to applicable Connecticut law and the Department would conduct its review and assessment of such application and premium rate request pursuant to Connecticut law.

9. On December 2, 2021, SHIP filed with the Department an Application for Rate Increases (SERFF Tr Number SHPT-133065666) ("Application") on twenty-one (21) of the in-force individual long-term care insurance policies issued in Connecticut seeking substantial premium increases on Connecticut policyholders. Such filing was made with the Department pursuant to General Statutes § 38a-501 which requires, among other items, that an issuer shall not use or change premium rates for a long-term care policy unless the rates have been filed with and approved by the Insurance Commissioner.

10. Long-term care insurance policies must comply with the basic requirements as set forth in General Statutes § 38a-501, for individual long-term care policies, and General Statutes § 38a-528, for group long-term care policies.

11. As part of the Application, the Special Deputy Regulator stated that under the Rehabilitation Plan: "your office's decision on the rates requested in the attached memorandum must be provided to us by February 15, 2022. If a response is not provided by this date, this filing and the requested rate increases will be deemed denied in their entirety. In accordance with the Approved Rehabilitation Plan, a filing deemed denied in its entirety will result in policyholder options being calculated and presented to policyholders for selection assuming your state has approved a 0% premium rate increase."

12. In the Q&A portion of the Opt-out Notification sent to the Department on September 30, 2021, the Rehabilitator identified that if a state rejects part or all of the requested premium rate modifications, the Rehabilitator will adjust the affected premium rates to the amount approved by the state and depending on the option elected by the

affected policyholder, benefits under the policy may be reduced to the amount that can be funded by the approved rate on an if knew basis.

13. The Application's Actuarial Memorandum further states that if a state approves an amount less than the full requested premium rate increase, policyholders will have four options provided to them, as described in the Rehabilitation, and election notification letters will be sent to such policyholders.

14. From December 2, 2021, through February 1, 2022, the Department submitted supplemental questions to SHIP concerning its Application and SHIP submitted responses.

15. Based upon the information contained in the Application and responses to Department questions, on February 14, 2022 the Department issued a Disapproval of the Application to SHIP ("Disapproval of the Application").

16. The Disapproval of the Application was based on the following:

a. According to the actuarial memorandum included in the rate filing submitted by SHIP, current premiums vary by issue age, daily benefit, benefit period, elimination period, inflation protection, any applicable riders selected, and any applicable discounts. The rate increase requested in this filing has been prepared on a policy-level basis using an If Knew Premium rating methodology. This means that the requested rate increase is dependent on each individual policyholder's characteristics (e.g., gender, issue age) and product features (e.g., benefit period, inflation protection), without regard to a policyholder's current attained age, state of issue, state of residence, health conditions, or premium-paying status.

b. The SHIP rate filing request is prepared on a seriatim basis for each individual policyholders characteristics (e.g. gender, issue age). This methodology is in direct conflict with how the original policy form defined rating classes. As a result, the Connecticut Insurance Department (CID) requested that SHIP provide equivalent

rate increases that are not based on gender, as gender was not an original defined rating class. The response the CID received from SHIP is as follows "Our actuarial model utilizes assumptions that vary by gender. Unfortunately, at this time we cannot devote the resources necessary to provide gender-neutral rate increases."

17. Despite the issuance of the Disapproval of the Application, SHIP has affirmatively notified the Department in the Application, through responses to Department questions on the Application, and forms of general communication that on or after February 15, 2022, it intends to proceed with transmitting election notifications to the Connecticut policyholders identified in its Application in which such policyholder will be forced to elect options identified in the Rehabilitation Plan which may include either substantial increases in premium rates or substantial reductions in benefits. Such actions are in direct violation of General Statutes § 38a-501.

18. SHIP is further in violation of Connecticut law as it is not licensed as an insurer by the Department. General Statutes § 38a-272 prohibits any person or insurer from doing, directly or indirectly, any of the acts of an insurance business, as defined in General Statutes § 38a-271, unless authorized under the general statutes. General Statutes § 38a-41 prohibits any insurers or health care center from doing any insurance business or health care business in Connecticut, except if authorized by the Insurance Commissioner.

CONCLUSIONS

The facts set forth in paragraphs 1 through 18 of the Findings of Fact herein demonstrate that SHIP is in violation of General Statutes §§ 38a-272 and 38a-41 and has further demonstrated immediate plans to violate General Statutes § 38a-501 and that the continuation of such activities would cause irreparable harm to the residents of the State of Connecticut. The public welfare, therefore, imperatively requires that SHIP, Respondent herein, be ordered to CEASE AND DESIST immediately from engaging in acts violating any provisions of Title 38a of the Connecticut General Statutes, principally from taking

any actions or transmitting any notices with the effect of reducing benefits or raising insurance rates on SHIP in-force long-term care policies issued in Connecticut, and conducting any further insurance business in Connecticut as an unlicensed entity, with the exception of continuing to administer existing Connecticut issued individual long-term care insurance policies as such insurance policies are guaranteed renewable.

Pursuant to General Statutes § 38a-17, IT IS THEREFORE ORDERED by the Insurance Commissioner:

That SHIP IMMEDIATELY CEASE AND DESIST from (1) engaging in acts in violation of any provisions of Title 38a of the Connecticut General Statutes; (2) transmitting notices identified in the Rehabilitation Plan and Application to SHIP policyholders with Connecticut issued policies the intent of which is to either elect raises to insurance premium rates or benefit reductions, or take any other action beyond those identified in the existing policies; and (3) conducting any further insurance business in the State of Connecticut as an unlicensed entity, with the exception of continuing to insure and administer existing Connecticut issued policies.

SO ORDERED this 15th day of February, 2022.

Andrew N. Mais
Insurance Commissioner

CERTIFICATION

It is hereby certified that the aforementioned was sent via certified mail, regular mail and electronically delivered on this 15th day of February, 2022 to the following:

SENIOR HEALTH INSURANCE
COMPANY OF PENNSYLVANIA
(IN REHABILITATION)
550 Congressional Blvd.
Suite 200
Carmel, IN 46032
via email: phcantilo@cb-firm.com; Rehabilitation@shipltc.com

Jared T. Kosky, Esq.
General Counsel

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF INSURANCE, SECURITIES AND BANKING

IN THE MATTER OF: Senior Health Insurance Company of Pennsylvania (In Rehabilitation), Respondent.	Case No.: IB-CD-1-22

SUMMARY CEASE AND DESIST ORDER

Pursuant to D.C. Official Code § 31-233, the Commissioner of the Department of Insurance, Securities and Banking hereby issues this summary cease and desist order against Senior Health Insurance Company of Pennsylvania ("SHIP") after determining based on knowledge and belief that SHIP is engaging or is about to engage in conduct prohibited by Chapters 1-55, of Title 31, and any implementing rule thereunder, and that immediate action is in the public interest. The predicate for this administrative action is set forth below.

1. SHIP is a Pennsylvania-domiciled life and health insurance company that became authorized to issue long-term care insurance ("LTC") policies in the District as a foreign insurer beginning in 1986 (NAIC Company Code 76325).

2. Beginning in 1995, SHIP has filed three requests for premium rate increases for its LTC policies issued in the District. SHIP's 1995 filing for a 12% increase was approved, its 1998 filing for a 16% increase was approved, and its 2003 filing for a 25% increase was denied. SHIP has not submitted any further

rate filings with the Department since 2003.

3. In recent years, SHIP experienced financial distress and faced the possibility of insolvency.

4. On January 29, 2020, upon the application of Jessica Altman, the Commissioner of Insurance for the Commonwealth of Pennsylvania, the Commonwealth Court of Pennsylvania,in suit number 1 SHP 2020, entered an Order of Rehabilitation placing SHIP into rehabilitation in accordance with the provisions of Pennsylvania law.

5. The Order of Rehabilitation appointed Commissioner Altman and her successorsin office as statutory rehabilitator of SHIP pursuant to the provisions of 40 P.S. §§ 221.14 – 221.18, and required the Rehabilitator to prepare a plan of rehabilitation. Commissioner Altman appointed Patrick Cantilo as Special Deputy Rehabilitator, with the power to act on the Rehabilitator's behalf.

6. SHIP currently has 5 in force policies issued in the District and subject to District law, with the average age of the District policyholders being 84 years-old.

7. On April 22, 2020, the Rehabilitator filed her Application for Approval of the Plan of Rehabilitation for SHIP and contemporaneously filed a Rehabilitation Plan.

8. The Rehabilitation Plan was approved by a Memorandum Opinion and Order of the Pennsylvania Commonwealth Court on August 24, 2021, as amended on November 4, 2021.

9. State insurance regulators from Massachusetts, Maine and

Washington intervened in rehabilitation proceedings and appealed the Order approving Rehabilitation Plan to the Pennsylvania Supreme Court (Middle District), No. 71 MAP 201. Approximately, 24 state insurance regulators, including the undersigned, have requested leave to support the intervening regulators as amici curie. The appeal remains pending before the Pennsylvania Supreme Court.

10. In late-January 2022, the Rehabilitator filed for approval by the Commissioner proposed premium rates for the District policyholders, which have been designated by the Rehabilitator as the "If Knew Premium Rates". Pursuant to the Rehabilitation Plan, the District, which elected to "Opt-Out" of the Rehabilitation Plan while reserving all rights, is being forced to review SHIP's proposed "If Knew Premium Rates" that have an average premium increase of 425%. If approved, the District policyholders will be mailed a "Coverage Election Package" for the "Opt-In" states that advises them of five policy options to select from that includes some combination of premium increases and/or benefit reductions, as well as a non-forfeiture option. Conversely, if SHIP's proposed "If Knew Premium Rates" are denied, either in whole or in part, the District policyholders will be mailed a "Coverage Election Package" for "Opt-Out" states advising them of four policy options that are inferior to the "Opt-In" options that includes another combination of premium increases and/or benefit reductions, as well as a non-forfeiture option.

11. Pursuant to the Rehabilitation Plan, District policyholders will be required to complete and return their election forms by mid-March 2022.

12. On February 2, 2022, the Rehabilitation Court approved the proposed premium rate plan and methodology established by Rehabilitator Plan that will be used by SHIP nationwide, including in the District.

13. Notwithstanding SHIP's "If Knew Premium Rate" filing submitted to the District, SHIP's rate plan and methodology established by the Rehabilitation Plan and approved by the Rehabilitation Court for the five "Opt-In" and four "Opt-Out" premium and benefit options from which policyholders, including District policyholders, are to select, has not, in its entirety with the accompanying "Coverage Election Packages" it intends to use, been filed with the District for review and approval under the District's LTC rate and form filing requirements.

14. The Rehabilitator has set a deadline of February 15, 2022, for the Commissioner to approve SHIP's "If Knew Premium Rate" filing. According to the Rehabilitation Plan, if the Commissioner does not approve SHIP's rate filing by February 15, then "Coverage Election Packages" will be mailed to the District policyholders, whereby they will be asked to select from the four "Opt-Out" options. Without complying with the District's rating filing requirements for long-term care policies, SHIP will be using insurance rates and forms that have not been approved; and consequently, will be relying on the Rehabilitation Court's approval of the Rehabilitation Plan and SHIP's rating plan and methodology filed with the Court, rather than the District's, to set rates and benefits for District policyholders.

15. Further, in addition to the pending appeal of the order approving the Rehabilitation Plan before the Pennsylvania Supreme Court, injunctions and

administrative cease and desist orders have been issued against SHIP, enjoining the Rehabilitator from implementing the Rehabilitation Plan, in South Carolina, Louisiana, North Dakota and Maine upon findings that the insurance regulator challenges to the Rehabilitation Plan demonstrated a likelihood of success on the merits and that relief was necessary to prevent irreparable harm. In each proceeding, SHIP and the Rehabilitator were named as parties.

16. In this context, the Rehabilitator is requiring District policyholders to make final and binding coverage elections under a cloud of legal risk that creates the potential for the disruption of the delivery of medical services. Moreover, the rate increases and reductions in benefits will have a permanent adverse effect on policyholders' guaranty association benefits in the event SHIP is placed into liquidation at a later date, which is likely given the uncertainty and necessity of additional rounds of rate increases and benefit reductions built into the multi-phased Rehabilitation Plan and SHIP's previous track-record. Even the Special Deputy Rehabilitator has conceded that restoring SHIP to solvency is unlikely.

17. Based on the foregoing predicate, there is substantial cause to believe that SHIP is transacting insurance business in the District in a manner that is causing or is reasonably expected to cause significant, imminent, and irreparable injury to District policyholders, including in violation of the following District laws and regulations:

18. The business of insurance in the District is regulated pursuant to Chapters 1 – 55, of Title 31, of the D.C. Official Code.

19. Pursuant to D.C. Official Code § 31-233, the Commissioner is

authorized to issue a summary cease and desist order against any person that is engaging or is about to engage in conduct prohibited by Chapters 1 – 55, of Title 31.

20. Pursuant to D.C. Official Code § 31-4712, every life insurance company shall file with the Commissioner for approval the classification of risks and the premium rates appertaining thereto, and policy forms.

21. Pursuant to D.C. Official Code §§ 31-2231 *et seq.*, no person shall engage in an unfair or deceptive act or practice in the business of insurance in the District.

22. Pursuant to D.C. Official Code §§ 31-2231.03, no person shall make, issue, circulate, or cause to be made, issued or circulated, an estimate, illustration, circular or statement, sales presentation, omission, or comparison that: (1) Misrepresents the benefits, advantages, conditions, or terms of a policy.

23. Pursuant to D.C. Official Code §§ 31-2231.04, no person shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in a notice, circular, pamphlet, letter, or poster, or over a radio or television station, or in any other way, an advertisement, announcement, or statement containing an assertion, representation, or statement with respect to the business of insurance or with respect to an insurer in the conduct of its insurance business which is untrue, deceptive, or misleading.

WHEREFORE, it is so Ordered this 15th day of February 2022 that SHIP and any of its principles, agents, employees, successors, and assigns are directed to cease and desist from implementing the Rehabilitation Plan in the District or otherwise interfering with the rights of SHIP's District policyholders or violating the insurance laws and regulations of the District, including by mailing "Coverage Election Packages" and notifying District policyholders of proposed rate or benefit modifications SHIP intends use in place of the policyholders' existing rates and benefits, none of which has been authorized by the Commissioner.

WHEREFORE, it is further Ordered that for the duration of this cease and desist order, SHIP shall continue to abide by the current policy terms, benefits and premium levels for District policyholders in effect prior to February 15, 2022.

This Order does not prohibit SHIP from curing any of its form or rate filing deficiencies or from obtaining the approval thereof.

Karima M. Woods
Commissioner
Department of Insurance, Securities and Banking

NOTICE OF RIGHT TO REQUEST A HEARING

Pursuant to D.C. Official Code § 31-233(b)(2), the Respondent has fifteen (15) calendar days from the date of receipt of this notice to request a hearing to determine whether the proposed action should be taken. If a hearing is requested, the Commissioner, or a designee, shall hold the hearing within thirty (30) days after the date the Commissioner receives your request. If a request for a hearing is not received by the Department within fifteen (15) days from the date of receipt of this notice, the Respondent's right to a hearing will be deemed waived and a final order may be issued.

In addition, pursuant to 26A DCMR §§ 3804.8 – 3804.11, the Respondent has ten (10) business days from the date of receipt of this notice to file a written answer. The answer should be made in writing, and shall admit, deny or admit with an explanation each charge and specification alleged. If an answer is not timely filed, the summary cease and desist order may be entered as final.

Your request for a hearing should be made in writing and addressed to Ms. Sharon Shipp, Deputy Commissioner, Department of Insurance, Securities and Banking, 1050 First Street, NE, Suite 801, Washington, DC 20002.

CONDUCT OF HEARING

If a hearing is requested, the hearing will be governed in accordance with the 26A DCMR §§ 3800 – 3819; and section 10 of the District of Columbia Administrative Procedure Act, D.C. Official Code § 2-509. The Respondent may appear personally or may be represented by legal counsel. The Respondent will have the right to produce witnesses and evidence on your behalf, and to cross-examine witnesses. The strict rules of evidence will not govern the administrative hearing. The Hearing

Officer shall have authority to administer oaths to witnesses.

Anyone testifying falsely after having been administered such an oath shall be subject to the penalties of perjury. Oral or documentary evidence may be received at the hearing. However, the Hearing Officer shall exclude irrelevant, immaterial, and unduly repetitious evidence. Every party shall have the right to present in person or by counsel his or her case and defenses by oral and documentary evidence, to submit rebuttal evidence, and to conduct such cross-examination as may be required for full and true disclosure of the facts.

No motion for a continuance will be granted unless good cause is shown in writing to the Hearing Officer and is made no later than five (5) days prior to the hearing date. Correspondence requesting a continuance should be directed to the Hearing Officer. A copy of any pleading or other written communication addressed to the Department of Insurance, Securities and Banking in this matter should also be sent to the attorney of record for the Department.

If the Respondent, any corporate officer, or any witness to be called, are deaf or because of a hearing impediment cannot readily understand or communicate the spoken English language, the Respondent or the witness may apply to the Department for the appointment of a qualified interpreter. In addition, if Respondent or any witnesses to be called require any other special accommodations, please contact the Hearing Officer at least five (5) business days prior to the hearing.

CERTIFICATE OF SERVICE

I hereby certify that on February 15, 2022, I caused a copy of the foregoing Summary Cease and Desist Order to be sent by certified mail to:

Jessica K. Altman
Rehabilitator

Patrick H. Cantilo
Cantilo & Bennett, L.L.P.
Special Deputy Rehabilitator

Senior Health Insurance Company
of Pennsylvania (In Rehabilitation)
550 Congressional Boulevard, Suite 200
Carmel, IN 46032

service@cb-firm.com

/s/Adam Levi
Adam Levi

BEFORE THE COMMISSIONER OF SECURITIES AND INSURANCE
OFFICE OF THE MONTANA STATE AUDITOR

In the Matter of the Proposed Agency Action Against SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (in rehabilitation)	Case No.: INS-2022-55 **TEMPORARY CEASE AND DESIST ORDER**

To: SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, in Rehabilitation
c/o Jessica Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, as Rehabilitator.
Office of the Insurance Commissioner
1326 Strawberry Square
Harrisburg, PA 17120

TEMPORARY CEASE AND DESIST ORDER

Pursuant to § 33-1-318, MCA, and based on the allegations of fact and conclusions of law set forth in the *Notice of Proposed Agency Action and Opportunity for Hearing* filed in this matter, it appears to the Commissioner that the Respondent has engaged in, or is about to engage in, acts or practices constituted violations of §§ 33-22-1101, 33-22-1114, 33-18-201 and 33-18-202, MCA and Administrative Rules of Montana (ARM) §§ 6.6.3121, 6.6.3122, and 6.6.3124.

Therefore, SHIP and its Rehabilitator, Special Deputy Rehabilitator, principals, employees, and agents are ORDERED to immediately cease and desist from the following actions:

(a) dissemination of any policyholder notifications, including Election Packages,[1] to policyholders within Montana without review and prior approval by the Commissioner;

(b) accepting or implementing the elections of any Montana policyholders made pursuant to the Election Packages and/or the Approved Plan.

(c) all other implementation of the Approved Plan within Montana.

PENALTIES

Pursuant to § 33-1-318, a violation of this Order is a separate violation for which the CSI may impose a fine not to exceed $5,000 per violation in addition to any other penalties imposed by law.

Dated this 2nd day of March, 2022.

Troy Downing
Commissioner of Securities and Insurance,
Office of the Montana State Auditor

[1] Capitalized terms in this Temporary Cease and Desist Order have the meanings assigned in the Notice of Proposed Agency Action.

CERTIFICATE OF SERVICE

I hereby certify that on March 7, 2022, I caused a copy of the foregoing Temporary Cease and Desist Order to be served on the following persons by the following means:

__X__ Mail

_____ E-Mail

SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, in Rehabilitation
c/o Jessica Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, as Rehabilitator.
Office of the Insurance Commissioner
1326 Strawberry Square
Harrisburg, PA 17120

Brandy Morrison
Paralegal

Ole Olson
Chief Legal Counsel
Commissioner of Securities and Insurance,
Office of the Montana State Auditor
840 Helena Avenue
Helena, MT 59601
Phone: (406) 444-2040
Fax: (406) 444-3497
OOlson@mt.gov

Kenneth K. Lay
CROWLEY FLECK, PLLP
900 North Last Chance Gulch, Suite 200
Helena, MT 59601
Phone: (406) 449-4165
Fax: (406) 449-5149
klay@crowleyfleck.com

Attorneys for the Commissioner of Securities and Insurance

BEFORE THE COMMISSIONER OF SECURITIES AND INSURANCE
OFFICE OF THE MONTANA STATE AUDITOR

In the Matter of the Proposed Agency Action Against SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (in rehabilitation)	Case No.: INS-2022-55 **NOTICE OF PROPOSED AGENCY ACTION AND OPPORTUNITY FOR HEARING**

To: SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, in Rehabilitation
c/o Jessica Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, as Rehabilitator.
Office of the Insurance Commissioner
1326 Strawberry Square
Harrisburg, PA 17120

The Commissioner of Securities and Insurance, Office of the Montana State Auditor ("Commissioner") has cause to believe that Senior Health Insurance Company of Pennsylvania (hereinafter, "SHIP"), including the Rehabilitator, Special Deputy Rehabiltator, SHIP's

principles, employees and agents have violated the Montana Insurance Code, §§ 33-1-101, et seq., MCA (the "Code"). The Commissioner proposes to take action against SHIP for violation of the Code, which may include cease and desist orders, where appropriate.

The Commissioner has authority to take such actions based on the following provisions of Montana law: §§ 33-1-311, 33-1-317, 33-1-318, 33-18-201, 33-18-202, 33-22-1103, 33-22-1114, 333-22-1120, MCA, and Administrative Rules of Montana (ARM) §§ 6.6.3121, 6.6.3122, and 6.6.3124.

ALLEGATIONS OF FACT

1. Senior Health Insurance Company of Pennsylvania ("SHIP") is a Pennsylvania-domiciled limited life insurance company.

2. SHIP is authorized to act as an insurer in Montana under § 33-2-101, MCA, though its license is presently inactive due to being in rehabilitation.

3. SHIP administers a closed block of long-term care insurance policies, including policies issued to Montana residents.

4. SHIP currently has approximately 181 policies issued and in force in Montana, approximately 141 of which will be affected by SHIP's actions that are the subject of this Notice of Proposed Agency Action.

5. SHIP's financial condition has been steadily deteriorating for many years, and it is likely that SHIP is irredeemably insolvent, with a current projected deficit in excess of $1 billion.

6. Despite SHIP's apparently hopeless financial condition, the Pennsylvania Insurance Department has not sought a declaration of insolvency, which would have triggered guarantee association coverage and protection for policyholders in Montana and elsewhere.

7. Instead, on application of the Pennsylvania Insurance Department, SHIP was placed into rehabilitation on January 29, 2020 by the Commonwealth Court of Pennsylvania (the "Pennsylvania Court"), with the ostensible goal of remedying SHIP's deteriorating financial condition for the benefit of policyholders, creditors and the public. *See* Docket No. 1 SHP, 2020 (the "Rehabilitation Proceeding").

8. Pennsylvania's Insurance Commissioner, Jessica K. Altman, is the court-appointed Rehabilitator ("Rehabilitator") of SHIP, and Patrick H. Cantilo is Special Deputy Rehabilitator ("SDR") of SHIP.

9. On April 20, 2020, the Rehabilitator filed an Application in the Rehabilitation Proceeding for Approval of the Plan of Rehabilitation for SHIP with the Pennsylvania Court, together with a proposed Rehabilitation Plan.

10. The Pennsylvania Court issued an Order on August 25, 2021, approving a Plan of Rehabilitation (the "Approved Plan"). The Rehabilitator filed the Approved Plan on September 30, 2021.

11. The Approved Plan attempts to address SHIP's substantial funding gap through forcing policyholders to accept unilaterally redesigned policies, based on a combination of drastic reductions in coverage and dramatic increases in premium rates. Central to the Approved Plan is a new premium rate—the "If Knew" premium—equivalent to the rate that would have produced acceptable loss ratios, had it been charged from inception.

12. SHIP's "If Knew" premium rates are substantially higher than the rates currently being paid by its Montana policyholders.

13. The Approved Plan would require Montana policyholders to choose among various redesigned policy alternatives, which would reduce benefits in order to keep their current

premiums, or dramatically increase premiums to keep their current benefits. Policyholders would be forced to elect one of four redesigned policy alternatives:

> (1) continue paying their current premiums, but have benefits reduced if their premium is less than the "If Knew" premium;
>
> (2) accept policy endorsements designed by the Rehabilitator, that provide selected benefits at a different premiums;
>
> (3) a Non-Forfeiture Option giving the policyholder a Reduced Paid-Up policy with limited benefits, but no future premiums; or
>
> (4) retain current policy benefits but pay the "If Knew" premium.

14. According to the Approved Plan, the Rehabilitator concluded that SHIP would not submit these benefit and premium rate modifications for approval to the Commissioner, or to other state insurance regulators.

15. Instead, the Approved Plan includes a purported "opt-out" process, under which state insurance commissioners can advise the Rehabilitator that a state has elected to "opt-out" of ratemaking portions of the Approved Plan. If a state does not opt out, the Approved Plan allows SHIP to send correspondence ("Election Packages") to policyholders requiring them to elect among various options for redesigned policies with increased premiums and/or reduced benefits, none of which have been approved by the Commissioner.

16. Although the Approved Plan's "opt-out" scheme ostensibly defers to state insurance commissioners and ratemaking authorities in the various states, that deference is illusory because the Approved Plan is coercively structured. Even if a state elects to "opt out" of SHIP's proposed rate increases, the Rehabilitator will simply force policyholders to accept redesigned policies with reduced and downgraded policyholder benefits, effectively terminating and replacing existing policies.

17. On September 30, 3031, the Rehabilitator and SDR sent the Commissioner an "Opt-Out Election Notice" under the Approved Plan, instructing the Commissioner that Montana must opt out of the Approved Plan by a specified date.

18. Montana did not opt out of, nor it affirmatively opt into, the Approved Plan. Instead, on November 5, 2021, the Commissioner sent the Rehabilitator and SDR a letter notifying them that the Commissioner "will not respond to the [Opt-Out Election] Notice because the Rehabilitator lacks the authority to impose rate or benefit changes on our policyholders without the [Commissioner's] approval. The CSI reserves all of its rights in this regard."

19. Nonetheless, the Rehabilitator has sent Election Packages to SHIP's Montana policyholders informing them that on or before March 11, 2022, they must make a final and binding election between the policy options presented by the Approved Plan, which include exorbitant premium increases and/or punitive reductions in benefits. The Election Packages offers policyholders redesigned policies with drastically different premiums and/or benefits than they presently enjoy, none of which have ever been submitted to, or approved by, the Commissioner.

ASSERTIONS OF LAW

20. The Commissioner of Securities and Insurance, Office of the Montana State Auditor ("CSI"), is under the control and supervision of the Commissioner. Sec. 2-15-1902 and 33-1-301, MCA.

21. The Commissioner is empowered to enforce applicable provisions of Montana law, including the Code, and is charged with administering the CSI "to ensure that the interests of insurance consumers are protected." Sec. 33-1-311(1) and (3), MCA.

22. The Commissioner and CSI have jurisdiction over his matter and authority to issue this Notice of Proposed Agency Action. Sec. 33-1-311, MCA.

23. Before making any long-term care policy available within Montana, the issuer must comply with the filing requirements set forth in A.R.M. § 6.6.3122, by making certain filings with the Commissioner. These include the disclosures required by A.R.M. § 6.6.3121, as well as the actuarial certifications and various other information described in A.R.M. § 6.6.3122(2)(b).

24. SHIP has violated or is about to violate A.R.M. § 6.6.3122, MCA, by making long-term insurance policies available without first complying with the notice and filing requirements of A.R.M. § 6.6.3122. The Election Packets offer, and attempt to force policyholders into accepting, redesigned long-term care policies despite the fact that required filings relating to such policies have not been submitted to, reviewed, or approved by the Commissioner.

25. Before implementing premium rate increases or notifying policyholders of premium rate increases, the issuer of a long-term care policy must comply with the notice and filing provisions of A.R.M. § 6.6.3124, by filing with the Commissioner all disclosures and information required by § 6.6.3121, as well as the actuarial certifications required by § 6.6.3124(3)(b), and information justifying the rate changes and complying with the requirements of § 6.6.3124(3)(c).

26. SHIP has violated A.R.M. § 6.6.3124 by sending Election Packets that attempt to force its Montana policyholders to accept redesigned policies requiring substantially higher rates and/or reduced benefits, without first submitting rates, actuarial certifications, and other required information justifying the rates for review and approval by the Commissioner.

27. No person shall engage in any unfair or deceptive act or practice in the business of insurance. Sec. 33-18-201, MCA.

28. It is an unfair and deceptive act or practice to misrepresent pertinent facts or insurance policy provisions relating to coverages at issue. Sec. 33-18-201(1).

29. SHIP has engaged in unfair and deceptive acts or practices by misrepresenting pertinent facts relating to policies and coverages, by sending policyholders Election Packages that offer redesigned policies as well as premiums and/or benefits that SHIP cannot legally offer (because such policies or policy modifications have never been submitted to, or approved by, the Commissioner).

30. It is an unfair and deceptive act or practice to make, issue, circulate, or cause to be made, issued, or circulated any estimate, illustration, circular, sales presentation, omission, comparison, or statement which misrepresents the benefits, advantages, conditions, or terms of any insurance policy. Sec. 33-18-202(1), MCA.

31. SHIP has engaged in unfair acts and deceptive acts and practices by issuing and sending circulars or statements (the Election Packages) that mislead policyholders and misrepresent the benefits, conditions and terms of SHIP's policies, by offering redesigned policies and/or requiring changes to premiums and benefits that SHIP cannot legally make, and by omitting the pertinent fact that such changes have not been submitted to or approved by the Commissioner.

32. A long-term care policy may not be offered in Montana unless it complies with the provisions of the Montana Long-Term Insurance Act, §§ 33-22-1101 *et seq.*, MCA. Long-term care policies may not be canceled, nonrenewed, or otherwise terminated on grounds other than the insured's or certificate holder's failure to pay premiums. Sec. 33-22-1114, MCA.

33. SHIP has violated the Long-Term Insurance Act by sending Election Packages to Montana policyholders contrary to Montana law, and with the understanding and intent that the policy terms offered therein will force policy lapses, result in the termination of policies, and/or require policyholders to accept drastically redesigned policies that effectively terminate and replace existing policies.

34. If allowed to continue, SHIP's various violations of Montana law as described herein will damage Montana policyholders by forcing lapse or termination of policies and imposing exorbitant premium increases and/or marked degradation of benefits.

35. If the Commissioner believes that an insurer is engaged or about to engage in a violation of, *inter alia*, Chapter 18 of Title 33, the Commissioner may, among other relief: (a) issue an order directing the person to cease and desist from continuing the act or practice, after reasonable notice and opportunity for a hearing; and (b) issue a temporary cease and desist order that must remain in effect until 10 days after the hearing is held. See. 33-1-318(1)(a) and (b), MCA.

36. SHIP's past and continuing violations warrant issuance of a temporary cease and desist order under § 33-1-318(1)(a) MCA and, after notice and opportunity for a hearing, a permanent cease and desist order under § 33-1-318(1)(b), MCA.

PROPOSED AGENCY ACTION

The Commissioner, considering the gravity of SHIP's violations, the need to protect the public health, safety and welfare of Montanans, and the need to defend the Commissioner's right to regulate insurance for the benefit and protection of Montana policyholders, intends to impose the following after a hearing conducted in accordance with § 33-1-701, MCA.

1. Issuance of a permanent Cease and Desist Order pursuant to § 33-1-318, MCA, as follows:

(a) enjoining SHIP from dissemination of any policyholder notifications, including Election Packages, within Montana without prior review and approval of the Commissioner as described above;

(b) enjoining SHIP from accepting or implementing the elections of any Montana policyholders made pursuant to the Election Packages and/or the Approved Plan.

(c) requiring SHIP to inform policyholders who may have received Election Packages that they are not required to make any election and that any election will not be implemented prior to the resolution of this action; and

(d) enjoining SHIP and its Rehabilitator, SDR, and other agents and employees to cease and desist from all other implementation of the Approved Plan within Montana.

2. Such other relief as may be just, proper, and available under Montana law.

STATEMENT OF RIGHTS

Respondent is entitled to contest the Commissioner's proposed action by requesting an administrative hearing. To do so, within 24 days of the date this Notice, Respondent must submit a hearing request in writing to Ole Olson, 840 Helena Avenue, Helena, MT 59601 or OOlson@mt.gov. A hearing request "must specify the grounds relied upon as a basis for the relief sought at the hearing." Section 33-1-701, MCA. It may also include a response to the allegations set forth above. If a hearing is requested, Respondent will be provided notice of the

time, place, and nature of the hearing. Respondent will be entitled to attend this hearing and respond and present evidence and arguments on all issues involved in this action.

Administrative hearings are conducted by an impartial hearing examiner appointed by the Commissioner under the provisions of the Montana Administrative Procedures Act. Formal proceedings may be waived pursuant to § 2-4-603, MCA. Respondent has the right to be represented by an attorney at any and all stages of this proceeding.

CONTACT WITH COMMISSIONER'S OFFICE

Please contact Ole Olson at (406) 444-1295 or OOlson@mt.gov with any questions or concerns. If represented by an attorney, please ensure the attorney makes that contact.

POSSIBILITY OF DEFAULT

Failure to timely provide a written hearing request shall result in the entry of a default order imposing the Commissioner's proposed action, without additional notice, pursuant to Admin. Rule Mont. 1.3.214.

Dated this 2nd day of March, 2022.

Ole Olson, Chief Legal Counsel
Commissioner of Securities and Insurance,
Office of the Montana State Auditor

CERTIFICATE OF SERVICE

I hereby certify that on March 2, 2022, I caused a copy of the foregoing Notice of Proposed Agency Action to be served on the following persons by the following means:

__X__ Mail

_____ E-Mail

SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, in Rehabilitation
c/o Jessica Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, as Rehabilitator.
Office of the Insurance Commissioner
1326 Strawberry Square
Harrisburg, PA 17120

Brandy Morrison
Paralegal

VERMONT

State of Vermont
Department of Financial Regulation
89 Main Street
Montpelier, VT 05620-3101

For consumer assistance:
[Banking] 888-568-4547
[Insurance] 800-964- 1784
[Securities] 877-550-3907
www.dfr.vermont.gov

VIA FIRST CLASS AND CERTIFIED MAIL

March 7, 2022

Senior Health Insurance Company of Pennsylvania (In Rehabilitation)
550 Congressional Boulevard, Suite 200
Carmel IN 46032

Re: In re: Senior Health Insurance Company of Pennsylvania; Docket No. 22-005-I

Dear Sir/Madam:

Enclosed please find the *Motion for Emergency Cease and Desist Order*, *Ex Parte Order to Cease and Desist, Notice of Right to Request Hearing*, and *Certificate of Service* in the above-captioned matter.

Sincerely,

/s/ Hillary Borcherding

Hillary Borcherding
Assistant General Counsel

Enclosures

cc: Jessica K. Altman, Rehabilitator, Pennsylvania Insurance Department
Patrick H. Cantilo, Esq.

STATE OF VERMONT
DEPARTMENT OF FINANCIAL REGULATION

IN RE: SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA	)))	**DOCKET NO. 22-005-I**

MOTION FOR EMERGENCY CEASE AND DESIST ORDER

Pursuant to 8 V.S.A. §§ 11, 12, 15, 3661, 8099, and DFR-2022-01 § 1.04(O), the Insurance Division makes this Motion requesting that the Commissioner of Financial Regulation issue an immediate cease and desist order (proposed order attached) against Senior Health Insurance Company of Pennsylvania (SHIP) because SHIP is transacting insurance business in this State in a manner that is causing or is reasonably expected to cause significant, imminent, and irreparable injury to Vermont policyholders, as more particularly set forth below.

FACTS ALLEGED

1. SHIP is a Pennsylvania-domiciled life and health insurance company that was never authorized to issue long-term care insurance (LTC) policies in Vermont.

2. SHIP's predecessors-in-interest, Transport Life Insurance Company and/or American Travelers Life Insurance Company, issued approximately 10 currently in-force life insurance policies in Vermont. It is unknown whether the companies were duly licensed in Vermont at the time of issuance.

3. SHIP now administers the policies issued in Vermont by its predecessors-in-interest.

4. Approximately fourteen (14) other SHIP-administered policies are held by Vermont residents who moved to Vermont after purchase.

5. All of the 24 SHIP policyholders described in paragraphs 2 - 4 are at least 80 years old and a clear majority are more than 90 years old. On information and belief, some policyholders are more than 100 years old.

6. In recent years, SHIP has experienced financial distress and faced the possibility of insolvency.

7. On January 29, 2020, upon the application of Jessica Altman, the Commissioner of Insurance for the Commonwealth of Pennsylvania, the Commonwealth Court of Pennsylvania, in suit number 1 SHP 2020, entered an Order of Rehabilitation placing SHIP into rehabilitation in accordance with the provisions of Pennsylvania law.

8. The Order of Rehabilitation appointed Commissioner Altman and her successors in office as statutory rehabilitator of SHIP pursuant to the provisions of 40 P.S. § 221.14, et seq. and required the Rehabilitator to prepare a plan of rehabilitation. Commissioner Altman appointed Patrick Cantilo as Special Deputy Rehabilitator, with the power to act on the Rehabilitator's behalf.

9. On April 22, 2020, the Rehabilitator filed her Application for Approval of the Plan of Rehabilitation for SHIP and contemporaneously filed a Rehabilitation Plan.

10. The Rehabilitation Plan was approved by a Memorandum Opinion and Order of the Pennsylvania Commonwealth Court on August 24, 2021, as amended on November 4, 2021.

11. The Commissioner and the regulators in other intervening jurisdictions appealed the Rehabilitation Plan to the Pennsylvania Supreme Court (Middle District), No. 71 MAP 201. By Order issued January 31, 2022, the Pennsylvania Supreme Court denied the insurance regulators'

request for stay pending appeal of the Rehabilitation Plan. The appeal remains pending before the Pennsylvania Supreme Court.

12. Upon information and belief, in late January 2022, without first filing its rates for approval with the Commissioner, the SHIP Rehabilitator mailed a "Coverage Election Package" to Vermont policyholders which advises them of forthcoming premium and/or benefit modifications that would purportedly begin as early as April 1, 2022. See Exhibit A (package as mailed to consumer in Maine; it is believed that substantially similar packages were sent nationwide, including in Vermont). The "Coverage Election Package" requires policyholders to complete and return their election form with a postmark date of no later than March 15, 2022. Id.

13. On February 2, 2022, the Rehabilitation Court purported to approve SHIP's use of nationwide premium rates including in Vermont.

14. The "Coverage Election Package" does not provide legally sufficient notice to Vermont policyholders of SHIP's proposed rate increase as required by Vermont law and DFR's Regulation H-2009-01.

15. The "Coverage Election Package" offers five coverage options to policyholders, including downgrading the policy, converting to a basic policy or to an enhanced basic policy, converting to an enhanced paid-up policy, and keeping their current policy. If a policyholder does not make a coverage election by the March 15, 2022 specified postmark date, SHIP states that it will, on its own, exercise the basic policy coverage option, resulting in a significant benefit reduction under the insurance policy.

16. The "Coverage Election Package" does not state that insurance rates are subject to state-by-state approval, including approval by the State of Vermont as to Vermont policies.

17. The "Coverage Election Package" does not disclose that the coverage options therein have not been approved by the Commissioner as required by law.

18. The "Coverage Election Package" does not disclose that the coverage options therein have not even been submitted to the Commissioner as required by law.

19. The "Coverage Election Package" fails to advise policyholders that the premium rates and policy modifications under the Rehabilitation Plan are on appeal to the Pennsylvania Supreme Court.

20. As set forth in the preceding paragraphs, SHIP purports to require Vermont policyholders to make final and binding coverage elections without any explanation to policyholders about how their rates and benefits would be reconfigured if the Rehabilitation Plan is overturned or otherwise modified by a court in a manner that affects rates and benefits.

21. Likewise, SHIP purports to force its elderly policyholders to choose between options, none of which have been approved by the Commissioner as required by law.

22. There appears to be significant doubt as to whether the Pennsylvania Supreme Court will uphold the rehabilitation plan. See, e.g., Farmer v. Altman, No. 2020-CP- 40-05802 (S.C. 5th Jud. Cir. Jan. 20, 2022) (granting preliminary injunctions against SHIP upon finding that the insurance regulator's challenges to the Rehabilitation Plan demonstrated a likelihood of success on the merits and that a preliminary injunction was necessary to prevent irreparable harm to policyholders).

EXHIBIT 1

(PART 4)

23. All policyholder elections and SHIP-imposed elections are purportedly deemed irrevocable in the Coverage Election Package, even if the Rehabilitation Plan is overturned or otherwise modified on appeal. Furthermore, any Vermont policyholder who selects the policy downgrade, the paid-up policy option, or their current policy terms could face yet more rate increases during Phase II of the Rehabilitation Plan, the details of which are unknown.

24. SHIP has not submitted to the Commissioner the premium rates that SHIP intends to use on insurance coverage provided to Vermont policyholders, purportedly beginning as early as April 1, 2022 based on elections SHIP purports to require by March 15, 2022.

25. SHIP has not obtained regulatory approval from the Commissioner for the premium rates that SHIP intends to use on insurance coverage provided to Vermont policyholders, purportedly beginning as early as April 1, 2022 and based on elections purportedly required to be made by March 15, 2022.

26. SHIP has not made all required regulatory filings with the Commissioner related to SHIP's transaction of the business of insurance in this State.

27. Among other matters, and not by limitation, Vermont policyholders have been and will be deceived and misled as a cumulative result of SHIP's:

a) failure to file proposed premium rates with the Commissioner;

b) failure to provide Vermont policyholders with the required advance notice of a premium rate increase for use with Vermont policies, including notice of the proposed rate, an explanation that it is subject to regulatory approval, the policyholder's right to request a hearing, the policyholder's right to provide

written comments on the proposed rate increase, and contact information for DFR's Insurance Division;

c) failure to provide Vermont policyholders with advance notice of premium rate implementation for Vermont policies; and

d) use of a "Coverage Election Form" for Vermont policies that is unfair or deceptive; contains misrepresentations; and/or is untrue, deceptive, or misleading.

28. Vermont policyholders have been and/or soon will be harmed by SHIP forcing them to make rushed and purportedly irreversible decisions about their existing long-term care insurance policies.

APPLICABLE LAW

29. Vermont law, Title 8, regulates entities that transact the business of insurance in the State.

30. Chapter 154 of Title 8 governs Long Term Care Insurance specifically.

31. Pursuant to authority expressly granted in Title 8, including Chapter 154, the Commissioner has promulgated Regulation H-2009-01, which provides among other things for important consumer protections relating to long-term care insurance.

32. SHIP is transacting the business of insurance in Vermont by, among other things, purporting to impose new rates and contract conditions on holders of long-term care insurance policies within the State.

33. Pursuant to Title 8, Chapter 1, Section 15 and § 3661, the Commissioner may issue such orders as are necessary to carry out the purposes of Title 8.

34. Pursuant to Department Regulation 2022-01 § 1.04(O), where the Commissioner is authorized by law to issue a cease-and-desist or other injunctive order, the Commissioner may do so without written or oral notice to the Respondent.

35. Pursuant to Title 8, Chapter 154 and Reg. H-2009-01, every insurer shall file for approval by the Commissioner every rate, rating formula, classification of risks, and every modification of any formula or classification that it proposes to use in this State in connection with individual health insurance policies, including LTC policies. Every such filing must be made not less than 60 days in advance of the stated effective date. The filing must contain sufficient information for the Commissioner to determine whether such filing meets the requirements that rates not be excessive, inadequate, or unfairly discriminatory. See 4-5 V.C.R. § 16 (citing 8 V.S.A. § 4062).

36. Pursuant to Reg. H-2009-01 as further explained in Insurance Bulletin No. 216, an insurer shall notify Vermont policyholders of a proposed premium rate increase forty-five (45) days after filing with the Department of Financial Regulation (Department). The written notice must show the proposed rate; state that the rate is subject to regulatory approval; and inform the policyholder of the right to provide oral or written comments on the proposed rate increase. See 4-5 V.C.R. § 9; 8 V.S.A. § 8084a.

37. Pursuant to Reg. H-2009-01, an insurer may not implement a premium increase for use in Vermont until it is approved by the Commissioner.

38. Pursuant to Reg. H-2009-01, an insurer shall provide written notice of a premium rate increase for use in Vermont to all affected Vermont policyholders at least forty-five (45) days before the effective date of any rate increase. See 4-5 V.C.R. § 9; 8 V.S.A. § 4062.

39. Pursuant to Title 8, Chapter 154 and Reg. H-2009-01, no person shall engage in an unfair or deceptive act or practice in the business of insurance in this State.

40. Pursuant to Title 8, Chapter 129, Section 4723 and Reg. H-2009-01, no person shall make, issue, or circulate, or cause to be made, issued, or circulated any estimate, illustration, circular, or statement misrepresenting the terms, benefits, or advantages of an insurance policy issued in this State. 4-5 V.C.R. § 23.

41. Pursuant to Title 8, Chapter 129 and Reg. H-2009-01, no person shall make, publish, disseminate, or circulate, or cause, directly or indirectly, to be made, published, disseminated, or circulated, in the form of a notice, circular, pamphlet, or letter, or in any other way, any statement regarding the person's transaction of insurance business in this State that is untrue, deceptive, or misleading.

42. Pursuant to Title 8, Chapter 101, Section 3661 and Department Regulation 2022-01 § 1.04(O), when the Commissioner believes that a person is engaging in conduct that is causing or is reasonably expected to cause significant, imminent, and irreparable injury to Vermont insurance consumers, the Commissioner may immediately issue a cease-and-desist order, without prior notice and hearing.

VIOLATIONS ALLEGED

Violation I

Failure to File Rates for Approval

43. SHIP violated and continues to violate Regulation H-2009-01 § 20 by failing to file for approval by the Commissioner the rates, rating formula, classification of risks, and every modification of any formula or classification that it proposes to use with policies in Vermont at least 60 days prior to the anticipated notice to the policyholders.

Violation II

Premium Rates: Notice of Filing

44. SHIP violated and continues to violate Regulation H-2009-01 §§ 9, 20 as further explained in Insurance Bulletin No. 216 by failing to provide written notice to Vermont policyholders of proposed premium rate increases. The written notice must show the proposed rate; state that the rate is subject to regulatory approval; and inform the policyholder of the right to provide written or oral comments on the proposed rate increase to the Department.

Violation III

Premium Rates: Implementation

45. SHIP violated and continues to violate Regulation H-2009-01 § 20 by communicating a purported effective date as soon as April 1, 2022 for implementation of premium rate increases under Vermont insurance policies without first having obtained approval by the Commissioner.

Violation IV

Premium Rates: 45-Day Notice

46. SHIP violated and continues to violate Regulation H-2009-01 § 20 and 8 V.S.A. § 8084a(e) by providing notice of premium rate increases affecting Vermont policyholders less than forty-five (45) days before implementation of the rate increase for use in Vermont, to be effective as soon as April 1, 2022.

Violation V

Policyholder Notice: Unfair or Deceptive Acts

47. SHIP violated and continues to violate 8 V.S.A. § 4723 by mailing a "Coverage Election Package" to Vermont policyholders that unfairly or deceptively discloses premium rates and

benefit modifications under a Vermont insurance policy, when such rates and modifications have never been submitted to or approved by the Commissioner.

Violation VI

Policyholder Notice: Misrepresentation

48. SHIP violated and continues to violate 8 V.S.A. § 4723 by mailing a "Coverage Election Package" to Vermont policyholders that misrepresents the premium rates and benefit modifications under a Vermont insurance policy.

CONCLUSION AND REQUEST FOR RELIEF

49. As set forth above in Paragraphs 1 through 48, SHIP bas engaged in and is continuing to engage in the business of insurance in this State in a manner that is contrary to Vermont law and is causing or is reasonably expected to cause significant, imminent, and irreparable injury to Vermont policyholders.

50. For all the foregoing reasons, the Insurance Division requests that the Commissioner issue an immediate cease and desist order requiring SHIP and its principals, employees, and agents (including the Rehabilitator and its deputies and agents) to:

a) Cease mailing the "Coverage Election Package" or any substantially similar material in this State, including, but not limited to, any material describing unapproved premium rate or benefit modification implementation, until further order of the Commissioner.

b) Communicate to all Vermont policyholders in writing, on a form approved by the Commissioner, that the "Coverage Election Package" has no effect in Vermont.

c) Cease implementation of any proposed rate increases in Vermont until such increases are reviewed and approved by the Commissioner.

d) Cease implementation of any rate increases in Vermont, effectuated on or after January 29, 2020, until such increases are reviewed and approved by the Commissioner.

e) Cease implementation of any decreases in coverage elected, on or after January 29, 2020, by an insured in Vermont until such elections are reviewed and approved by the Commissioner.

Dated at Montpelier, Vermont this _4th_ day of March, 2022.

Kevin Gaffney, Deputy Commissioner of Insurance
Department of Financial Regulation

By: Hillary Borcherding

Hillary Borcherding
Assistant General Counsel
89 Main Street
Montpelier, VT 05620-3101
(802) 249-6512
Hillary.borcherding@vermont.gov

Exhibit A

SHIP
SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
(IN REHABILITATION)
P.O. Box 64675, St. Paul MN 55164-0675

Action Required By: March 15, 2022

[redacted]

IMMEDIATE ACTION REQUIRED

Dear [redacted]

I'm writing today with important information about your long-term care insurance from Senior Health Insurance Company of Pennsylvania (In Rehabilitation) ("SHIP") and to thank you for your patience and understanding as we guide the company through the rehabilitation process.

As part of this process, you have a very important decision to make at this time. A number of new coverage options are available to you. You are required to select only one option by March 15, 2022.

To get started, please refer to the enclosed "Step-by-Step Guide for Policyholders" and follow these simple steps:

Step 1: Review your personalized options.

Step 2: Learn more about each option.

Step 3: Indicate your choice on the attached Coverage Election Form, detach and mail the completed form to SHIP in the enclosed postage-paid return envelope as soon as possible.

You'll find more details in the "Important Information for Policyholders" booklet and "Summary of Current Coverage" document provided. To watch our informational video series and learn more, visit us online at **shipltc.com**. Please know we are here to help you. We understand you have a lot invested in your current policy and you want to make sure you will have protection when you need it. Just call us at (833) 894-8577.

Sincerely,

Patrick H. Cantilo

Patrick H. Cantilo
Special Deputy Rehabilitator

Please note that your Coverage Election Form must be postmarked by March 15, 2022.

9594

Coverage Election Form

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)

POLICYHOLDER NAME: [redacted]

POLICY NUMBER: [redacted]

ELECTION EFFECTIVE DATE: April 1, 2022

IMPORTANT: This form must be signed and postmarked by March 15, 2022.

Best way to reach you, if we have questions.

Phone:

Email:

Select the option that best suits your needs.

Policy Feature	Your Current Policy	Option 1 Downgrade Your Policy	Option 2 Convert to a Basic Policy	Option 2a Convert to an Enhanced Basic Policy	Option 3 Convert to an Enhanced Paid-Up Policy	DEFAULT Option 4 Keep Your Current Coverage
Billable Annual Premium	$1,350	N/A	$835	N/A	$0	$1,350
Annual Premium	$1,350	N/A	$835	N/A	$0	$1,350
Annual Premium Change (%)	N/A	N/A	-38%	N/A	-100%	0%
Maximum Lifetime Benefit	$146,000	N/A	$146,000	N/A	$73,000	$146,000
Maximum Lifetime Benefit Change (%)	N/A	N/A	0%	N/A	-50%	0%
Phase Two Rate Increase/Benefit Reduction Possible	N/A	N/A	No	N/A	No	Yes
SELECT ONE ▶		❑	❑	❑	❑	❑

Sign below.

I understand the election I have made above and acknowledge that I have made the election voluntarily. I agree that the changes I have requested will become effective April 1, 2022 and cannot be reversed after March 15, 2022.

I understand that if I do not clearly mark only one election, or if I do not return this signed form postmarked by March 15, 2022, I will receive Option 4 by default.

Signature: Date: / / Month Day Year

Print name here:

Signatory authority: ☐ Power of Attorney ☐ Conservator ☐ Other:

Return this form in the postage-paid envelope postmarked by March 15, 2022.
Questions? Call **(833) 894-8577**, Monday through Friday, 8:00 a.m. to 6:00 p.m. EST.

UNV045%PLB9348382

PO Box 64675, St. Paul, MN 55164-0675

SHIP-EP-LTREF-0122

Summary of Current Coverage

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)

INSURED: [redacted]

POLICY NUMBER: [redacted]

STATE OF ISSUE: ME

STATE OF RESIDENCE: ME

CURRENT ANNUAL PREMIUM: $1,350

DATE ISSUED: 11/1/1989

ISSUE AGE: 60

CURRENT AGE: 91

SUMMARY AS OF: 7/31/2021

CURRENT POLICY STATUS: Premium Paying - Not On Claim

Policy Feature	Current Coverage	Description
Maximum Benefit Period[1,2]	1,460 Days	The maximum duration during which benefits will be available under the policy.
Maximum Daily Benefit[3]	NH: $100.00 HHC: $100.00	The maximum daily dollar amount available on a covered date of care as specified in the policy, for each eligible type of care. NH = Nursing Home, ALF = Assisted Living Facility, HHC = Home Health Care.
Maximum Lifetime Benefit[1]	$146,000	The maximum benefit amount available for the life of the policy, reflecting inflation assuming benefits start now. This benefit amount may not include eligible Restoration of Benefits associated with the policy.
Benefit Account Value (Pool of Money)	No	"Yes" means the policy benefits are measured in dollars paid up to the Maximum Lifetime Benefit. "No" means the policy benefits are measured in days paid up to the Maximum Benefit Period days.
Elimination Period[1]	0 Days	The time period during which a policyholder qualifies for benefits but for which no benefits are yet payable.
Reimbursement Type[2]	Indemnity	The method by which the Daily Benefit will be paid out. Reimbursement provides coverage for the actual expenses of care up to specified limits. Indemnity pays the full daily benefit amount regardless of expenses incurred.
Inflation Benefit	No Inflation	A rider purchased or a policy provision that provides for defined increases in benefits at regular intervals in order to protect against the effects of inflation on the cost of care.
Extension of Benefits	Included	A provision in the policy permitting claim payments to continue for a policy on claim that lapses due to non-payment of premium.
Restoration of Benefits	Included	A policy provision under which the benefit period for a policyholder will be restored to the original Maximum Benefit Period after receiving some or all claim benefits if the policyholder does not need or receive care during a specified period of time (such as 180 days).
Return of Premium Benefit	Not Included	A rider purchased or policy provision which provides for the return of a percentage of premium paid by the policyholder (such as 80%) in consideration of the absence of claim payments during a given period of time in which the policy was in force (such as ten years), or upon policy termination.
Waiver of Premium Benefit	Included	A policy provision under which the policyholder is no longer required to pay premiums for coverage in specified circumstances, such as eligibility for benefits.

1. Your Maximum Benefit Period, Maximum Lifetime Benefit, and Elimination Period may be lower than what is shown if you are currently receiving benefits or have received benefits in the past.
2. Maximum Benefit Period and Reimbursement Type are shown for the highest level of care covered by the policy.
3. Some policies may have Monthly or Weekly benefits instead of Daily benefits.

Note: This document is being provided solely for your convenience and is for reference only. It is not a comprehensive explanation of policy terms or benefits and is not intended to modify or amend any policy provision. All benefit determinations will be processed in accordance with the terms and conditions set forth in your policy and any policy rider(s).

Additional Useful Coverage Information

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)

Coverage information provided on this page does not represent your current coverage. It has been provided to inform you of possible premium and coverage information associated with your policy in future phases of the Rehabilitation Plan. Please refer to the "Important Information for Policyholders" booklet for more detailed information. We encourage you and your trusted advisor to consider this additional useful information as you make your election decision.

INSURED: [redacted] **POLICY NUMBER:** [redacted]

Policy Feature	Current Coverage	Description
Rehabilitation Plan Required Benefit Eligibility	No	"Yes" means the benefit eligibility requirements outlined in the SHIP Rehabilitation Plan will apply to your policy. Rehabilitation Plan Benefit Eligibility requires that you 1) be expected to require care for at least 90 days, and be unable to perform two or more Activities of Daily Living (i.e., eating, dressing, bathing, transferring, toileting, and continence) without substantial hands-on or standby assistance; or 2) for at least 90 days, need substantial assistance due to a severe cognitive impairment. In either case a licensed healthcare professional must certify a plan of care. "No" means the benefit eligibility requirements outlined in the SHIP Rehabilitation Plan do not apply. The benefit eligibility requirements of your policy do not change.
GA Coverage Limit	$300,000	Guaranty Associations (GAs) provide coverage for eligible policyholders of insurance companies that are placed in liquidation. GAs offer continuation of coverage up to a defined GA Coverage Limit that is determined by state of residence of the policyholder. This coverage reflects the GA Coverage Limit in your state of residence that would apply in the event SHIP were to be placed in liquidation in the future.
GA Fully Covered	Yes	"Yes" means your projected Maximum Lifetime Benefit is less than or equal to the GA Coverage Limit in your state of residence. "No" means your projected Maximum Lifetime Benefit is greater than the GA Coverage Limit in your state of residence. This is only a projection which may change with changes in circumstances. You may also want to compare the GA Coverage Limit to the Maximum Lifetime Benefit of your policy as shown on the Coverage Election Form.
Potential Uncovered Benefits	$0	The portion of your Maximum Lifetime Benefit as shown on the Coverage Election Form that exceeds the GA Coverage Limit in your state of residence. Uncovered benefits apply only if a company is placed in liquidation.
Expected Liquidation Rate Increase	0%	This rate increase is the rate increase that could be pursued if SHIP is placed in liquidation. It is a projected number based on certain assumptions made today and could change in the future.
Self-Sustaining Annual Premium	$1,875	This premium is the annual premium that could be charged to fully fund your policy. It is a projected number based on certain financial assumptions made today, including assets available, benefit payments, and expenses.

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SHIP
SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
(IN REHABILITATION)

Choosing the Right Coverage Option

A Step-by-Step Guide for Policyholders

Step One: Review Your Personalized Options

Prepared For [redacted]
Policy Number [redacted]

This chart shows the options currently available to you. Use it to compare the details most important to you.

Policy Feature	Option 1 Downgrade Your Policy	Option 2 Convert to a Basic Policy	Option 2a Convert to an Enhanced Basic Policy	Option 3 Convert to an Enhanced Paid-Up Policy	DEFAULT Option 4 Keep Your Current Coverage
Maximum Benefit Period	N/A	1,825 Days	N/A	913 Days	1,460 Days
Maximum Daily Benefit	N/A	NH: $80.00 HHC: $80.00	N/A	NH: $80.00 HHC: $80.00	NH: $100.00 HHC: $100.00
Maximum Lifetime Benefit	N/A	$146,000	N/A	$73,000	$146,000
Benefit Account Value (Pool of Money)	N/A	Yes	N/A	Yes	No
Elimination Period	N/A	90 Days	N/A	90 Days	0 Days
Reimbursement Type	N/A	Indemnity	N/A	Indemnity	Indemnity
Inflation Benefit	N/A	No Inflation	N/A	No Inflation	No Inflation
Extension of Benefits	N/A	Not Included	N/A	Not Included	Included
Restoration of Benefits	N/A	Not Included	N/A	Not Included	Included
Return of Premium Benefit	N/A	Not Included	N/A	Not Included	Not Included
Waiver of Premium Benefit	N/A	Not Included	N/A	Not Included	Included
Billable Annual Premium	N/A	$835	N/A	$0	$1,350
Annual Premium	N/A	$835	N/A	$0	$1,350
Rehabilitation Plan Required Benefit Eligibility	N/A	Yes	N/A	Yes	No
Phase Two Rate Increase/Benefit Reduction Possible	N/A	No	N/A	No	Yes

Note: If you do not return your Coverage Election Form on time, the Option identified as "Default" will be deemed to be your choice. Annual Premium is the cost of coverage for policy features listed under each option. Billable Annual Premium is that amount minus any premium that is currently being waived.

In the event the Company is placed in liquidation in the future, available benefits may be reduced below those identified in Your Personalized Options, except for Option 3.

Step Two: Learn More About Each Option

We understand that no two policyholders are alike. To help you navigate through the process of making your election decision, we've outlined several preferences to consider that may be important for you to think about. **Please review the policy features outlined in your Personalized Options chart on page two of this guide. Some options may not apply to all policies. Options that do not apply to you will appear on your Personalized Options chart with a designation of N/A (Not Applicable) per the policy features.**

If your preference is to...	Consider these options	A bit about the options...
Maintain your current premium (recognizing that benefits may be reduced in Phase Two of the Rehabilitation Plan)	**Option 1** (Downgrade Your Policy)	• This option offers reduced benefits while allowing your premium to remain the same. • Your benefits will be reduced as shown on your Personalized Options chart on page two of this guide. • The premium rates and benefits associated with this option are not guaranteed and may change significantly in Phase Two of the Rehabilitation Plan.
Adjust your premium and benefits (designed to balance premium and benefits)	**Option 2** (Convert to a Basic Policy) **Option 2a** (Convert to an Enhanced Basic Policy)	• These options offer benefits available on a new Basic Policy (Option 2) or a new Enhanced Basic Policy (Option 2a). Option 2a may offer a longer benefit period and more inflation protection. For some policyholders Option 2 may provide the same coverage as Option 2a. • The new premium for this new policy will correspond to the benefits displayed on your Personalized Options chart on page two of this guide. • These options aim to strike a balance between Option 1 and Option 4, but with two significant benefits: 1. You are protected from mandatory future premium rate increases or benefit reductions in Phase Two of the Rehabilitation Plan. 2. There is an added safety net where your benefits will not be reduced below coverage levels provided in liquidation.
Stop paying premium altogether (while maintaining a basic level of coverage)	**Option 3** (Convert to an Enhanced Paid-Up Policy)	• This option offers a paid up insurance policy with benefits displayed on your Personalized Options chart on page two of this guide. This means you will no longer have to pay premium, and coverage will terminate when the Maximum Lifetime Benefit is exhausted. • The benefits associated with this option are generally richer than those offered as part of a traditional (non-Rehabilitation) nonforfeiture option. • This option will not be subject to premium rate increases or benefit reductions in Phase Two of the Rehabilitation Plan.
Preserve your current benefits (recognizing that premium may be increased in Phase Two of the Rehabilitation Plan)	**Option 4** (Keep Your Current Coverage)	• This option offers continuation of current coverage at a potentially higher premium rate. • You will have the same level of protection you have now at the premium amount displayed on your Personalized Option chart on page two of this guide. • The premium rates and benefits associated with this option are not guaranteed and may change significantly in Phase Two of the Rehabilitation Plan.
Have certainty (with respect to the premium you will pay and the benefits you will receive throughout the Rehabilitation process)	**Option 2** (Convert to a Basic Policy) **Option 2a** (Convert to an Enhanced Basic Policy) **Option 3** (Convert to an Enhanced Paid-Up Policy)	• All 3 of these options offer certainty that you will not be subject to mandatory premium rate increases or benefit reductions in Phase Two of the Rehabilitation Plan.

Step Three: Indicate Your Choice On The Enclosed Form

Your Coverage Election Form must be signed and postmarked by March 15, 2022.

1. Tell us how we can reach you, if we have questions.
2. Indicate the option you prefer by checking the block associated with your selected option. You should select only one option.
3. Sign your name and date the form.
4. Mail in the postage-paid return envelope.

Coverage Election Form

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)

POLICYHOLDER NAME: John J. Sample
POLICY NUMBER: 8321
ELECTION EFFECTIVE DATE: 4/20/2022
IMPORTANT: This form must be signed and postmarked by February 28, 2022.

Best way to reach you, if we have questions.

1 **Phone:** _____
Email: _____

Select the option that best suits your needs.

Policy Feature	Your Current Policy	Option 1 Downgrade Your Policy	Option 2 (DEFAULT) Convert to a Basic Policy	Option 2a Convert to an Enhanced Basic Policy	Option 3 Convert to an Enhanced Paid-Up Policy	Option 4 Keep Your Current Coverage
Billable Annual Premium	$2,887	$2,887	$1,188	$1,248	$0	$3,362
Annual Premium	$2,887	$2,887	$1,188	$1,248	$0	$3,362
Annual Premium Change (%)	N/A	0%	-58.85%	-56.77%	-100%	16.45%
Maximum Lifetime Benefit	Unlimited	Unlimited	$394,644	$493,305	$246,652	Unlimited
Maximum Lifetime Benefit Change (%)	N/A	0%	-60.54%	-50.67%	-75.33%	0%
Phase Two Rate Increase/Benefit Reduction Possible	N/A	Yes	No	No	No	Yes
SELECT ONE ▶		☐	☐	☐	☐	☐

2

Sign below.

I understand the election I have made above and acknowledge that I have made the election voluntarily. I agree that the changes I have requested will become effective April 20,2022 and cannot be reversed after February 28, 2022.

I understand that if I do not clearly mark only one election, or if I do not return this signed form postmarked by February 28, 2022, I will receive Option 2 by default.

3

Signature: _____ Date: ___ / ___ / ___ (Month / Day / Year)

Print name here: _____

Signatory authority: ☐ Power of Attorney ☐ Conservator ☐ Other: _____

Return this form in the postage-paid envelope postmarked by [Decision Date].
Questions? Call **(833) 894-8577**, Monday through Friday, 8:00 a.m. to 6:00 p.m. EST.

P.O. Box 64675, St. Paul, MN 55164-0675

SHIP-EP-LTREF-0122

BUSINESS
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SENIOR HEALTH INS
OF PENNSYLVANIA (I
PO BOX 64675
ST. PAUL, MN 55164-0675

IF YOU DON'T RETURN YOUR COVERAGE ELECTION FORM ON TIME, YOU WILL AUTOMATICALLY RECEIVE THE DEFAULT OPTION IDENTIFIED ON YOUR PERSONALIZED OPTIONS CHART AND ON YOUR COVERAGE ELECTION FORM.

Understanding the Policy Features in Your Personalized Options chart.

The information provided in Step One of the guide was customized just for you. It details the options available to you and provides cost and benefit information for each option. We encourage you to carefully evaluate the benefits, premium, and possibility of future rate increases/benefit reductions in light of your personal situation with a family member or trusted advisor. Maximum Lifetime Benefit and Annual Premium have been provided to enable you and your advisor to compare the maximum lifetime benefits to annual cost for each option.

Policy Feature	Description
Maximum Benefit Period[1,2]	The maximum length of time your policy pays benefits.
Maximum Daily Benefit[3]	The most you can collect each day for each type of care: Nursing Home (NH), Assisted Living Facility (ALF), Home Health Care (HHC). Your policy may include certain additional benefits. If your policy includes additional benefits that are based on your NH, ALF, or HHC benefit amount(s), the maximum daily benefit amount for the additional benefits will change based on the option you choose. To learn more about additional benefits please refer to the Glossary of Terms in your Important Information for Policyholders brochure.
Maximum Lifetime Benefit[1]	The maximum benefit amount you can collect from your policy assuming benefit payments begin now. This benefit amount may not include eligible Restoration of Benefits associated with the policy.
Benefit Account Value (Pool of Money)	"Yes" means policy benefits are measured by the total dollar amount paid. "No" means they are measured by the number of days benefits are paid.
Elimination Period[1,4]	The length of time you must wait after becoming eligible for benefits before you are eligible to receive benefit payments.
Reimbursement Type[2, 5]	Reimbursement means you're covered for actual expenses up to the applicable limit. Indemnity means you'll be paid the full daily amount, regardless of expenses incurred.
Inflation Benefit	A rider or policy provision that increases your coverage at regular intervals to guard against inflation.
Extension of Benefits	A policy provision that allows claim payments to continue, even if your policy lapses for non-payment.
Restoration of Benefits	A policy provision that restores your benefits to the original maximum level, if no claims are filed for an extended period of time, such as 180 days.
Return of Premium Benefit	This policy provision or rider provides for return of some or all of the policy premium paid if you do not have claims during a given time frame (such as ten years or the time your policy was in force).
Waiver of Premium Benefit[4]	With this policy provision, you are not required to pay premiums under certain specified circumstances such as while you are on claim.
Rehabilitation Plan Required Benefit Eligibility[4]	"Yes" means the benefit eligibility requirements outlined in the SHIP Rehabilitation Plan will apply to your policy if you select this option. Rehabilitation Plan Benefit Eligibility requires that you 1) be expected to require care for at least 90 days, and be unable to perform two or more Activities of Daily Living (i.e., eating, dressing, bathing, transferring, toileting, and continence) without substantial hands-on or standby assistance; or 2) for at least 90 days, need substantial assistance due to a severe cognitive impairment. In either case a licensed healthcare professional must certify a plan of care. "No" means the benefit eligibility requirements outlined in the SHIP Rehabilitation Plan do not apply. The benefit eligibility requirements of your policy do not change.

1. Your Maximum Benefit Period, Maximum Lifetime Benefit, and Elimination Period may be lower than what is shown if you are currently receiving benefits or have received benefits in the past.
2. Maximum Benefit Period and Reimbursement Type are shown for the highest level of care covered by the policy.
3. Some policies may have Monthly or Weekly benefits instead of Daily benefits.
4. If these features change under an option and benefit eligibility for a claim has been approved prior to the Effective Date, these modifications will only apply to future claims.
5. Under Option 1, if your Reimbursement Type changes from Indemnity to Reimbursement and benefit eligibility for a claim has been approved prior to the Effective Date, this Policy Feature modification will only apply to future claims.

Note: Refer to the Glossary of Terms in the "Important Information for Policyholders" booklet for a more detailed description of each Policy Feature.

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Questions About Your Options?

Q1. When will my new coverage or premium go into effect?

Your new coverage or premium will go into effect on the Election Effective Date listed on your Coverage Election Form.

Q2. Can I change my decision once I return the Coverage Election Form?

You can change your decision until the deadline indicated on your Coverage Election Form. Coverage Election Forms post-marked after this date will not be accepted. It is important to submit your Form on time.

Q3. What happens if I do not return my Coverage Election Form?

If you do not return your Coverage Election Form, the Option identified as "Default" on your Personalized Options chart (on page two of this guide) and on your Coverage Election Form will be deemed to be your choice. Please be sure to make an election and return your completed Coverage Election Form on time.

Q4. What happens if I return my Coverage Election Form without a signature or if I do not select only one option?

Under these circumstances, your Coverage Election Form will be considered invalid. The Option identified as "Default" on your Personalized Options chart (on page two of the guide) and on your Coverage Election Form will be deemed to be your choice. Please be sure to submit a properly completed and signed form.

Q5. What happens if I cannot find my Coverage Election Form?

If you have misplaced your Coverage Election Form, please contact (833) 894-8577. We will promptly send you a new Coverage Election Form.

Q6. Do I need to send any money with my completed Coverage Election Form?

No. You do not need to send any money with your completed Coverage Election Form. You will continue to be billed in the same way you are billed now. If you have not paid premium recently and premium becomes due, a premium notice will be mailed to the address on file.

Q7. Can my premiums increase in Phase Two of the Rehabilitation Plan?

If you elect Option 1 or Option 4, your policy may be subject to additional rate increases in Phase Two of the Rehabilitation Plan. You would be notified in advance of any required premium increase. Similar to Phase One, customized options would be prepared and fully explained to you.

Q8. Can my benefits be reduced in Phase Two of the Rehabilitation Plan?

If you elect Option 1 or Option 4, your policy may be subject to additional benefit reductions in Phase Two of the Rehabilitation Plan. You would be notified in advance of any required benefit reduction. Similar to Phase One, customized options would be prepared and fully explained to you.

Q9. What happens if I cancel or lapse my coverage, instead of making a coverage decision?

If you cancel or lapse your policy *before* your Option becomes effective, your coverage will be converted to a standard paid-up policy. Coverage provided by a standard paid-up policy equals the total premium paid by you since the issue date of your policy, reduced by the sum of any claim payments and any returned premium payments made to you since the issue date of your policy.

If you cancel or lapse your policy *after* your Option becomes effective, your coverage will be converted to the Enhanced Paid-Up Policy as described under Option 3 on your Personalized Options chart on page two of this guide.

Q10. I am currently receiving benefits under my long-term care policy. Do I still have to return the Coverage Election Form?

Yes. You must return your completed Coverage Election Form even if you are currently receiving claim benefit payments. Your benefits may change, depending on the Option you select. If you choose an Option that changes your benefits, your new benefits will start on the date your Option becomes effective. If you do not return your Coverage Election Form, the Option identified as "Default" will be deemed to be your choice.

Q11. What is the difference between Annual Premium and Billable Annual Premium?

Annual Premium is the cost of coverage for policy features listed under each option on your Personalized Options chart. Billable Annual Premium is that amount minus any premium that is currently being waived.

If you currently pay the full premium amount, your Annual Premium and Billable Annual Premium are the same. If your premiums are currently being waived, and your new Annual Premium is greater than the waived premium amount, you will be billed the Annual Billable Premium when your new option becomes effective.

Q12. I currently do not have to pay premium because my policy is on waiver of premium. Do I still have to return the Coverage Election Form?

Yes. You must return your completed Coverage Election Form even if you are currently not paying premium.

More Questions? Call (833) 894-8577. Monday through Friday, 8:00 a.m. to 6:00 p.m. EST.

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OF PENNSYLVANIA
(IN REHABILITATION)

The information in this brochure provides general guidance and does not address any specific claims or circumstances. It does not constitute a binding legal statement and is not intended to serve as legal advice or complete legal descriptions. Any forward-looking statements are based on current expectations and assumptions that are subject to change. For full legal information, review the Rehabilitation Plan and applicable Court filings found on the SHIP website: **shipltc.com**.

SHIP-EP-BRO-0122

SHIP

SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
(IN REHABILITATION)

Important Information
for Policyholders

Understanding the situation and the action you need to take.

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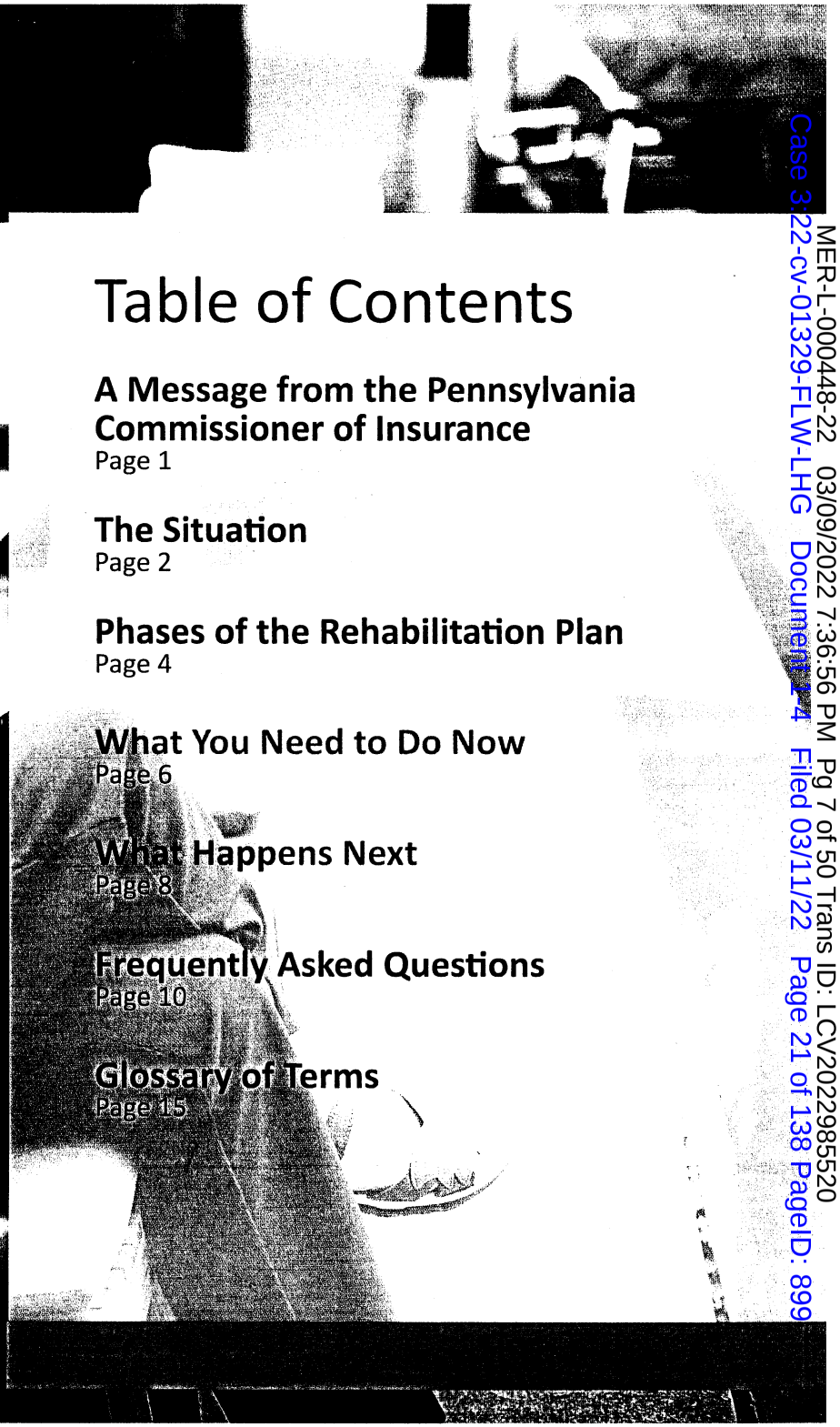

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pennsylvania
INSURANCE DEPARTMENT

Dear Policyholder,

Over the past year, I assembled a rehabilitation team of experts and have worked closely with them to help address the financial difficulties experienced by SHIP, your long-term care insurance company.

Based on our evaluation, we prepared a comprehensive Rehabilitation Plan and filed the Plan with the Pennsylvania Commonwealth Court for the Court's review and approval. The Court approved our recommended Rehabilitation Plan.

The Plan involves a number of changes, including making adjustments to insurance policies. This brochure and the other documents included in this Election Package have been thoughtfully designed to help you select the policy modification option that best meets your needs as we implement the Approved Rehabilitation Plan.

You are encouraged to review the information carefully and consult with a family member or trusted advisor to choose the option on your Coverage Election Form that is best for your situation. If you have questions, we are here to help. Just call **(833) 894-8577**.

With warm regards,

Jessica K. Altman
Pennsylvania Commissioner of Insurance

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The Situation

Senior Health Insurance Company of Pennsylvania ("SHIP") is in rehabilitation. *What does that mean?*

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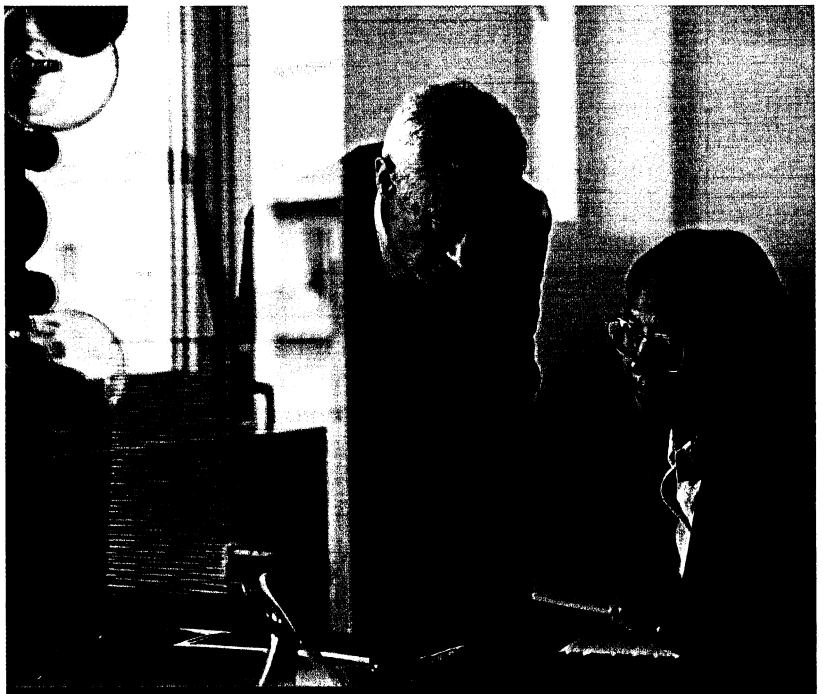
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)

The insurance industry is monitored and regulated by state insurance departments to protect the interests of policyholders. If an insurance company's financial condition indicates the company does not have adequate funds to fully pay for expected future claims, a court-supervised process called "rehabilitation" is initiated.

On January 29, 2020, SHIP was placed in rehabilitation by the Commonwealth Court of Pennsylvania. This rehabilitation order placed the company under the control of the Pennsylvania Insurance Department. The Pennsylvania insurance commissioner was appointed as SHIP's Rehabilitator to oversee the financial situation, stabilize current operations, develop a rehabilitation plan to maximize the protection of policyholders, and plan for SHIP's future.

After SHIP was ordered into rehabilitation, the Rehabilitator assembled a team of experts, including a Special Deputy Rehabilitator, to carefully evaluate SHIP's financial problems and explore ways to correct them. Together, that team developed a proposed Rehabilitation Plan. The proposed Rehabilitation Plan was filed with and approved by the Commonwealth Court of Pennsylvania, after a week-long evidentiary hearing and more than a month of post hearing briefing.



On January 29, 2020, SHIP was placed in rehabilitation by the Commonwealth Court of Pennsylvania.

Important Details about the Rehabilitation Plan

The Plan's principal goal is to correct the Company's financial condition through policy modifications with a focus on protecting policyholder interests. Providing options to policyholders based on individual circumstances is also an important part of the Plan.

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Phases of the Rehabilitation Plan

Phase One begins immediately following approval of the Plan by the Commonwealth Court of Pennsylvania. The goal is to reduce substantially or eliminate the financial deficit by modifying the policies. Reducing or eliminating the financial deficit will enable the company to provide meaningful long-term care coverage to policyholders. This will be achieved by a combination of premium rate increases and policy benefit modifications. This Election Package has been prepared to present policyholders with premium rate increase and policy benefit modification options that will help achieve the goal of the Plan. The Options in the Election Package have been customized for each policyholder and have been prepared using the current policy status (i.e., on claim or not on claim and premium-paying or on premium waiver) for each policy. Policyholders will be asked to select the Option that best meets their needs.

Policies that require modification in Phase One are those paying a current premium below the "If Knew Premium", which is the premium that should have been charged when the policies were originally issued based on a variety of factors known today about the SHIP policies such as historical claim payments, premium rate increases, policy termination rates, and investment returns.

Phase Two will begin after the results of Phase One have been evaluated. The goal is to narrow or eliminate any financial deficit remaining after Phase One. The timing and details will depend on the results achieved in Phase One. Whether or not Phase Two will be implemented may be subject to change depending on the circumstances following Phase One.

Premium rate increases and policy benefit modifications may be required for policyholders who elected Option 1 (Downgrade Your Policy) or Option 4 (Keep Your Current Coverage) in Phase One. Policyholders will be notified in advance of any required rate increases and benefit reductions. Similar to Phase One, customized options for each policyholder will be prepared and fully explained. Certain policyholders, including those who elected Option 2 (Convert to a Basic Policy), Option 2a (Convert to an Enhanced Basic Policy), or Option 3 (Convert to an Enhanced Paid-Up Policy) in Phase One, will not face mandatory rate increases or policy benefit modifications in Phase Two of the Plan.

Phase Three will begin after the results of Phase Two have been evaluated. It does not include any policyholder modifications and will not require policyholder elections. This phase is the administrative and final phase.

We're Working Hard to Find Solutions for You

The Rehabilitation process is complicated and the financial stability of SHIP is a serious matter. The Rehabilitation team meets regularly to work through the many issues that arise during the Rehabilitation process. The Election Package you received has been customized to help you make an important decision about your SHIP long-term care policy. If you have more than one policy, you will receive an Election Package for each policy. You must make a separate election for each policy.

We understand how important your long-term care insurance coverage is to you and your family. We designed this personalized Election Package to help you make an election that best meets your needs. Coverage options presented have been thoughtfully designed to help you choose a solution that meets your needs as we implement the changes brought about by the approved Rehabilitation Plan.

Here's How You Can Stay Informed

Communicating with you about ongoing rehabilitation activities is our top priority. We will continue to send you notices and share updates about rehabilitation and the court process. You are also encouraged to regularly visit SHIP's website at **shipltc.com/court-documents**

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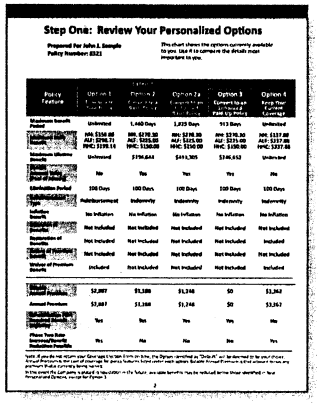
What You Need to Do Now

Select one Option and mail your decision by the deadline indicated on your Coverage Election Form.

Use the enclosed "Step-by-Step Guide for Policyholders" to help you choose an option that best suits your needs.

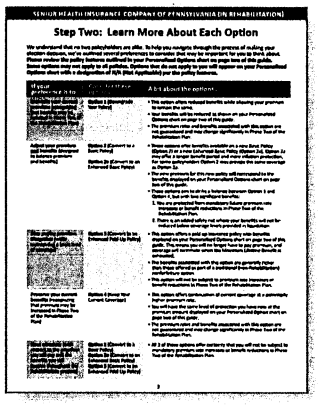
You can also visit us online at shipltc.com to watch our informational video series.

1


Step One: Review Your Personalized Options

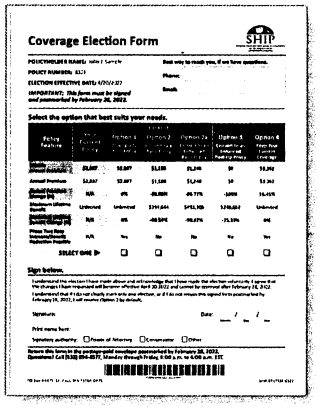
Step One: Review your Personalized Options chart. It was designed with you in mind and provides important cost and benefit information for each option. You are encouraged to review the information carefully and consult with a family member or trusted advisor to choose the option that is best for your situation.

2


Step Two: Learn More About Each Option

Step Two: Learn more about each option. Compare your options in light of your personal situation. Carefully evaluate the benefits, premium, and possibility of future policy modifications of each option.

3


Coverage Election Form

Step Three: Complete, sign, and date your Coverage Election Form. Return the Form in the enclosed postage-paid envelope.

YOUR COMPLETED FORM MUST BE POSTMARKED BY THE DATE INDICATED ON YOUR COVERAGE ELECTION FORM.

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What Happens Next

After you have selected the option that best suits your needs, here's what you need to know about next steps.

1. **SHIP will review your Coverage Election Form** to make sure it is complete. You can help us by making sure to:
   - Select only ONE option on the Coverage Election Form.
   - Sign and clearly date the Form.
   - Return ONLY the completed Coverage Election Form in the self-addressed postage-paid return envelope.

   PLEASE NOTE, IF SOMEONE ELSE SIGNS THE FORM ON YOUR BEHALF, THE SIGNING AUTHORIZATION MUST BE ON FILE WITH SHIP.

2. **If your Coverage Election Form is complete,** SHIP will mail you a written confirmation of your Election upon receipt and will process your selected Option.

3. **If your Coverage Election Form is NOT completed correctly,** if there is time, SHIP will mail you another Coverage Election Form explaining what needs to be corrected. You must complete this new Coverage Election Form. The Form must be returned and postmarked by the date noted on the Form. If you did not submit or correctly complete your Election Form on time, the Default Option will be processed.

4. **Any modification resulting from your selected Option** will be effective on the Election Effective Date, listed on your Coverage Election Form. If your Option changes your benefits and you are currently receiving claim payments, your new benefits will start on the Election Effective Date. You should continue submitting claims in the same manner you have in the past.

In the event a policyholder's circumstances change as specified in the Plan before the Initial Plan Effective Date (for example by going on claim, becoming eligible for premium waiver, going off claim, or losing a premium waiver) the policyholder will be sent a new Election Package and will be required to select a new option from among options applicable to the new circumstances.

5. **If a premium payment is due**, you will continue to be billed in the same way you are billed now. If you do not currently pay premiums and a premium payment is due as a result of the Option you have elected, you will receive a premium notice mailed to the address on file. It is important for you to pay premiums as they become due to preserve your coverage.

6. **If you do not make the premium payment when due**, your coverage will be converted to a paid-up policy. If the date of lapse is before the Election Effective Date, your policy will convert to a standard paid-up policy which has a maximum benefit amount equal to the total amount paid by you in premium since the issue date of your policy, reduced by the sum of any claim payments and any returned premium payments made to you since the issue date of your policy. If the date of the lapse is after the Election Effective Date, your policy will convert to the Enhanced Paid-Up policy as described under Option 3 on your Personalized Options chart on page two of the guide enclosed.

7. **A Summary of Current Coverage document,** a policy endorsement, and a schedule of benefits that reflect your policy modifications and features will be mailed to you within a few weeks after your Election Effective Date, listed on your Coverage Election Form.

Need More Information? Call (833) 894-8577.

Monday through Friday, 8:00 a.m. to 6:00 p.m. EST.

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Frequently Asked Questions

Q1. What is Rehabilitation?

Rehabilitation is a court-supervised process intended to remedy an insurance company's impaired financial condition for the benefit of policyholders and creditors.

On January 29, 2020, Senior Health Insurance Company of Pennsylvania ("SHIP") was placed in rehabilitation by the Commonwealth Court of Pennsylvania (the "Court"). The Court appointed Pennsylvania Insurance Commissioner Jessica K. Altman (the "Commissioner") as Rehabilitator, and she appointed Patrick H. Cantilo as Special Deputy Rehabilitator ("SDR").

The Rehabilitator is charged with protecting SHIP's policyholders, creditors, and the public, including making sure policyholders' coverage continues as long as premiums are paid when due, subject to Plan modifications. Under rehabilitation, the Commissioner conducts an independent, in-depth financial analysis of the insurance company and evaluates and implements opportunities to improve the companies' financial status. The Rehabilitator's actions are dictated by Pennsylvania laws and regulations and are subject to review by the Commonwealth Court of Pennsylvania.

Q2. What is the purpose of the Election Package?

The Rehabilitator and her Rehabilitation team prepared a comprehensive Rehabilitation Plan and filed the Plan with the Pennsylvania Commonwealth Court for the Court's review and approval. The Court recently approved the Rehabilitation Plan.

The approved Plan involves a number of changes, including making adjustments to insurance policies. These adjustments to the insurance policies include premium rate changes and policy benefit modification options. The purpose of the Election Package is to help policyholders select the option that best meets policyholder needs.

Q3. What actions do I need to take?

You need to make an important choice about your long-term care insurance coverage. Options for your coverage have been thoughtfully customized with you in mind. Refer to the enclosed "Step-by-Step Guide for Policyholders" and follow these steps:

Step 1: Review your "Personalized Options" on page 2.
Step 2: Review "Learn More About Each Option" on page 3.
Step 3: Indicate your choice on the enclosed Coverage Election Form and mail the completed form to SHIP in the enclosed postage-paid return envelope by the deadline indicated on the form.

Q4. How can I learn more about SHIP's rehabilitation and the Election Package?

We created an informational video series to help our policyholders, their families and advisors better understand the content of this Election Package, get help understanding their choices and learn how to choose their best option.

The video series is available online at **shipltc.com** and is accessible from smartphones, tablets, and laptops. It also features information on the phases of the rehabilitation plan, how to notify us of your decision, and what you can expect after completing and returning your Coverage Election Form.

Q5. I am currently receiving claim benefits. Do I need to do anything different?

Claims for policy benefits will continue to be processed and paid in the normal course of business. You should continue submitting claims in the same manner that you have in the past. Any policy or benefit modifications resulting from your selected Option on the enclosed Coverage Election Form will become effective on the Election Effective Date listed on that Form.

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Q6. What happens if I decide to stop paying my premiums?
If you cancel or lapse your policy before the Election Effective Date, your coverage will be converted to a standard paid-up policy. Coverage provided by this policy will have a maximum benefit amount which equals the total amount paid by you in premium since the issue date of your policy, reduced by the sum of any claim payments and any returned premium payments made to you since the issue date of your policy.

If you cancel or lapse your policy after the Election Effective Date, your coverage will be converted to the Enhanced Paid-Up Policy as described under Option 3 on your Personalized Options chart on page two of the enclosed Step-by-Step Guide for Policyholders. Policy Feature amounts for cancelled or lapsed policies could be different from those displayed under Option 3 due to policy-specific benefit payments and inflation.

Q7. Can I do anything to avoid possible mandatory premium increases or benefit reductions in Phase Two?
You can select one of Options 2, 2a, or 3 in Phase One. Policyholders who choose those options in Phase One are not subject to mandatory modifications in Phase Two.

Q8. Are any policies exempt from mandatory premium increases or benefit reductions in Phase Two regardless of which Option they choose in Phase One?
Options 2, 2a, and 3 are exempt from mandatory modifications in Phase Two. If you select Option 1 or Option 4 in Phase One, you may or may not be exempt from mandatory modifications in Phase Two. If the Guaranty Association Coverage Limit (found on the "Summary of Current Coverage" document) is equal to or greater than the Maximum Lifetime Benefit (of the Phase One Option chosen), you will be exempt from mandatory modifications in Phase Two. If the Annual Premium (of the Phase One Option chosen) is equal to or greater than the Hypothetical Phase Two Annual Premium (found on the enclosed "Summary of Current Coverage" document), you may be exempt from mandatory modifications in Phase Two. Otherwise, selecting Options 1 or 4 may not exempt you from Phase Two modifications.

Q9. If my policy is not subject to mandatory modifications in Phase Two, can I still choose a different Option at that time?
Certain voluntary changes can be made in Phase Two, but you cannot increase coverage.

Q10. Are policyholder elections permanent?
Yes. Once the Coverage Election Form due date passes, you cannot change the option you selected. If the Coverage Election Form is not received on time, you cannot change the "Default" option. All benefit and/or premium changes elected (or defaulted to) pursuant to the Court-approved Rehabilitation Plan are permanent changes to the policy.

Q11. Have any other rehabilitation alternatives been considered?
A number of alternatives have been explored and the Rehabilitator determined they are either not feasible or that the Plan is preferable under the current circumstances.

Q12. Is there a possibility SHIP could be liquidated?
The Pennsylvania Commonwealth Court could decide at some time in the future to place SHIP into liquidation.

Q13. How is liquidation different from rehabilitation?
Under rehabilitation, the Pennsylvania Insurance Commissioner evaluates and implements actions to restore the company's financial condition to a favorable status. The Insurance Commissioner recommends liquidation when the Commissioner believes rehabilitation efforts should no longer be pursued.

In the insurance industry, rehabilitation is a process that allows the Rehabilitator to formulate a plan for restructuring the company and/or modifying the policies to protect policyholder interests. Liquidation is a court-directed process that prescribes the disposition of assets and liabilities for an insurer when it is determined that future policyholder obligations cannot be fully met.

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Q14. What would happen if SHIP were liquidated?
If SHIP were ordered into liquidation, it is probable that state insurance guaranty associations would continue coverage for policyholders up to applicable statutory coverage limits. Generally, Guaranty Associations become responsible for an insurer's obligations only if the insurer is found by the Court to be insolvent and placed in liquidation. If SHIP is placed in liquidation, policyholders may be subject to future rate increases and benefit reductions.

SHIP has not been placed in liquidation. Therefore, no Guaranty Association is responsible for SHIP's policy obligations at this time. For information about state guaranty associations, please visit **nolhga.com**.

Q15. How does coverage in the Rehabilitation Plan compare to coverage in liquidation?
Under the Rehabilitation Plan you have at least one option that provides coverage greater than or equal to coverage you would receive in liquidation from the Guaranty Associations. The Plan offers other options unlikely to be available in liquidation.

Q16. Where can I get more details about these matters?
The Approved Rehabilitation Plan is on SHIP's website. Please visit **shipltc.com**.

Additional Questions? Call (833) 894-8577.

Monday through Friday, 8:00 a.m. to 6:00 p.m. EST.

Glossary of Terms

Additional Benefits: Some long-term care policies include benefits other than nursing home, facility, home health care, or adult day care. Examples of these include, but are not limited to, bed reservation benefit, respite care, hospice care, caregiver training, medic alert, prescription drug benefit, homemaker services, and ambulance services.

Benefits: Money an insurance company pays to policyholders or care providers for services the insurance policy covers.

Benefit Account Value (Pool of Money): A policy provision that indicates whether the policy includes benefits in dollars up to the total Maximum Lifetime Benefit or includes each day paid up to the Maximum Benefit Period days.

Claim: A request made to pay benefits for eligible services.

Commonwealth Court or Court: The Commonwealth Court of Pennsylvania, which is the rehabilitation court for SHIP and has exclusive authority over SHIP's rehabilitation.

Coverage Election Form: The election form, included in this Election Package, on which a policyholder specifies the Option he or she chooses under the Rehabilitation Plan to modify their policy.

Effective Date: The date the provisions of the Rehabilitation Plan, including modification of long-term care policies and Policyholder Elections, will become effective following approval of the Rehabilitation Plan.

Elimination Period: The time period during which a policyholder qualifies for benefits but for which no benefits are yet payable.

Extension of Benefits: A provision in the policy permitting claim payments to continue for a policy on claim that lapses due to non-payment of premium.

Guaranteed Renewable Policy: An insurance company guarantees the policyholder the right to renew the policy for life, as long as the policyholder pays the premiums on time. Most long-term care insurance policies are guaranteed renewable.

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Guaranty Association: Organizations created by statute in each state that are responsible for continuation of insurance coverage for eligible policyholders of insurance companies that are placed in liquidation. These organizations offer continuation of coverage up to a defined Guaranty Association Coverage Limit that is determined by state of residence of the policyholder.

Inflation Benefit: A rider purchased or a policy provision that provides for defined increases in benefits at regular intervals in order to protect against the effect of inflation on the cost of care.

Lapse: When a policyholder owes premium on their insurance policy but stops paying the premium, resulting in the termination of the policy and loss of insurance protection and benefits.

Liquidation: A legal step a state insurance department takes when an insurance company can't recover from its financial troubles.

Long-Term Care Insurance: Insurance that offers benefits to pay for nursing home care, home health care, and/or other services for individuals who can't perform daily living activities or must be supervised due to illness or cognitive impairment.

Maximum Benefit Period: The maximum duration during which benefits will be available under the policy.

Maximum Daily Benefit: The maximum daily dollar amount available on a covered date of care as specified in the policy, for each eligible type of care. NH= Nursing Home, ALF= Assisted Living Facility, HHC= Home Health Care.

Maximum Lifetime Benefit: The maximum benefit amount available for the life of the policy, reflecting inflation assuming benefits start now. This benefit amount may not include eligible Restoration of Benefits associated with the policy.

Policy Benefit Limit: The maximum benefit amount a policy will pay. Some policies define the policy benefit limit in years (one, two, three or more, or even lifetime). Others define the policy benefit limit as a total dollar amount. Policies often use words such as "total lifetime benefit," "maximum lifetime benefit," or "total plan benefit" to describe their maximum benefit limit.

Glossary of Terms

Policy Modifications: Premium rate changes or benefit reductions implemented for each policyholder in accordance with the terms of the Rehabilitation Plan.

Policyholder Election: The election by a policyholder to modify the premiums or benefits of his or her policy under the Rehabilitation Plan.

Policyholder Election Date: The date by which the Coverage Election Form must be properly completed, signed, and postmarked in order for the election to be effective.

Premium: The amount you pay for your insurance coverage.

Rehabilitation: A court-supervised process intended to remedy an insurance company's financial deterioration for the benefit of policyholders and creditors.

Rehabilitation Plan: A plan to correct an insurance company's financial situation through policy modifications and other cost cutting measures while protecting policyholder interests. The plan is proposed by the Rehabilitator and approved by the Court.

Rehabilitator: The state insurance commissioner appointed by the Court to oversee an insurance company's rehabilitation process. The commissioner takes legal control of the company and does an independent, in-depth financial analysis of the company. The commissioner is charged with the protection of the company's policyholders, creditors, and the public. The rehabilitator's actions are dictated by the laws and regulations of the state and are subject to review by the Court. Jessica K. Altman is the Rehabilitator for SHIP.

Reimbursement Type: The method by which the Daily Benefit will be paid out. Reimbursement provides coverage for the actual expenses of care up to specified limits. Indemnity pays the full daily benefit amount regardless of expenses incurred.

Reinstatement Provisions: A policy provision that provides for a policyholder who meets certain conditions to reinstate their policy after it has been canceled because premiums were not paid on time.

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Glossary of Terms

Restoration of Benefits: A policy provision under which the benefit period for a policyholder will be restored to the original Maximum Benefit Period after receiving some or all claim benefits if the policyholder does not need or receive care during a specified period of time (such as 180 days).

Return of Premium Benefit: A rider purchased or policy provision which provides for the return of a percentage of premium paid by the policyholder (such as 80%) in consideration of the absence of claim payments during a given period of time in which the policy was in force (such as ten years), or upon policy termination.

Special Deputy Rehabilitator: An individual appointed by the Rehabilitator to oversee the day-to-day affairs of the company and to prepare a plan for the company's rehabilitation. Patrick H. Cantilo is the Special Deputy Rehabilitator for SHIP.

State Insurance Commissioner: A state regulator who heads the state insurance department and monitors and regulates insurance agents and companies. Jessica K. Altman is the State Insurance Commissioner in Pennsylvania.

State Insurance Department: The state regulatory agency responsible for administering laws and regulations for all types of insurance.

Waiver of Premium Benefit: A policy provision under which the policyholder is no longer required to pay premiums for coverage in specified circumstances, such as eligibility for benefits.

Need More Information? Call (833) 894-8577.

Monday through Friday, 8:00 a.m. to 6:00 p.m. EST.

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STATE OF VERMONT
DEPARTMENT OF FINANCIAL REGULATION

IN RE: SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA	**)** **)** **)**	**DOCKET NO. 22-005-I**

EX PARTE ORDER TO CEASE & DESIST

Senior Health Insurance Company of Pennsylvania – Long Term Care

On March 4, 2022, through counsel, the DFR Insurance Division submitted a Motion for Ex Parte Cease & Desist Order alleging that Senior Health Insurance Company of Pennsylvania (SHIP) is transacting insurance business in this State in a manner that is causing or is reasonably expected to cause significant, imminent, and irreparable injury to Vermont policyholders. See Motion attached hereto. I have reviewed the alleged violations specified in the Motion, which are incorporated herein by reference, and find, based on the allegations, that good cause exists for me to issue the requested Ex Parte Cease and Desist Order.

Ex Parte
CEASE AND DESIST ORDER

This order is issued pursuant to 8 V.S.A. §§ 11, 12, 15, 3661(a), 8809, and DFR-2022-01 § 1.04(O). I believe that SHIP is violating Vermont law and regulations as described in the DFR Insurance Division's March 4, 2022 Motion for Ex Parte Cease & Desist Order.

Effective immediately, except as expressly provided herein, SHIP and its principals, employees, and agents (including the Rehabilitator and its deputies and agents) shall halt disseminating, implementing, or enforcing in this State the "Coverage Election Package" or otherwise interfering with the rights of SHIP's Vermont policyholders or violating the insurance

laws and regulations of this State, including, but not limited to, notifying Vermont policyholders of proposed rate or benefit modifications under SHIP policies or requesting that Vermont policyholders select rates or benefits different under SHIP policies from those authorized by the Vermont DFR and called for under the terms of the contract, charging additional premium, or withholding, delaying, or encumbering benefits in whole or in part, until such time as otherwise ordered by the Vermont DFR.

This Order does not prohibit SHIP from filing a premium increase request, or a proposed schedule of rates for proposed voluntary policy modifications, for review by the Commissioner in the manner prescribed by Vermont law, with sufficient supporting information to enable the Commissioner to determine whether the requested rates are neither inadequate, excessive, nor unfairly discriminatory. This Order does not prohibit SHIP from sending notices of any such filings to consumers if the notices have been reviewed by the Commissioner for accuracy and compliance with Vermont law and have not been disapproved.

NOTICE OF RIGHT TO HEARING

SHIP is hereby given NOTICE that a hearing will be afforded in this matter if they so request in accordance with Department of Financial Regulation Administration Procedures No. 2022-01 § 1.04(O) within thirty (30) days from the date of the mailing of this Notice. Any such request must be delivered to the attention of the Docket Clerk, Beth Sides, 89 Main Street, Montpelier, Vermont 05620-3101.

The Department of Financial Regulation is located at 89 Main Street, City Center, 3d Floor, Montpelier, Vermont. If a hearing is requested, one will be scheduled within thirty (30) days after the Department's receipt of such a request.

Such hearing in this matter will be conducted in accordance with the contested case procedures prescribed in 3 V.S.A. § 809 and Department of Financial Regulation Administrative Procedures Rule No. 2022-01. All parties have the right to represent themselves or to be represented throughout the proceedings by legal counsel.

FAILURE TO REQUEST A HEARING IN A TIMELY MANNER OR TO ATTEND A HEARING THAT HAS BEEN SCHEDULED MAY RESULT IN THE ENTRY OF A

DEFAULT JUDGMENT AGAINST YOU FOR THE RELIEF REQUESTED BY THE DEPARTMENT.

BY ORDER OF THE COMMISSIONER OF FINANCIAL REGULATION

Dated at Montpelier, Vermont this 6th day of March, 2022.

By:

Michael S. Pieciak
Commissioner of Financial Regulation
Vermont Department of Financial Regulation

STATE OF VERMONT
DEPARTMENT OF FINANCIAL REGULATION

IN RE: SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA	)))	**DOCKET NO. 22-005-I**

CERTIFICATE OF SERVICE

I certify that on March 7, I served a copy of the *Motion for Emergency Cease and Desist Order, Ex Parte Order to Cease and Desist* and *Notice of Right to Request Hearing* in the above captioned matter, to the following parties by certified, first-class, and electronic mail at the following addresses:

Senior Health Insurance Company of Pennsylvania (In Rehabilitation)
550 Congressional Boulevard, Suite 200
Carmel IN 46032

Jessica K. Altman, and her successors in office
Rehabilitator
Pennsylvania Insurance Department
1326 Strawberry Square
Harrisburg, PA 17120
re-in-commissioner@pa.gov.

Patrick H. Cantilo
Cantilo & Bennett, L.L.P.
Special Deputy Rehabilitator
550 Congressional Boulevard, Suite 200
Carmel, IN 46032

Dated at Montpelier, Vermont this 7th day of March 2022.

Insurance Division
Vermont Department of Financial Regulation

By: /s/ Hillary Borcherding

Hillary Borcherding
Assistant General Counsel
89 Main Street
Montpelier, VT 05620-3101
(802) 249-6512
Hillary.borcherding@vermont.gov

STATE OF MAINE
BUREAU OF INSURANCE

In re: Senior Health Insurance Company of Pennsylvania (SHIP) (in rehabilitation) Docket No. INS-22-200	**EMERGENCY CEASE AND DESIST ORDER & NOTICE OF PENDING PROCEEDING AND HEARING**

On February 8, 2022, through counsel, Maine Bureau of Insurance Staff submitted a Verified Complaint alleging that Senior Health Insurance Company of Pennsylvania (SHIP) is transacting insurance business in this State in a manner that is causing or is reasonably expected to cause significant, imminent, and irreparable injury to Maine policyholders. (*See* Verified Complaint attached hereto.) I have reviewed the alleged violations specified in Counts I through VIII of the Verified Complaint, which are incorporated herein by reference, and find, based on the verified allegations, that good cause exists for me to issue the requested Emergency Cease and Desist Order.

EMERGENCY CEASE AND DESIST ORDER

Effective immediately, except as otherwise provided herein, SHIP and its principals, employees, and agents shall halt disseminating, implementing, or enforcing in this State the "Coverage Election Package" or otherwise interfering with the rights of SHIP's Maine policyholders or violating the insurance laws and regulations of this State, including, but not limited to, notifying Maine policyholders of proposed rate or benefit modifications under Maine policies or requesting that Maine policyholders select rates or benefits different under Maine policies from those authorized by the Maine Superintendent and called for under the terms of the contract, charging additional premium, or withholding, delaying or encumbering benefits in whole or in part, until such time as otherwise ordered by the Maine Superintendent.

This Order does not prohibit filing a premium increase request, or a proposed schedule of rates for proposed voluntary policy modifications, for review by the Superintendent in the manner prescribed by Maine law with sufficient supporting information to enable the Superintendent to determine whether the requested rates are neither inadequate, excessive, nor unfairly discriminatory. This Order does not prohibit SHIP from sending notices of any such filing to consumers if the notices have been reviewed by the Superintendent for accuracy and compliance with Maine law, and have not been disapproved.

NOTICE OF
PENDING PROCEEDING AND HEARING

Pursuant to 24-A M.R.S.A. §§ 229 and 230, 5 M.R.S. § 9052, and Insurance Rule Chapter 350, the Superintendent hereby gives notice that a public hearing will be held in the above-captioned matter beginning at 9:00 a.m. on February 18, 2022, unless a later date is agreed to by the Superintendent and all parties. Members of the public, including SHIP policyholders, are invited to attend the hearing. The hearing will take place by an audio-visual link, and instructions for registering for and attending the hearing remotely, by either audio-visual link or telephone, will be posted on the Bureau of Insurance website.

The purpose of the proceeding and hearing is for the Superintendent to determine whether grounds exist to continue in force a Cease and Desist Order against SHIP and to consider appropriate sanctions for any proven violations and such additional remedial measures as may be appropriate for the protection of Maine policyholders.

SHIP is a party to this proceeding. Bureau of Insurance Staff filing the Verified Complaint will be participating in this matter in an advocacy capacity, including presenting evidence and questioning witnesses. Persons wishing to intervene as parties in this proceeding

shall file their applications in writing with the Superintendent no later than 3:00 p.m. on February 16, 2022. *See* 5 M.R.S. § 9054. Applicants should either hand deliver their intervention applications to the attention of the Superintendent at the offices of the Bureau of Insurance, 76 Northern Avenue, Gardiner, Maine or mail them to the Superintendent at the following address:

Eric Cioppa, Superintendent
Bureau of Insurance
Maine Department of Professional and Financial Regulation
#34 State House Station
Augusta, Maine 04333-0034

The Superintendent will conduct the proceeding and hearing in accordance with the provisions of the Maine Administrative Procedure Act, 5 M.R.S. chapter 375, subchapter 4; 24-A M.R.S. §§ 229 to 236; Bureau of Insurance Rule chapter 350; and any rulings of the Superintendent. All parties to the proceeding have the right to present evidence and witnesses at the hearing and have the right to be represented by counsel. Failure of any party to appear may result in disposition by default with respect to that party. The Superintendent, however, may set aside a default for good cause.

The Department of Professional and Financial Regulation does not discriminate on the basis of disability in the admission to, access to, or operation of its programs, services, or activities. Individuals in need of auxiliary aid for effective communication at the hearing are invited to make their needs and preference known to the Superintendent of Insurance sufficiently in advance of the hearing so that appropriate arrangements can be made.

PER ORDER OF THE SUPERINTENDENT OF INSURANCE

February 8, 2022

Eric A. Cioppa
Superintendent

STATE OF MAINE
BUREAU OF INSURANCE

In re: Senior Health Insurance Company of Pennsylvania (SHIP) (in rehabilitation)	VERIFIED COMPLAINT AND REQUEST FOR EMERGENCY CEASE AND DESIST ORDER

Pursuant to 24-A M.R.S. § 12-A(2-A), the Staff of the Maine Bureau of Insurance make this Verified Compliant requesting that the Superintendent of Insurance issue an immediate cease and desist order against Senior Health Insurance Company of Pennsylvania (SHIP) because SHIP is transacting insurance business in this State in a manner that is causing or is reasonably expected to cause significant, imminent, and irreparable injury to Maine policyholders, as more particularly set forth below.

FACTS ALLEGED

1. SHIP is a Pennsylvania-domiciled life and health insurance company that became authorized to issue long-term care insurance (LTC) policies in Maine beginning in 1991 (Maine License Number LHF32655).

2. Beginning in 2010, SHIP filed with the Maine Superintendent premium rate filings on various of its policyholder forms used in the State; and the Maine Superintendent approved the rate filings that were actuarially justified. From 2010 through 2019, SHIP submitted nine (9) rate filings for approval by the Maine Superintendent. (Prior to 2010, Conseco Senior Health Insurance Company was the company filing the rates and made numerous rate filings with the Maine Superintendent.) Recent disapprovals by the Maine Superintendent included SHIP rate filings in 2011 for 838 policyholders who had prior increases of 56%-202% accumulated over the years; and in 2019 for 336 policyholders where SHIP's

filing did not meet the requirements for a justified increase. An increase approved in 2018 affecting 97 policyholders was reduced from 40% to 34% and phased-in over two years.

3. In recent years, SHIP experienced financial distress and faced the possibility of insolvency.

4. On January 29, 2020, upon the application of Jessica Altman, the Commissioner of Insurance for the Commonwealth of Pennsylvania, the Commonwealth Court of Pennsylvania, in suit number 1 SHP 2020, entered an Order of Rehabilitation placing SHIP into rehabilitation in accordance with the provisions of Pennsylvania law.

5. The Order of Rehabilitation appointed Commissioner Altman and her successors in office as statutory rehabilitator of SHIP pursuant to the provisions of 40 P.S. § 221.14, et seq. and required the Rehabilitator to prepare a plan of rehabilitation. Commissioner Altman appointed Patrick Cantilo as Special Deputy Rehabilitator, with the power to act on the Rehabilitator's behalf.

6. On March 9, 2020, SHIP consented to an order of suspension of its certificate of authority in Maine which Order stipulates in relevant part that SHIP "may not transact any new insurance business in Maine, but will be allowed to continue to renew and service existing business. [SHIP] must continue to make required filings and pay all required fees and taxes."

7. SHIP currently has approximately 350 policies still in force that were issued in Maine and subject to Maine law and, upon information and belief, the average age of SHIP's Maine policyholders is over 86 years.

8. On April 22, 2020, the Rehabilitator filed her Application for Approval of the Plan of Rehabilitation for SHIP and contemporaneously filed a Rehabilitation Plan.

9. On September 15, 2020, the Maine Superintendent was granted intervention as a party in the Rehabilitation Proceeding.

10. The Rehabilitation Plan was approved by a Memorandum Opinion and Order of the Pennsylvania Commonwealth Court on August 24, 2021, as amended on November 4, 2021.

11. The Maine Superintendent and the other intervening jurisdictions appealed the Rehabilitation Plan to the Pennsylvania Supreme Court (Middle District), No. 71 MAP 201. By Order issued January 31, 2022, the Pennsylvania Supreme Court denied the insurance regulators' request for stay pending appeal of the Rehabilitation Plan. The appeal otherwise remains pending before the Pennsylvania Supreme Court.

12. In late-January 2022, without first filing its rates for approval with the Maine Superintendent, upon information and belief, the SHIP Rehabilitator mailed a "Coverage Election Package" to Maine policyholders which advises them of forthcoming premium and/or benefit modifications that would begin as early as April 1, 2022. (*See* Exhibit A.) The "Coverage Election Package" requires Maine policyholders to complete and return their election form with a postmark date of no later than March 15, 2022. (*See* Exhibit A hereto.)

13. On February 2, 2022, the Rehabilitation Court approved SHIP's use of nationwide premium rates including in Maine.

14. The "Coverage Election Package" does not provide legally sufficient notice to Maine policyholders of SHIP's proposed rate increase as required by 24-A M.R.S. § 5084.

15. The "Coverage Election Package" offers five coverage options to Maine policyholders, including downgrading the policy, converting to a basic policy or to an enhanced basic policy, converting to an enhanced paid-up policy, and keeping their current policy. If a Maine policyholder does not make a coverage election by the March 15, 2022 specified

postmark date, SHIP will on its own exercise the basic policy coverage option, resulting in a significant benefit reduction under a Maine insurance policy.

16. The "Coverage Election Package" fails to advise Maine Policyholders that the premium rates and policy modifications under the Rehabilitation Plan are on appeal to the Pennsylvania Supreme Court. SHIP thus is requiring Maine policyholders to make final and binding coverage elections without any explanation to Maine policyholders about how their rates and benefits would be reconfigured if the Rehabilitation Plan is overturned or otherwise modified by the court in a manner that affects rates and benefits. *See*, *e.g.*, the State of Louisiana, No. C-713794-22 (19th Judicial Dist. Ct.), and State of South Carolina, No. 2020-CP-40-05802 (S.C. C.C.P.), actions where each state court granted preliminary injunctions against SHIP upon finding that the insurance regulator's challenges to the Rehabilitation Plan demonstrated a likelihood of success on the merits and that a preliminary injunction was necessary to prevent irreparable harm to policyholders.

17. All Maine policyholder elections and SHIP-imposed elections are deemed irrevocable even if the Rehabilitation Plan is overturned or otherwise modified on appeal. Furthermore, any Maine policyholder that selects the policy downgrade, the paid-up policy option, or their current policy terms could face more rate increases during Phase II of the Rehabilitation Plan.

18. SHIP has not submitted to the Maine Superintendent the premium rates that SHIP intends to use on insurance coverage provided to Maine policyholders, beginning as early as April 1, 2022.

19. SHIP has not obtained regulatory approval by the Maine Superintendent for the premium rates that SHIP intends to use on insurance coverage provided to Maine policyholders, beginning as early as April 1, 2022.

20. SHIP has not made all required regulatory filings with the Maine Superintendent related to SHIP's transaction of insurance in this State, as prescribed by Order of the Superintendent issued March 9, 2020, and consented to by the Rehabilitator on behalf of SHIP.

21. Among other matters, and not by limitation, as a cumulative result of SHIP's:

(a) failure to file proposed premium rates with the Maine Superintendent for use with Maine policies;

(b) failure to provide Maine policyholders with the required advance notice of a premium rate increase for use with Maine policies, including notice of the proposed rate, an explanation that it is subject to regulatory approval, the policyholder's right to request a hearing, the policyholder's right to provide written comments on the proposed rate increase, and contact information for the Maine Bureau of Insurance;

(c) failure to provide Maine policyholders with a minimum 90-day advance notice of premium rate implementation for Maine policies;

(d) use of a "Coverage Election Form" for Maine policies that is unfair or deceptive; contains misrepresentations; and/or is untrue, deceptive, or misleading;

Maine policyholders will be harmed by SHIP forcing them to make rushed and irreversible decisions about their existing Maine long-term care insurance policies.

APPLICABLE LAW

22. The Maine Insurance Code, Title 24-A M.R.S., regulates entities that transact insurance in the State.

23. Pursuant to 24-A M.R.S. § 9, "transacting insurance" includes, "whether by mail or any other means," solicitation or inducement, negotiations, effectuation of a contract of insurance, or transaction of matters subsequent to the effectuation and arising out of such a contract.

24. Pursuant to 24-A M.R.S. §§ 214 and 215, the Maine Superintendent may seek enforcement against any person who knowingly violates any order of the Superintendent.

25. Pursuant to 24-A M.R.S. § 2736(1), every insurer shall file for approval by the Maine Superintendent every rate, rating formula, classification of risks, and every modification of any formula or classification that it proposes to use in this State in connection with individual health insurance policies, including LTC policies. Every such filing must be made not less than sixty (60) days in advance of the stated effective date. The filing must contain sufficient information for the Maine Superintendent to determine whether such filing meets the requirements that rates not be excessive, inadequate, or unfairly discriminatory. *See* 24-A M.R.S. § 2736(2).

26. Pursuant to 24-A M.R.S. § 5084(1), an insurer shall notify Maine policyholders of a proposed premium rate increase within thirty (30) days of making its filing. The written notice must show the proposed rate; state that the rate is subject to regulatory approval; inform the policyholder of the right to request a hearing; inform the policyholder of the right to provide written comments on the proposed rate increase; and provide the policyholder with contact information for the Maine Bureau of Insurance.

27. Pursuant to 24-A M.R.S. § 5084(2), an insurer .may not implement a premium increase for use in Maine until it is approved by the Maine Superintendent.

28. Pursuant to Maine insurance rule Ch. 420, § 8, an insurer shall provide written notice of a premium rate increase for use in Maine to all affected Maine policyholders at least ninety (90) days before the effective date of any rate increase; and "[a]n increase in premium rates may not be implemented until 90 days after the notice is provided."

29. Pursuant to 24-A M.R.S. § 2152, no person shall engage in an unfair or deceptive act or practice in the business of insurance in this State.

30. Pursuant to 24-A M.R.S. § 2153, no person shall make, issue, or circulate, or cause to be made, issued, or circulated any estimate, illustration, circular, or statement misrepresenting the terms, benefits, or advantages of an insurance policy issued in this State.

31. Pursuant to 24-A M.R.S. § 2154, no person shall make, publish, disseminate, or circulate, or cause, directly or indirectly, to be made, published, disseminated, or circulated, in the form of a notice, circular, pamphlet, or letter, or in any other way, any statement regarding the person's transaction of insurance business in this State that is untrue, deceptive, or misleading.

32. Pursuant to 24-A M.R.S. § 12-A(2-A), upon a verified complaint showing that a person is engaging in conduct that is causing or is reasonably expected to cause significant, imminent, and irreparable injury to Maine insurance consumers, the Maine Superintendent may immediately issue a cease and desist order, without prior notice and hearing.

33. Pursuant to 24-A M.R.S. § 12-A, following a hearing, the Maine Superintendent may assess civil penalties against any person who violates any provision of Title 24-A, any rule adopted by the Maine Superintendent, or any lawful order of the Maine Superintendent; order refunds of any overcharges for charges by an insurer to any person that are not in conformity with a filing that is required to be submitted to the Maine Superintendent for approval under Title

24-A; and order restitution for any insured injured by a violation of Title 24-A for which civil penalties may be assessed.

VIOLATIONS ALLEGED

Count I – Knowingly Violating Superintendent Order

34. SHIP violated and continues to violate 24-A M.R.S. §§ 214 and 215 by knowingly violating the March 9, 2020 Order of the Maine Superintendent, as consented to by the Rehabilitator on behalf of SHIP, in declining to make required Maine regulatory filings with the Maine Superintendent, including, but not limited to, premium rate filings for use with policies in Maine pursuant to 24-A M.R.S. § 2736.

Count II – Failure to File Rates for Approval

35. SHIP violated and continues to violate 24-A M.R.S. § 2736(1) by failing to file for approval by the Maine Superintendent the rates, rating formula, classification of risks, and every modification of any formula or classification that it proposes to use with policies in Maine at least sixty (60) days in advance of the stated effective date of the modifications.

Count III – Premium Rates: Notice of Filing

36. SHIP violated and continues to violate 24-A M.R.S. § 5084(1) by failing to provide written notice to Maine policyholders of proposed premium rate increases for use in Maine within thirty (30) days of making a rate filing. The written notice must show the proposed rate; state that the rate is subject to regulatory approval; inform the policyholder of the right to request a hearing; inform the policyholder of the right to provide written comments on the proposed rate increase; and provide the policyholder with contact information for the Maine Bureau of Insurance.

Count IV – Premium Rates: Implementation

37. SHIP violated and continues to violate 24-A M.R.S. § 5084(2) by communicating an effective date as soon as April 1, 2022 for implementation of premium rate increases under Maine insurance policies without first having obtained approval by the Maine Superintendent.

Count V – Premium Rates: 90-Day Notice

38. SHIP violated and continues to violate Maine insurance rule Ch. 420, § 8 by attempting to implement premium rate increases to Maine policyholders less than ninety (90) days before implementation of the rate increase for use in Maine, to be effective as soon as April 1, 2022.

Count VI – Policyholder Notice: Unfair or Deceptive Acts

39. SHIP violated and continues to violate 24-A M.R.S. § 2152 by mailing a "Coverage Election Package" to Maine policyholders that unfairly or deceptively discloses the premium rates and benefit modifications under a Maine insurance policy.

Count VII – Policyholder Notice: Misrepresentation

40. SHIP violated and continues to violate 24-A M.R.S. § 2153 by mailing a "Coverage Election Package" to Maine policyholders that misrepresents the premium rates and benefit modifications under a Maine insurance policy.

Count VIII – Policyholder Notice: Untrue, Deceptive, or Misleading Statements

41. SHIP violated and continues to violate 24-A M.R.S. § 2154 by mailing a "Coverage Election Package" to Maine policyholders that contains untrue, deceptive, or misleading statements regarding premium rates and benefit modifications under a Maine insurance policy.

CONCLUSION AND REQUEST FOR RELIEF

42. As set forth above in Paragraphs 1 through 41, SHIP has engaged in and is continuing to engage in the business of insurance in this State in a manner that is causing or is reasonably expected to cause significant, imminent, and irreparable injury to Maine policyholders.

43. For all the foregoing reasons, the Staff of the Bureau of Insurance request that the Maine Superintendent issue an immediate cease and desist order requiring SHIP and its principals, employees, and agents to halt all "Cover Election Package" activities in this State, including, but not limited to, premium rate or benefit modification implementation, unless and until further order of the Superintendent.

February 8, 2022

Respectfully submitted

AARON M. FREY, Attorney General

THOMAS C. STURTEVANT, JR.
LISA A. WILSON
Assistant Attorneys General

Attorneys for Bureau of Insurance Staff

VERIFICATION

The foregoing allegations are all true to the best of my knowledge and belief.

Mary Hooper, Bureau of Ins., Life and Health Actuary

STATE OF MAINE
SOMERSET, SS. February 8, 2022

Personally appeared the above-named Mary Hooper, Maine Bureau of Insurance, Life and Health Actuary, and made oath that the allegations in the foregoing Verified Complaint are true and correct to the best of her knowledge and belief.

Before me,

Notary Public

NICHOLE J CLARK
NOTARY PUBLIC
State of Maine
My Comm. Expires June 22, 2028

SHIP
SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
(IN REHABILITATION)
P.O. Box 64675, St. Paul MN 55164-0675

Action Required By: March 15, 2022

[redacted]

IMMEDIATE ACTION REQUIRED

Dear [redacted]

I'm writing today with important information about your long-term care insurance from Senior Health Insurance Company of Pennsylvania (In Rehabilitation) ("SHIP") and to thank you for your patience and understanding as we guide the company through the rehabilitation process.

As part of this process, you have a very important decision to make at this time. A number of new coverage options are available to you. You are required to select only one option by March 15, 2022.

To get started, please refer to the enclosed "Step-by-Step Guide for Policyholders" and follow these simple steps:

Step 1: Review your personalized options.

Step 2: Learn more about each option.

Step 3: Indicate your choice on the attached Coverage Election Form, detach and mail the completed form to SHIP in the enclosed postage-paid return envelope as soon as possible.

You'll find more details in the "Important Information for Policyholders" booklet and "Summary of Current Coverage" document provided. To watch our informational video series and learn more, visit us online at **shipltc.com**. Please know we are here to help you. We understand you have a lot invested in your current policy and you want to make sure you will have protection when you need it. Just call us at (833) 894-8577.

Sincerely,

Patrick H. Cantilo

Patrick H. Cantilo
Special Deputy Rehabilitator

Please note that your Coverage Election Form must be postmarked by March 15, 2022.

9594

Coverage Election Form

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)

POLICYHOLDER NAME: [redacted]

POLICY NUMBER: [redacted]

ELECTION EFFECTIVE DATE: April 1, 2022

IMPORTANT: This form must be signed and postmarked by March 15, 2022.

Best way to reach you, if we have questions.

Phone:

Email:

Select the option that best suits your needs.

Policy Feature	Your Current Policy	Option 1 Downgrade Your Policy	Option 2 Convert to a Basic Policy	Option 2a Convert to an Enhanced Basic Policy	Option 3 Convert to an Enhanced Paid-Up Policy	DEFAULT Option 4 Keep Your Current Coverage
Billable Annual Premium	$1,350	N/A	$835	N/A	$0	$1,350
Annual Premium	$1,350	N/A	$835	N/A	$0	$1,350
Annual Premium Change (%)	N/A	N/A	-38%	N/A	-100%	0%
Maximum Lifetime Benefit	$146,000	N/A	$146,000	N/A	$73,000	$146,000
Maximum Lifetime Benefit Change (%)	N/A	N/A	0%	N/A	-50%	0%
Phase Two Rate Increase/Benefit Reduction Possible	N/A	N/A	No	N/A	No	Yes
SELECT ONE ▶		❑	❑	❑	❑	❑

Sign below.

I understand the election I have made above and acknowledge that I have made the election voluntarily. I agree that the changes I have requested will become effective April 1, 2022 and cannot be reversed after March 15, 2022.

I understand that if I do not clearly mark only one election, or if I do not return this signed form postmarked by March 15, 2022, I will receive Option 4 by default.

Signature: Date: / / Month Day Year

Print name here:

Signatory authority: ☐ Power of Attorney ☐ Conservator ☐ Other:

Return this form in the postage-paid envelope postmarked by March 15, 2022.
Questions? Call **(833) 894-8577**, Monday through Friday, 8:00 a.m. to 6:00 p.m. EST.

UNV045%PLB9348382

PO Box 64675, St. Paul, MN 55164-0675

SHIP-EP-LTREF-0122

Summary of Current Coverage

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)

INSURED: [redacted]

POLICY NUMBER: [redacted]

STATE OF ISSUE: ME

STATE OF RESIDENCE: ME

CURRENT ANNUAL PREMIUM: $1,350

DATE ISSUED: 11/1/1989

ISSUE AGE: 60

CURRENT AGE: 91

SUMMARY AS OF: 7/31/2021

CURRENT POLICY STATUS: Premium Paying - Not On Claim

Policy Feature	Current Coverage	Description
Maximum Benefit Period[1,2]	1,460 Days	The maximum duration during which benefits will be available under the policy.
Maximum Daily Benefit[3]	NH: $100.00 HHC: $100.00	The maximum daily dollar amount available on a covered date of care as specified in the policy, for each eligible type of care. NH = Nursing Home, ALF = Assisted Living Facility, HHC = Home Health Care.
Maximum Lifetime Benefit[1]	$146,000	The maximum benefit amount available for the life of the policy, reflecting inflation assuming benefits start now. This benefit amount may not include eligible Restoration of Benefits associated with the policy.
Benefit Account Value (Pool of Money)	No	"Yes" means the policy benefits are measured in dollars paid up to the Maximum Lifetime Benefit. "No" means the policy benefits are measured in days paid up to the Maximum Benefit Period days.
Elimination Period[1]	0 Days	The time period during which a policyholder qualifies for benefits but for which no benefits are yet payable.
Reimbursement Type[2]	Indemnity	The method by which the Daily Benefit will be paid out. Reimbursement provides coverage for the actual expenses of care up to specified limits. Indemnity pays the full daily benefit amount regardless of expenses incurred.
Inflation Benefit	No Inflation	A rider purchased or a policy provision that provides for defined increases in benefits at regular intervals in order to protect against the effects of inflation on the cost of care.
Extension of Benefits	Included	A provision in the policy permitting claim payments to continue for a policy on claim that lapses due to non-payment of premium.
Restoration of Benefits	Included	A policy provision under which the benefit period for a policyholder will be restored to the original Maximum Benefit Period after receiving some or all claim benefits if the policyholder does not need or receive care during a specified period of time (such as 180 days).
Return of Premium Benefit	Not Included	A rider purchased or policy provision which provides for the return of a percentage of premium paid by the policyholder (such as 80%) in consideration of the absence of claim payments during a given period of time in which the policy was in force (such as ten years), or upon policy termination.
Waiver of Premium Benefit	Included	A policy provision under which the policyholder is no longer required to pay premiums for coverage in specified circumstances, such as eligibility for benefits.

1. Your Maximum Benefit Period, Maximum Lifetime Benefit, and Elimination Period may be lower than what is shown if you are currently receiving benefits or have received benefits in the past.
2. Maximum Benefit Period and Reimbursement Type are shown for the highest level of care covered by the policy.
3. Some policies may have Monthly or Weekly benefits instead of Daily benefits.

Note: This document is being provided solely for your convenience and is for reference only. It is not a comprehensive explanation of policy terms or benefits and is not intended to modify or amend any policy provision. All benefit determinations will be processed in accordance with the terms and conditions set forth in your policy and any policy rider(s).

Additional Useful Coverage Information

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)

Coverage information provided on this page does not represent your current coverage. It has been provided to inform you of possible premium and coverage information associated with your policy in future phases of the Rehabilitation Plan. Please refer to the "Important Information for Policyholders" booklet for more detailed information. We encourage you and your trusted advisor to consider this additional useful information as you make your election decision.

INSURED: [redacted] **POLICY NUMBER:** [redacted]

Policy Feature	Current Coverage	Description
Rehabilitation Plan Required Benefit Eligibility	No	"Yes" means the benefit eligibility requirements outlined in the SHIP Rehabilitation Plan will apply to your policy. Rehabilitation Plan Benefit Eligibility requires that you 1) be expected to require care for at least 90 days, and be unable to perform two or more Activities of Daily Living (i.e., eating, dressing, bathing, transferring, toileting, and continence) without substantial hands-on or standby assistance; or 2) for at least 90 days, need substantial assistance due to a severe cognitive impairment. In either case a licensed healthcare professional must certify a plan of care. "No" means the benefit eligibility requirements outlined in the SHIP Rehabilitation Plan do not apply. The benefit eligibility requirements of your policy do not change.
GA Coverage Limit	$300,000	Guaranty Associations (GAs) provide coverage for eligible policyholders of insurance companies that are placed in liquidation. GAs offer continuation of coverage up to a defined GA Coverage Limit that is determined by state of residence of the policyholder. This coverage reflects the GA Coverage Limit in your state of residence that would apply in the event SHIP were to be placed in liquidation in the future.
GA Fully Covered	Yes	"Yes" means your projected Maximum Lifetime Benefit is less than or equal to the GA Coverage Limit in your state of residence. "No" means your projected Maximum Lifetime Benefit is greater than the GA Coverage Limit in your state of residence. This is only a projection which may change with changes in circumstances. You may also want to compare the GA Coverage Limit to the Maximum Lifetime Benefit of your policy as shown on the Coverage Election Form.
Potential Uncovered Benefits	$0	The portion of your Maximum Lifetime Benefit as shown on the Coverage Election Form that exceeds the GA Coverage Limit in your state of residence. Uncovered benefits apply only if a company is placed in liquidation.
Expected Liquidation Rate Increase	0%	This rate increase is the rate increase that could be pursued if SHIP is placed in liquidation. It is a projected number based on certain assumptions made today and could change in the future.
Self-Sustaining Annual Premium	$1,875	This premium is the annual premium that could be charged to fully fund your policy. It is a projected number based on certain financial assumptions made today, including assets available, benefit payments, and expenses.

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SHIP
SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
(IN REHABILITATION)

Choosing the Right Coverage Option

A Step-by-Step Guide for Policyholders

Step One: Review Your Personalized Options

Prepared For [redacted]
Policy Number [redacted]

This chart shows the options currently available to you. Use it to compare the details most important to you.

Policy Feature	Option 1 Downgrade Your Policy	Option 2 Convert to a Basic Policy	Option 2a Convert to an Enhanced Basic Policy	Option 3 Convert to an Enhanced Paid-Up Policy	DEFAULT Option 4 Keep Your Current Coverage
Maximum Benefit Period	N/A	1,825 Days	N/A	913 Days	1,460 Days
Maximum Daily Benefit	N/A	NH: $80.00 HHC: $80.00	N/A	NH: $80.00 HHC: $80.00	NH: $100.00 HHC: $100.00
Maximum Lifetime Benefit	N/A	$146,000	N/A	$73,000	$146,000
Benefit Account Value (Pool of Money)	N/A	Yes	N/A	Yes	No
Elimination Period	N/A	90 Days	N/A	90 Days	0 Days
Reimbursement Type	N/A	Indemnity	N/A	Indemnity	Indemnity
Inflation Benefit	N/A	No Inflation	N/A	No Inflation	No Inflation
Extension of Benefits	N/A	Not Included	N/A	Not Included	Included
Restoration of Benefits	N/A	Not Included	N/A	Not Included	Included
Return of Premium Benefit	N/A	Not Included	N/A	Not Included	Not Included
Waiver of Premium Benefit	N/A	Not Included	N/A	Not Included	Included
Billable Annual Premium	N/A	$835	N/A	$0	$1,350
Annual Premium	N/A	$835	N/A	$0	$1,350
Rehabilitation Plan Required Benefit Eligibility	N/A	Yes	N/A	Yes	No
Phase Two Rate Increase/Benefit Reduction Possible	N/A	No	N/A	No	Yes

Note: If you do not return your Coverage Election Form on time, the Option identified as "Default" will be deemed to be your choice. Annual Premium is the cost of coverage for policy features listed under each option. Billable Annual Premium is that amount minus any premium that is currently being waived.

In the event the Company is placed in liquidation in the future, available benefits may be reduced below those identified in Your Personalized Options, except for Option 3.

Step Two: Learn More About Each Option

We understand that no two policyholders are alike. To help you navigate through the process of making your election decision, we've outlined several preferences to consider that may be important for you to think about. **Please review the policy features outlined in your Personalized Options chart on page two of this guide. Some options may not apply to all policies. Options that do not apply to you will appear on your Personalized Options chart with a designation of N/A (Not Applicable) per the policy features.**

If your preference is to...	Consider these options	A bit about the options...
Maintain your current premium (recognizing that benefits may be reduced in Phase Two of the Rehabilitation Plan)	**Option 1** (Downgrade Your Policy)	• This option offers reduced benefits while allowing your premium to remain the same. • Your benefits will be reduced as shown on your Personalized Options chart on page two of this guide. • The premium rates and benefits associated with this option are not guaranteed and may change significantly in Phase Two of the Rehabilitation Plan.
Adjust your premium and benefits (designed to balance premium and benefits)	**Option 2** (Convert to a Basic Policy) **Option 2a** (Convert to an Enhanced Basic Policy)	• These options offer benefits available on a new Basic Policy (Option 2) or a new Enhanced Basic Policy (Option 2a). Option 2a may offer a longer benefit period and more inflation protection. For some policyholders Option 2 may provide the same coverage as Option 2a. • The new premium for this new policy will correspond to the benefits displayed on your Personalized Options chart on page two of this guide. • These options aim to strike a balance between Option 1 and Option 4, but with two significant benefits: 1. You are protected from mandatory future premium rate increases or benefit reductions in Phase Two of the Rehabilitation Plan. 2. There is an added safety net where your benefits will not be reduced below coverage levels provided in liquidation.
Stop paying premium altogether (while maintaining a basic level of coverage)	**Option 3** (Convert to an Enhanced Paid-Up Policy)	• This option offers a paid up insurance policy with benefits displayed on your Personalized Options chart on page two of this guide. This means you will no longer have to pay premium, and coverage will terminate when the Maximum Lifetime Benefit is exhausted. • The benefits associated with this option are generally richer than those offered as part of a traditional (non-Rehabilitation) nonforfeiture option. • This option will not be subject to premium rate increases or benefit reductions in Phase Two of the Rehabilitation Plan.
Preserve your current benefits (recognizing that premium may be increased in Phase Two of the Rehabilitation Plan)	**Option 4** (Keep Your Current Coverage)	• This option offers continuation of current coverage at a potentially higher premium rate. • You will have the same level of protection you have now at the premium amount displayed on your Personalized Option chart on page two of this guide. • The premium rates and benefits associated with this option are not guaranteed and may change significantly in Phase Two of the Rehabilitation Plan.
Have certainty (with respect to the premium you will pay and the benefits you will receive throughout the Rehabilitation process)	**Option 2** (Convert to a Basic Policy) **Option 2a** (Convert to an Enhanced Basic Policy) **Option 3** (Convert to an Enhanced Paid-Up Policy)	• All 3 of these options offer certainty that you will not be subject to mandatory premium rate increases or benefit reductions in Phase Two of the Rehabilitation Plan.

Step Three: Indicate Your Choice On The Enclosed Form

Your Coverage Election Form must be signed and postmarked by March 15, 2022.

1. Tell us how we can reach you, if we have questions.
2. Indicate the option you prefer by checking the block associated with your selected option. You should select only one option.
3. Sign your name and date the form.
4. Mail in the postage-paid return envelope.

Coverage Election Form

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)

POLICYHOLDER NAME: John J. Sample
POLICY NUMBER: 8321
ELECTION EFFECTIVE DATE: 4/20/2022
IMPORTANT: This form must be signed and postmarked by February 28, 2022.

Best way to reach you, if we have questions.

1 **Phone:**
Email:

Select the option that best suits your needs.

Policy Feature	Your Current Policy	Option 1 Downgrade Your Policy	Option 2 (DEFAULT) Convert to a Basic Policy	Option 2a Convert to an Enhanced Basic Policy	Option 3 Convert to an Enhanced Paid-Up Policy	Option 4 Keep Your Current Coverage
Billable Annual Premium	$2,887	$2,887	$1,188	$1,248	$0	$3,362
Annual Premium	$2,887	$2,887	$1,188	$1,248	$0	$3,362
Annual Premium Change (%)	N/A	0%	-58.85%	-56.77%	-100%	16.45%
Maximum Lifetime Benefit	Unlimited	Unlimited	$394,644	$493,305	$246,652	Unlimited
Maximum Lifetime Benefit Change (%)	N/A	0%	-60.54%	-50.67%	-75.33%	0%
Phase Two Rate Increase/Benefit Reduction Possible	N/A	Yes	No	No	No	Yes
SELECT ONE ▶		☐	☐	☐	☐	☐

2

Sign below.

I understand the election I have made above and acknowledge that I have made the election voluntarily. I agree that the changes I have requested will become effective April 20,2022 and cannot be reversed after February 28, 2022.

I understand that if I do not clearly mark only one election, or if I do not return this signed form postmarked by February 28, 2022, I will receive Option 2 by default.

3

Signature: Date: / / (Month / Day / Year)

Print name here:

Signatory authority: ☐ Power of Attorney ☐ Conservator ☐ Other:

Return this form in the postage-paid envelope postmarked by [Decision Date].
Questions? Call **(833) 894-8577**, Monday through Friday, 8:00 a.m. to 6:00 p.m. EST.

P.O. Box 64675, St. Paul, MN 55164-0675

SHIP-EP-LTREF-0122

BUSINESS
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4

SENIOR HEALTH INS
OF PENNSYLVANIA (I
PO BOX 64675
ST. PAUL, MN 55164-0675

IF YOU DON'T RETURN YOUR COVERAGE ELECTION FORM ON TIME, YOU WILL AUTOMATICALLY RECEIVE THE DEFAULT OPTION IDENTIFIED ON YOUR PERSONALIZED OPTIONS CHART AND ON YOUR COVERAGE ELECTION FORM.

Understanding the Policy Features in Your Personalized Options chart.

The information provided in Step One of the guide was customized just for you. It details the options available to you and provides cost and benefit information for each option. We encourage you to carefully evaluate the benefits, premium, and possibility of future rate increases/benefit reductions in light of your personal situation with a family member or trusted advisor. Maximum Lifetime Benefit and Annual Premium have been provided to enable you and your advisor to compare the maximum lifetime benefits to annual cost for each option.

Policy Feature	Description
Maximum Benefit Period[1,2]	The maximum length of time your policy pays benefits.
Maximum Daily Benefit[3]	The most you can collect each day for each type of care: Nursing Home (NH), Assisted Living Facility (ALF), Home Health Care (HHC). Your policy may include certain additional benefits. If your policy includes additional benefits that are based on your NH, ALF, or HHC benefit amount(s), the maximum daily benefit amount for the additional benefits will change based on the option you choose. To learn more about additional benefits please refer to the Glossary of Terms in your Important Information for Policyholders brochure.
Maximum Lifetime Benefit[1]	The maximum benefit amount you can collect from your policy assuming benefit payments begin now. This benefit amount may not include eligible Restoration of Benefits associated with the policy.
Benefit Account Value (Pool of Money)	"Yes" means policy benefits are measured by the total dollar amount paid. "No" means they are measured by the number of days benefits are paid.
Elimination Period[1,4]	The length of time you must wait after becoming eligible for benefits before you are eligible to receive benefit payments.
Reimbursement Type[2, 5]	Reimbursement means you're covered for actual expenses up to the applicable limit. Indemnity means you'll be paid the full daily amount, regardless of expenses incurred.
Inflation Benefit	A rider or policy provision that increases your coverage at regular intervals to guard against inflation.
Extension of Benefits	A policy provision that allows claim payments to continue, even if your policy lapses for non-payment.
Restoration of Benefits	A policy provision that restores your benefits to the original maximum level, if no claims are filed for an extended period of time, such as 180 days.
Return of Premium Benefit	This policy provision or rider provides for return of some or all of the policy premium paid if you do not have claims during a given time frame (such as ten years or the time your policy was in force).
Waiver of Premium Benefit[4]	With this policy provision, you are not required to pay premiums under certain specified circumstances such as while you are on claim.
Rehabilitation Plan Required Benefit Eligibility[4]	"Yes" means the benefit eligibility requirements outlined in the SHIP Rehabilitation Plan will apply to your policy if you select this option. Rehabilitation Plan Benefit Eligibility requires that you 1) be expected to require care for at least 90 days, and be unable to perform two or more Activities of Daily Living (i.e., eating, dressing, bathing, transferring, toileting, and continence) without substantial hands-on or standby assistance; or 2) for at least 90 days, need substantial assistance due to a severe cognitive impairment. In either case a licensed healthcare professional must certify a plan of care. "No" means the benefit eligibility requirements outlined in the SHIP Rehabilitation Plan do not apply. The benefit eligibility requirements of your policy do not change.

1. Your Maximum Benefit Period, Maximum Lifetime Benefit, and Elimination Period may be lower than what is shown if you are currently receiving benefits or have received benefits in the past.
2. Maximum Benefit Period and Reimbursement Type are shown for the highest level of care covered by the policy.
3. Some policies may have Monthly or Weekly benefits instead of Daily benefits.
4. If these features change under an option and benefit eligibility for a claim has been approved prior to the Effective Date, these modifications will only apply to future claims.
5. Under Option 1, if your Reimbursement Type changes from Indemnity to Reimbursement and benefit eligibility for a claim has been approved prior to the Effective Date, this Policy Feature modification will only apply to future claims.

Note: Refer to the Glossary of Terms in the "Important Information for Policyholders" booklet for a more detailed description of each Policy Feature.

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Questions About Your Options?

Q1. When will my new coverage or premium go into effect?

Your new coverage or premium will go into effect on the Election Effective Date listed on your Coverage Election Form.

Q2. Can I change my decision once I return the Coverage Election Form?

You can change your decision until the deadline indicated on your Coverage Election Form. Coverage Election Forms post-marked after this date will not be accepted. It is important to submit your Form on time.

Q3. What happens if I do not return my Coverage Election Form?

If you do not return your Coverage Election Form, the Option identified as "Default" on your Personalized Options chart (on page two of this guide) and on your Coverage Election Form will be deemed to be your choice. Please be sure to make an election and return your completed Coverage Election Form on time.

Q4. What happens if I return my Coverage Election Form without a signature or if I do not select only one option?

Under these circumstances, your Coverage Election Form will be considered invalid. The Option identified as "Default" on your Personalized Options chart (on page two of the guide) and on your Coverage Election Form will be deemed to be your choice. Please be sure to submit a properly completed and signed form.

Q5. What happens if I cannot find my Coverage Election Form?

If you have misplaced your Coverage Election Form, please contact (833) 894-8577. We will promptly send you a new Coverage Election Form.

Q6. Do I need to send any money with my completed Coverage Election Form?

No. You do not need to send any money with your completed Coverage Election Form. You will continue to be billed in the same way you are billed now. If you have not paid premium recently and premium becomes due, a premium notice will be mailed to the address on file.

Q7. Can my premiums increase in Phase Two of the Rehabilitation Plan?

If you elect Option 1 or Option 4, your policy may be subject to additional rate increases in Phase Two of the Rehabilitation Plan. You would be notified in advance of any required premium increase. Similar to Phase One, customized options would be prepared and fully explained to you.

Q8. Can my benefits be reduced in Phase Two of the Rehabilitation Plan?

If you elect Option 1 or Option 4, your policy may be subject to additional benefit reductions in Phase Two of the Rehabilitation Plan. You would be notified in advance of any required benefit reduction. Similar to Phase One, customized options would be prepared and fully explained to you.

Q9. What happens if I cancel or lapse my coverage, instead of making a coverage decision?

If you cancel or lapse your policy *before* your Option becomes effective, your coverage will be converted to a standard paid-up policy. Coverage provided by a standard paid-up policy equals the total premium paid by you since the issue date of your policy, reduced by the sum of any claim payments and any returned premium payments made to you since the issue date of your policy.

If you cancel or lapse your policy *after* your Option becomes effective, your coverage will be converted to the Enhanced Paid-Up Policy as described under Option 3 on your Personalized Options chart on page two of this guide.

Q10. I am currently receiving benefits under my long-term care policy. Do I still have to return the Coverage Election Form?

Yes. You must return your completed Coverage Election Form even if you are currently receiving claim benefit payments. Your benefits may change, depending on the Option you select. If you choose an Option that changes your benefits, your new benefits will start on the date your Option becomes effective. If you do not return your Coverage Election Form, the Option identified as "Default" will be deemed to be your choice.

Q11. What is the difference between Annual Premium and Billable Annual Premium?

Annual Premium is the cost of coverage for policy features listed under each option on your Personalized Options chart. Billable Annual Premium is that amount minus any premium that is currently being waived.

If you currently pay the full premium amount, your Annual Premium and Billable Annual Premium are the same. If your premiums are currently being waived, and your new Annual Premium is greater than the waived premium amount, you will be billed the Annual Billable Premium when your new option becomes effective.

Q12. I currently do not have to pay premium because my policy is on waiver of premium. Do I still have to return the Coverage Election Form?

Yes. You must return your completed Coverage Election Form even if you are currently not paying premium.

More Questions? Call (833) 894-8577. Monday through Friday, 8:00 a.m. to 6:00 p.m. EST.

SHIP

SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
(IN REHABILITATION)

The information in this brochure provides general guidance and does not address any specific claims or circumstances. It does not constitute a binding legal statement and is not intended to serve as legal advice or complete legal descriptions. Any forward-looking statements are based on current expectations and assumptions that are subject to change. For full legal information, review the Rehabilitation Plan and applicable Court filings found on the SHIP website: **shipltc.com**.

SHIP

SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
(IN REHABILITATION)

Important Information
for Policyholders

Understanding the situation and the action you need to take.

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Case 3:22-cv-01329-FLW-LHG Document 1-4 Filed 03/11/22 Page 59 of 138 PageID: 937

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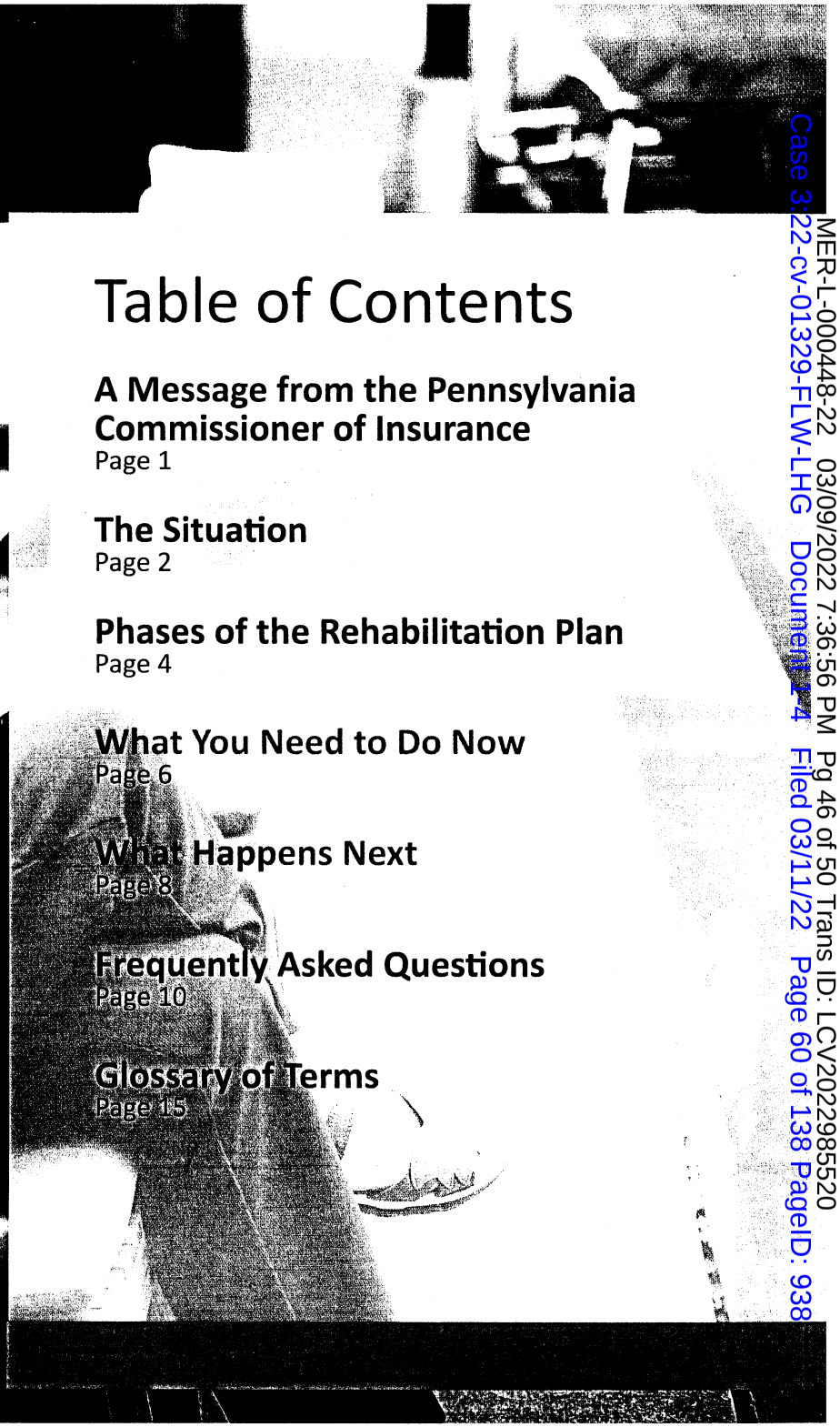

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pennsylvania
INSURANCE DEPARTMENT

Dear Policyholder,

Over the past year, I assembled a rehabilitation team of experts and have worked closely with them to help address the financial difficulties experienced by SHIP, your long-term care insurance company.

Based on our evaluation, we prepared a comprehensive Rehabilitation Plan and filed the Plan with the Pennsylvania Commonwealth Court for the Court's review and approval. The Court approved our recommended Rehabilitation Plan.

The Plan involves a number of changes, including making adjustments to insurance policies. This brochure and the other documents included in this Election Package have been thoughtfully designed to help you select the policy modification option that best meets your needs as we implement the Approved Rehabilitation Plan.

You are encouraged to review the information carefully and consult with a family member or trusted advisor to choose the option on your Coverage Election Form that is best for your situation. If you have questions, we are here to help. Just call **(833) 894-8577**.

With warm regards,

Jessica K. Altman
Pennsylvania Commissioner of Insurance

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Case 3:22-cv-01329-FLW-LHG Document 1-4 Filed 03/11/22 Page 61 of 138 PageID: 939

The Situation

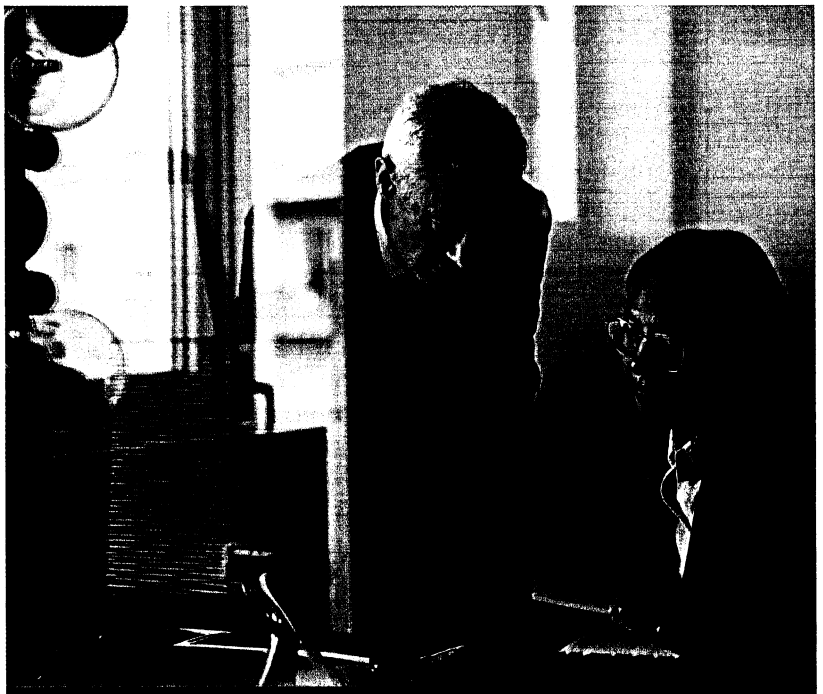
Senior Health Insurance Company of Pennsylvania ("SHIP") is in rehabilitation. *What does that mean?*

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)

The insurance industry is monitored and regulated by state insurance departments to protect the interests of policyholders. If an insurance company's financial condition indicates the company does not have adequate funds to fully pay for expected future claims, a court-supervised process called "rehabilitation" is initiated.

On January 29, 2020, SHIP was placed in rehabilitation by the Commonwealth Court of Pennsylvania. This rehabilitation order placed the company under the control of the Pennsylvania Insurance Department. The Pennsylvania insurance commissioner was appointed as SHIP's Rehabilitator to oversee the financial situation, stabilize current operations, develop a rehabilitation plan to maximize the protection of policyholders, and plan for SHIP's future.

After SHIP was ordered into rehabilitation, the Rehabilitator assembled a team of experts, including a Special Deputy Rehabilitator, to carefully evaluate SHIP's financial problems and explore ways to correct them. Together, that team developed a proposed Rehabilitation Plan. The proposed Rehabilitation Plan was filed with and approved by the Commonwealth Court of Pennsylvania, after a week-long evidentiary hearing and more than a month of post hearing briefing.



On January 29, 2020, SHIP was placed in rehabilitation by the Commonwealth Court of Pennsylvania.

Important Details about the Rehabilitation Plan

The Plan's principal goal is to correct the Company's financial condition through policy modifications with a focus on protecting policyholder interests. Providing options to policyholders based on individual circumstances is also an important part of the Plan.

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Phases of the Rehabilitation Plan

Phase One begins immediately following approval of the Plan by the Commonwealth Court of Pennsylvania. The goal is to reduce substantially or eliminate the financial deficit by modifying the policies. Reducing or eliminating the financial deficit will enable the company to provide meaningful long-term care coverage to policyholders. This will be achieved by a combination of premium rate increases and policy benefit modifications. This Election Package has been prepared to present policyholders with premium rate increase and policy benefit modification options that will help achieve the goal of the Plan. The Options in the Election Package have been customized for each policyholder and have been prepared using the current policy status (i.e., on claim or not on claim and premium-paying or on premium waiver) for each policy. Policyholders will be asked to select the Option that best meets their needs.

Policies that require modification in Phase One are those paying a current premium below the "If Knew Premium", which is the premium that should have been charged when the policies were originally issued based on a variety of factors known today about the SHIP policies such as historical claim payments, premium rate increases, policy termination rates, and investment returns.

Phase Two will begin after the results of Phase One have been evaluated. The goal is to narrow or eliminate any financial deficit remaining after Phase One. The timing and details will depend on the results achieved in Phase One. Whether or not Phase Two will be implemented may be subject to change depending on the circumstances following Phase One.

Premium rate increases and policy benefit modifications may be required for policyholders who elected Option 1 (Downgrade Your Policy) or Option 4 (Keep Your Current Coverage) in Phase One. Policyholders will be notified in advance of any required rate increases and benefit reductions. Similar to Phase One, customized options for each policyholder will be prepared and fully explained. Certain policyholders, including those who elected Option 2 (Convert to a Basic Policy), Option 2a (Convert to an Enhanced Basic Policy), or Option 3 (Convert to an Enhanced Paid-Up Policy) in Phase One, will not face mandatory rate increases or policy benefit modifications in Phase Two of the Plan.

Phase Three will begin after the results of Phase Two have been evaluated. It does not include any policyholder modifications and will not require policyholder elections. This phase is the administrative and final phase.

We're Working Hard to Find Solutions for You

The Rehabilitation process is complicated and the financial stability of SHIP is a serious matter. The Rehabilitation team meets regularly to work through the many issues that arise during the Rehabilitation process. The Election Package you received has been customized to help you make an important decision about your SHIP long-term care policy. If you have more than one policy, you will receive an Election Package for each policy. You must make a separate election for each policy.

We understand how important your long-term care insurance coverage is to you and your family. We designed this personalized Election Package to help you make an election that best meets your needs. Coverage options presented have been thoughtfully designed to help you choose a solution that meets your needs as we implement the changes brought about by the approved Rehabilitation Plan.

Here's How You Can Stay Informed

Communicating with you about ongoing rehabilitation activities is our top priority. We will continue to send you notices and share updates about rehabilitation and the court process. You are also encouraged to regularly visit SHIP's website at **shipltc.com/court-documents**

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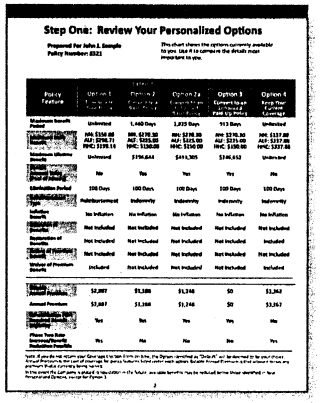
What You Need to Do Now

Select one Option and mail your decision by the deadline indicated on your Coverage Election Form.

Use the enclosed "Step-by-Step Guide for Policyholders" to help you choose an option that best suits your needs.

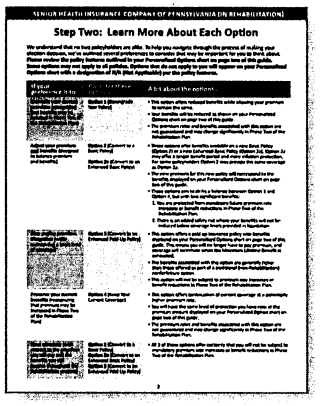
You can also visit us online at shipltc.com to watch our informational video series.

1


Step One: Review Your Personalized Options

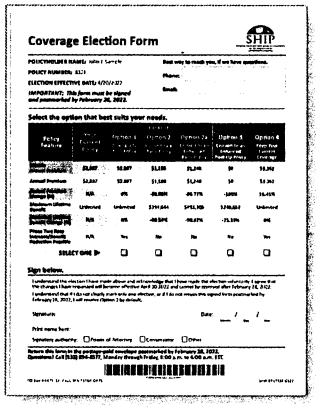
Step One: Review your Personalized Options chart. It was designed with you in mind and provides important cost and benefit information for each option. You are encouraged to review the information carefully and consult with a family member or trusted advisor to choose the option that is best for your situation.

2


Step Two: Learn More About Each Option

Step Two: Learn more about each option. Compare your options in light of your personal situation. Carefully evaluate the benefits, premium, and possibility of future policy modifications of each option.

3


Coverage Election Form

Step Three: Complete, sign, and date your Coverage Election Form. Return the Form in the enclosed postage-paid envelope.

YOUR COMPLETED FORM MUST BE POSTMARKED BY THE DATE INDICATED ON YOUR COVERAGE ELECTION FORM.

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What Happens Next

After you have selected the option that best suits your needs, here's what you need to know about next steps.

1. **SHIP will review your Coverage Election Form** to make sure it is complete. You can help us by making sure to:
   - Select only ONE option on the Coverage Election Form.
   - Sign and clearly date the Form.
   - Return ONLY the completed Coverage Election Form in the self-addressed postage-paid return envelope.

   PLEASE NOTE, IF SOMEONE ELSE SIGNS THE FORM ON YOUR BEHALF, THE SIGNING AUTHORIZATION MUST BE ON FILE WITH SHIP.

2. **If your Coverage Election Form is complete,** SHIP will mail you a written confirmation of your Election upon receipt and will process your selected Option.

3. **If your Coverage Election Form is NOT completed correctly,** if there is time, SHIP will mail you another Coverage Election Form explaining what needs to be corrected. You must complete this new Coverage Election Form. The Form must be returned and postmarked by the date noted on the Form. If you did not submit or correctly complete your Election Form on time, the Default Option will be processed.

4. **Any modification resulting from your selected Option** will be effective on the Election Effective Date, listed on your Coverage Election Form. If your Option changes your benefits and you are currently receiving claim payments, your new benefits will start on the Election Effective Date. You should continue submitting claims in the same manner you have in the past.

In the event a policyholder's circumstances change as specified in the Plan before the Initial Plan Effective Date (for example by going on claim, becoming eligible for premium waiver, going off claim, or losing a premium waiver) the policyholder will be sent a new Election Package and will be required to select a new option from among options applicable to the new circumstances.

5. **If a premium payment is due**, you will continue to be billed in the same way you are billed now. If you do not currently pay premiums and a premium payment is due as a result of the Option you have elected, you will receive a premium notice mailed to the address on file. It is important for you to pay premiums as they become due to preserve your coverage.

6. **If you do not make the premium payment when due**, your coverage will be converted to a paid-up policy. If the date of lapse is before the Election Effective Date, your policy will convert to a standard paid-up policy which has a maximum benefit amount equal to the total amount paid by you in premium since the issue date of your policy, reduced by the sum of any claim payments and any returned premium payments made to you since the issue date of your policy. If the date of the lapse is after the Election Effective Date, your policy will convert to the Enhanced Paid-Up policy as described under Option 3 on your Personalized Options chart on page two of the guide enclosed.

7. **A Summary of Current Coverage document,** a policy endorsement, and a schedule of benefits that reflect your policy modifications and features will be mailed to you within a few weeks after your Election Effective Date, listed on your Coverage Election Form.

Need More Information? Call (833) 894-8577.

Monday through Friday, 8:00 a.m. to 6:00 p.m. EST.

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Frequently Asked Questions

Q1. What is Rehabilitation?

Rehabilitation is a court-supervised process intended to remedy an insurance company's impaired financial condition for the benefit of policyholders and creditors.

On January 29, 2020, Senior Health Insurance Company of Pennsylvania ("SHIP") was placed in rehabilitation by the Commonwealth Court of Pennsylvania (the "Court"). The Court appointed Pennsylvania Insurance Commissioner Jessica K. Altman (the "Commissioner") as Rehabilitator, and she appointed Patrick H. Cantilo as Special Deputy Rehabilitator ("SDR").

The Rehabilitator is charged with protecting SHIP's policyholders, creditors, and the public, including making sure policyholders' coverage continues as long as premiums are paid when due, subject to Plan modifications. Under rehabilitation, the Commissioner conducts an independent, in-depth financial analysis of the insurance company and evaluates and implements opportunities to improve the companies' financial status. The Rehabilitator's actions are dictated by Pennsylvania laws and regulations and are subject to review by the Commonwealth Court of Pennsylvania.

Q2. What is the purpose of the Election Package?

The Rehabilitator and her Rehabilitation team prepared a comprehensive Rehabilitation Plan and filed the Plan with the Pennsylvania Commonwealth Court for the Court's review and approval. The Court recently approved the Rehabilitation Plan.

The approved Plan involves a number of changes, including making adjustments to insurance policies. These adjustments to the insurance policies include premium rate changes and policy benefit modification options. The purpose of the Election Package is to help policyholders select the option that best meets policyholder needs.

Q3. What actions do I need to take?

You need to make an important choice about your long-term care insurance coverage. Options for your coverage have been thoughtfully customized with you in mind. Refer to the enclosed "Step-by-Step Guide for Policyholders" and follow these steps:

Step 1: Review your "Personalized Options" on page 2.
Step 2: Review "Learn More About Each Option" on page 3.
Step 3: Indicate your choice on the enclosed Coverage Election Form and mail the completed form to SHIP in the enclosed postage-paid return envelope by the deadline indicated on the form.

Q4. How can I learn more about SHIP's rehabilitation and the Election Package?

We created an informational video series to help our policyholders, their families and advisors better understand the content of this Election Package, get help understanding their choices and learn how to choose their best option.

The video series is available online at **shipltc.com** and is accessible from smartphones, tablets, and laptops. It also features information on the phases of the rehabilitation plan, how to notify us of your decision, and what you can expect after completing and returning your Coverage Election Form.

Q5. I am currently receiving claim benefits. Do I need to do anything different?

Claims for policy benefits will continue to be processed and paid in the normal course of business. You should continue submitting claims in the same manner that you have in the past. Any policy or benefit modifications resulting from your selected Option on the enclosed Coverage Election Form will become effective on the Election Effective Date listed on that Form.

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Q6. What happens if I decide to stop paying my premiums?
If you cancel or lapse your policy before the Election Effective Date, your coverage will be converted to a standard paid-up policy. Coverage provided by this policy will have a maximum benefit amount which equals the total amount paid by you in premium since the issue date of your policy, reduced by the sum of any claim payments and any returned premium payments made to you since the issue date of your policy.

If you cancel or lapse your policy after the Election Effective Date, your coverage will be converted to the Enhanced Paid-Up Policy as described under Option 3 on your Personalized Options chart on page two of the enclosed Step-by-Step Guide for Policyholders. Policy Feature amounts for cancelled or lapsed policies could be different from those displayed under Option 3 due to policy-specific benefit payments and inflation.

Q7. Can I do anything to avoid possible mandatory premium increases or benefit reductions in Phase Two?
You can select one of Options 2, 2a, or 3 in Phase One. Policyholders who choose those options in Phase One are not subject to mandatory modifications in Phase Two.

Q8. Are any policies exempt from mandatory premium increases or benefit reductions in Phase Two regardless of which Option they choose in Phase One?
Options 2, 2a, and 3 are exempt from mandatory modifications in Phase Two. If you select Option 1 or Option 4 in Phase One, you may or may not be exempt from mandatory modifications in Phase Two. If the Guaranty Association Coverage Limit (found on the "Summary of Current Coverage" document) is equal to or greater than the Maximum Lifetime Benefit (of the Phase One Option chosen), you will be exempt from mandatory modifications in Phase Two. If the Annual Premium (of the Phase One Option chosen) is equal to or greater than the Hypothetical Phase Two Annual Premium (found on the enclosed "Summary of Current Coverage" document), you may be exempt from mandatory modifications in Phase Two. Otherwise, selecting Options 1 or 4 may not exempt you from Phase Two modifications.

Q9. If my policy is not subject to mandatory modifications in Phase Two, can I still choose a different Option at that time?
Certain voluntary changes can be made in Phase Two, but you cannot increase coverage.

Q10. Are policyholder elections permanent?
Yes. Once the Coverage Election Form due date passes, you cannot change the option you selected. If the Coverage Election Form is not received on time, you cannot change the "Default" option. All benefit and/or premium changes elected (or defaulted to) pursuant to the Court-approved Rehabilitation Plan are permanent changes to the policy.

Q11. Have any other rehabilitation alternatives been considered?
A number of alternatives have been explored and the Rehabilitator determined they are either not feasible or that the Plan is preferable under the current circumstances.

Q12. Is there a possibility SHIP could be liquidated?
The Pennsylvania Commonwealth Court could decide at some time in the future to place SHIP into liquidation.

Q13. How is liquidation different from rehabilitation?
Under rehabilitation, the Pennsylvania Insurance Commissioner evaluates and implements actions to restore the company's financial condition to a favorable status. The Insurance Commissioner recommends liquidation when the Commissioner believes rehabilitation efforts should no longer be pursued.

In the insurance industry, rehabilitation is a process that allows the Rehabilitator to formulate a plan for restructuring the company and/or modifying the policies to protect policyholder interests. Liquidation is a court-directed process that prescribes the disposition of assets and liabilities for an insurer when it is determined that future policyholder obligations cannot be fully met.

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Q14. What would happen if SHIP were liquidated?
If SHIP were ordered into liquidation, it is probable that state insurance guaranty associations would continue coverage for policyholders up to applicable statutory coverage limits. Generally, Guaranty Associations become responsible for an insurer's obligations only if the insurer is found by the Court to be insolvent and placed in liquidation. If SHIP is placed in liquidation, policyholders may be subject to future rate increases and benefit reductions.

SHIP has not been placed in liquidation. Therefore, no Guaranty Association is responsible for SHIP's policy obligations at this time. For information about state guaranty associations, please visit **nolhga.com**.

Q15. How does coverage in the Rehabilitation Plan compare to coverage in liquidation?
Under the Rehabilitation Plan you have at least one option that provides coverage greater than or equal to coverage you would receive in liquidation from the Guaranty Associations. The Plan offers other options unlikely to be available in liquidation.

Q16. Where can I get more details about these matters?
The Approved Rehabilitation Plan is on SHIP's website. Please visit **shipltc.com**.

Additional Questions? Call (833) 894-8577.

Monday through Friday, 8:00 a.m. to 6:00 p.m. EST.

Glossary of Terms

Additional Benefits: Some long-term care policies include benefits other than nursing home, facility, home health care, or adult day care. Examples of these include, but are not limited to, bed reservation benefit, respite care, hospice care, caregiver training, medic alert, prescription drug benefit, homemaker services, and ambulance services.

Benefits: Money an insurance company pays to policyholders or care providers for services the insurance policy covers.

Benefit Account Value (Pool of Money): A policy provision that indicates whether the policy includes benefits in dollars up to the total Maximum Lifetime Benefit or includes each day paid up to the Maximum Benefit Period days.

Claim: A request made to pay benefits for eligible services.

Commonwealth Court or Court: The Commonwealth Court of Pennsylvania, which is the rehabilitation court for SHIP and has exclusive authority over SHIP's rehabilitation.

Coverage Election Form: The election form, included in this Election Package, on which a policyholder specifies the Option he or she chooses under the Rehabilitation Plan to modify their policy.

Effective Date: The date the provisions of the Rehabilitation Plan, including modification of long-term care policies and Policyholder Elections, will become effective following approval of the Rehabilitation Plan.

Elimination Period: The time period during which a policyholder qualifies for benefits but for which no benefits are yet payable.

Extension of Benefits: A provision in the policy permitting claim payments to continue for a policy on claim that lapses due to non-payment of premium.

Guaranteed Renewable Policy: An insurance company guarantees the policyholder the right to renew the policy for life, as long as the policyholder pays the premiums on time. Most long-term care insurance policies are guaranteed renewable.

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Guaranty Association: Organizations created by statute in each state that are responsible for continuation of insurance coverage for eligible policyholders of insurance companies that are placed in liquidation. These organizations offer continuation of coverage up to a defined Guaranty Association Coverage Limit that is determined by state of residence of the policyholder.

Inflation Benefit: A rider purchased or a policy provision that provides for defined increases in benefits at regular intervals in order to protect against the effect of inflation on the cost of care.

Lapse: When a policyholder owes premium on their insurance policy but stops paying the premium, resulting in the termination of the policy and loss of insurance protection and benefits.

Liquidation: A legal step a state insurance department takes when an insurance company can't recover from its financial troubles.

Long-Term Care Insurance: Insurance that offers benefits to pay for nursing home care, home health care, and/or other services for individuals who can't perform daily living activities or must be supervised due to illness or cognitive impairment.

Maximum Benefit Period: The maximum duration during which benefits will be available under the policy.

Maximum Daily Benefit: The maximum daily dollar amount available on a covered date of care as specified in the policy, for each eligible type of care. NH= Nursing Home, ALF= Assisted Living Facility, HHC= Home Health Care.

Maximum Lifetime Benefit: The maximum benefit amount available for the life of the policy, reflecting inflation assuming benefits start now. This benefit amount may not include eligible Restoration of Benefits associated with the policy.

Policy Benefit Limit: The maximum benefit amount a policy will pay. Some policies define the policy benefit limit in years (one, two, three or more, or even lifetime). Others define the policy benefit limit as a total dollar amount. Policies often use words such as "total lifetime benefit," "maximum lifetime benefit," or "total plan benefit" to describe their maximum benefit limit.

Glossary of Terms

Policy Modifications: Premium rate changes or benefit reductions implemented for each policyholder in accordance with the terms of the Rehabilitation Plan.

Policyholder Election: The election by a policyholder to modify the premiums or benefits of his or her policy under the Rehabilitation Plan.

Policyholder Election Date: The date by which the Coverage Election Form must be properly completed, signed, and postmarked in order for the election to be effective.

Premium: The amount you pay for your insurance coverage.

Rehabilitation: A court-supervised process intended to remedy an insurance company's financial deterioration for the benefit of policyholders and creditors.

Rehabilitation Plan: A plan to correct an insurance company's financial situation through policy modifications and other cost cutting measures while protecting policyholder interests. The plan is proposed by the Rehabilitator and approved by the Court.

Rehabilitator: The state insurance commissioner appointed by the Court to oversee an insurance company's rehabilitation process. The commissioner takes legal control of the company and does an independent, in-depth financial analysis of the company. The commissioner is charged with the protection of the company's policyholders, creditors, and the public. The rehabilitator's actions are dictated by the laws and regulations of the state and are subject to review by the Court. Jessica K. Altman is the Rehabilitator for SHIP.

Reimbursement Type: The method by which the Daily Benefit will be paid out. Reimbursement provides coverage for the actual expenses of care up to specified limits. Indemnity pays the full daily benefit amount regardless of expenses incurred.

Reinstatement Provisions: A policy provision that provides for a policyholder who meets certain conditions to reinstate their policy after it has been canceled because premiums were not paid on time.

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Glossary of Terms

Restoration of Benefits: A policy provision under which the benefit period for a policyholder will be restored to the original Maximum Benefit Period after receiving some or all claim benefits if the policyholder does not need or receive care during a specified period of time (such as 180 days).

Return of Premium Benefit: A rider purchased or policy provision which provides for the return of a percentage of premium paid by the policyholder (such as 80%) in consideration of the absence of claim payments during a given period of time in which the policy was in force (such as ten years), or upon policy termination.

Special Deputy Rehabilitator: An individual appointed by the Rehabilitator to oversee the day-to-day affairs of the company and to prepare a plan for the company's rehabilitation. Patrick H. Cantilo is the Special Deputy Rehabilitator for SHIP.

State Insurance Commissioner: A state regulator who heads the state insurance department and monitors and regulates insurance agents and companies. Jessica K. Altman is the State Insurance Commissioner in Pennsylvania.

State Insurance Department: The state regulatory agency responsible for administering laws and regulations for all types of insurance.

Waiver of Premium Benefit: A policy provision under which the policyholder is no longer required to pay premiums for coverage in specified circumstances, such as eligibility for benefits.

Need More Information? Call (833) 894-8577.

Monday through Friday, 8:00 a.m. to 6:00 p.m. EST.

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LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor

KATHLEEN A. BIRRANE
Commissioner

GREGORY M. DERWART
Deputy Commissioner

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February 15, 2022

CERTIFIED MAIL
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Jessica K. Altman
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Patrick H. Cantilo
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Re: *Maryland Insurance Administration v.* Senior Health Insurance Company of Pennsylvania
Case No.: MIA-2022-02-011

Dear Commissioner Altman and Special Deputy Rehabilitator Cantilo:

Enclosed please find an order disapproving the proposed rate increase sought in Maryland by Senior Health Insurance Company of Pennsylvania. The reasons for the disapproval are spelled out in the order.

Pursuant to §11-503 of the Insurance Article, Annotated Code of Maryland, an appeal may be commenced by filing a notice of appeal with the Circuit Court for Baltimore City and a copy of the notice of appeal with the Commissioner within 30 days of the date of this order. The Commissioner shall be made a party to any such appeal.

Very truly yours,

Kathleen A. Birrane
Insurance Commissioner

Enclosure
cc: Bradley Boban, Associate Commissioner
J. Van Lear Dorsey, Principal Counsel
Craig Ey, Director of Communications

IN RE:	*	**BEFORE THE**
PROPOSED RATE INCREASE SUBMITTED BY SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, IN REHABILITATION	*	**MARYLAND INSURANCE COMMISSIONER**
	*	**CASE NO.: MIA-2022-02-011**

* * * * * * * * * * * * * *

ORDER OF DISAPPROVAL

The matter before the Commissioner is the request to increase long term care rates filed by the Rehabilitator of the Senior Health Insurance Company of Pennsylvania ("SHIP"), Patrick H. Cantilo as Special Deputy Rehabilitator of SHIP, and SHIP, in Rehabilitation (collectively referred to as "Respondents") (the "Rate Filing").[1] The Rate Filing proposes to increase by as much as 1,361.09% the rates to be charged by SHIP on certain policies of long term care insurance issued in Maryland that are administered by SHIP.

A virtual quasi-legislative hearing on the Rate Filing was held on February 11, 2022[2] Representatives of SHIP attended the hearing, as did members of the public.[3]

For the reasons set forth herein, the Rate Filing is hereby DISAPPROVED.

[1] Md. Ann. Code, Ins. Art., §11-703(b) (2017 Repl. Vol.) prohibits a carrier from changing the premium rate charged to an insured under a long-term care insurance policy unless and until the proposed rate change has been filed with and approved by the Commissioner.

[2] Notice of the hearing was issued on January 10, 2022 and posted on the MIA website. *See* https://insurance.maryland.gov/Consumer/Pages/Long-Term-Care-Hearing-February-112022.aspx.

[3] The hearing can be viewed in its entirety on the MIA's website at: https://www.youtube.com/watch?v=aB39x1UeXoo.

FINDINGS OF FACT

1. SHIP is a life and health insurance company domiciled in the Commonwealth of Pennsylvania. It administers a closed block of long-term care insurance policies issued in over forty states.

2. Prior to November 12, 2008, SHIP operated as Conseco Senior Health Insurance Company.[4] From 1997 to 2000, a number of other long term care insurance companies merged into, or were acquired by Conseco Senior Health Insurance Company.

3. On November 12, 2008, the Pennsylvania Insurance Department ("PID") approved a solvent run-off plan pursuant to which the ownership of Conseco Senior Health Insurance Company was transferred to a Trust and the company was renamed "Senior Health Insurance Company of Pennsylvania," known colloquially as "SHIP." The Trust was formed with the authorization and input of PID with the intent to guide SHIP's run-off as a non-profit enterprise. All of the policies administered by SHIP were issued on or before 2003.

4. Only a small fraction of SHIP's original business remains in force. The average SHIP policyholder in Maryland is approximately 85 years of age and the average policyholder on claim is approximately 90 years old.

5. The entity now known as SHIP was issued a Certificate of Authority to conduct the business of insurance in Maryland on December 18, 1986. As of July 31, 2021, SHIP administers 901 policies that were originally issued in Maryland.

6. SHIP has been insolvent since at least December 31, 2018, having reported a deficit of approximately a half-billion dollars as of that date. Consequently, on January 23, 2020, PID

[4] *See*, https://www.shipltc.com/history.

filed an Application for an Order placing SHIP into rehabilitation with the Commonwealth Court of Pennsylvania (the "Rehabilitation Proceedings").[5] SHIP consented to the Application.

7. On January 29, 2020, the Commonwealth Court of Pennsylvania (the "PA CC") granted the application and entered an Order of Rehabilitation. The Order of Rehabilitation appointed the Pennsylvania Commissioner of Insurance as the Rehabilitator. Patrick H. Cantilo was appointed by the Rehabilitator as Special Deputy Rehabilitator of SHIP.

8. The Rehabilitator filed her Application for Approval of a Plan of Rehabilitation on June 12, 2020. An Amended Plan of Rehabilitation was filed on October 21, 2020, then superseded by a Second Amended Rehabilitation Plan (the "Plan") filed on May 3, 2021. The Order of the PA CC was issued on August 24, 2021 and amended on November 4, 2021.

9. Three states, Massachusetts, Maine and Washington (the "Intervenor States"), intervened in the Rehabilitation Proceedings. Maryland is not a party to the Rehabilitation Proceedings. Maryland did, however, submit formal comments and amended formal comments in the Rehabilitation Proceedings raising objections to the Plan.

10. SHIP's financial condition has continued to deteriorate and its current deficit is approximately $1.2 billion. The Special Deputy Rehabilitator has confirmed that SHIP cannot be restored to solvency and that the Plan cannot eliminate the deficit. Nonetheless, the Rehabilitator has declined to seek a declaration of insolvency or to seek to convert the rehabilitation to liquidation, actions which would trigger guaranty association coverage.

11. On September 21, 2021, the Intervenor States filed an appeal from the Order approving the Plan. That appeal is currently pending before the Pennsylvania Supreme Court.

[5] The Application and all filings referenced herein can be accessed at: http://www.shipltc.com/court-documents.

Approximately twenty other state insurance regulators, including the Maryland Commissioner, have expressed their support for the stay as *amici curiae*. The stay was denied on January 31, 2022.

12. 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, entities that would be subject to assessment under a liquidation order triggering guaranty association protection, appeared as intervenors in the Rehabilitation Proceedings to fully support the Plan.

13. Under the Plan, Respondents intend to establish and implement rates increases for in force long term care policies and to offer, in lieu of or in conjunction with those rate changes, benefit reductions. The Plan authorizes the Rehabilitator to do this unilaterally and without the need to file with, and obtain the approval of, the insurance regulators of the states in which the policies subject to those changes were issued.

14. The Plan contains a so-called "opt-out" process for states that object to the Rehabilitator's attempt to ignore the laws of the various states in which the policies were sold and pursuant to which SHIP was authorized to do business. Under these "opt-out" provisions, the Rehabilitator must file her proposed rate changes in any state that has opted out of the rate and benefit changes identified in the Plan. If a state does not approve the Rehabilitator's rates as filed, the Plan authorizes the Rehabilitator to unilaterally implement further downgrades to individual benefits and to allow policyholders to avoid the downgrade by voluntarily paying the disapproved rate, all without authorization from the issue state.

15. Under the Plan, Respondents gave states until November 15, 2021, to provide written notice, under oath, of their decision to "opt-out." The MIA submitted the required "opt-out" notice on November 15, 2021 ("Notice of Opt-Out letter"). The Notice of Opt-Out letter

stated that it was being submitted "in protest," that it was submitted "in order to prevent the Rehabilitator staff from taking the position that Maryland has failed to preserve the options purportedly provided to state regulators under the Plan," and that "[t]he State of Maryland and the MIA reserve all objections to the Plan, to jurisdiction and to all of its rights, remedies, and options." *Id.* The letter also stated that, "SHIP must file its rates and forms, as well as any proposed adjustment in benefits to address approved rates, with the MIA for prior review and potential approval." *Id.*

16. On December 2, 2021, Respondents submitted the Rate Filing.

Details of the Rate Filing

17. The Rate Filing includes an Actuarial Memorandum, prepared by Oliver Wyman Actuarial Consulting, Inc. ("Oliver Wyman"), which states:

> **As an opt-out State, you will have until February 15, 2022 to provide a disposition as to the premium rate modifications requested herein, otherwise this filing will be deemed denied in its entirety. A filing deemed denied in its entirety will result in policyholder options being calculated and implemented as if the state had approved a 0% premium rate increase for all policies.**
>
> If your state submits an opt-out election that is acknowledged by the Rehabilitator, but subsequently approves the requested rate increase in full, your state will be treated as if it had not opted out of the Plan (i.e., it will be deemed an Opt-In State). Policyholders issued in your state will be included in the Plan in the same manner as policies issued in states that did not opt out ("Opt-In States").
>
> If your state approves the requested rate increase in part, policy benefits may be reduced to amounts that can be supported by the approved rates on an IF Knew Premium rating basis depending on the Plan options elected by affected policyholders

Actuarial Memorandum at 1 (emphasis in original).

18. The Actuarial Memorandum also contains an actuarial certification which states in part:

> The rate filing is being requested in accordance with and subject to the terms of the Plan. Compliance with the applicable requirements of the 2017 NAIC model Regulation and **applicable laws and regulations in your state were not considered in preparing this rate submission.**

Actuarial Memorandum at 11 (emphasis added).

19. Currently, there are 901 long-term care policies administered by SHIP in force in Maryland. According to the Actuarial Memorandum, 393 of these policies are impacted by the Rate Filing. The requested premium increases range from 0.08% to 1,361.09%. The average rate increase requested is 136.0%.

20. The current annualized premium of policies impacted by the rate increase request is $1,187,727. If granted as filed, the Rate Filing will increase the annualized premium of policies impacted to $2,802,962.

21. According to the Actuarial Memorandum, the proposed rate increase applies to 13 policy forms. Respondents did not indicate the policy forms applicable to the 508 policyholders who are allegedly not impacted by the proposed rate increase in the Actuarial Memorandum, but admitted at the rate hearing that at least some of the policyholders not subject to the rate increase had one of the policy forms listed below.

22. The chart below lists all Maryland policy forms, the number of Maryland policyholders for each form and the impact of the proposed rate increase that is applicable. Policy forms in bold are listed in the Actuarial Memorandum.

	Increase	No Increase	Paid-Up NFO	Total
Policy Form	Policy count	Policy count	Policy Count	Policy Count
10618	-	1	-	1
10902	3	0	-	3
10922	4	3	-	7
10955	104	16	18	138

10956	6	0	-	6
11001	60	6	19	85
500003	7	1	2	10
FQ-LTC	23	10	8	41
HHC-1	29	31	17	77
HHC-2	-	10	6	16
HHC-3	2	5	4	11
HHC-4	11	23	11	45
LTC-1	32	36	67	135
LTC-3	5	6	1	12
LTC-6	107	143	54	304
LTC-89	-	3	1	4
WD	-	4	2	6
Total	**393**	**298**	**210**	**901**

See Seriatim File with Covered Lives and Premium Information_20210731.xlxs.

23. Respondents assert that there are 508 Maryland policyholders who will not be subject to the proposed rate increases. It is clear, however, that some of these policyholders will still be substantially impacted by the Plan. Of the 508 policyholders, 210 currently have paid-up nonforfeiture policies. Another 196 are policyholders for whom Respondents are not seeking a rate increase, because the current premium is either equal to or greater than the premium sought under the proposal. However, 102 are currently subject to a premium waiver and are not paying premium, but have current premium less than the calculated "If-Knew" premium. With respect to that group, the Rehabilitator intends to reduce the benefits available to these individuals to meet the benefit amounts allegedly supported by the premium calculated under the "If-Knew" methodology (described below). Actuarial Memorandum at 9.

24. All of the policies in question are "guaranteed renewable," which means "the policyholder has the right to continue long-term care insurance in force during the lifetime of the covered person by the timely payment of premium; and [the] insurer may not decline to renew the policy or unilaterally make any change in any provision of the policy while the policy is in force, except that the insurer may revise the premium rates on a class basis." *See* COMAR 31.14.01.01.02B(16); 31.14.01.04.A(9).

25. The requested rate increase "varies on a seriatim basis." Actuarial Memorandum at 3. This means that the premium rate is calculated *at the policy level*. The Actuarial Memorandum explains that "the requested rate increase is dependent on each individual policyholder's characteristics (e.g., gender, issue age) and product feature (e.g., benefit period, inflation protection), without regard to policyholder's current attained age, state of issue, state of residence, health conditions or premium-paying status." Actuarial Memorandum at 5-6. As discussed below, this includes consideration of rating factors that were not utilized at the time the policies were issued.

26. In addition, the rate increases have been calculated using what is known as the "If-Knew" rating methodology. "If-Knew increases have been described as "increase[s] to the premium rates such that the resulting rates, if in effect from inception of the form, would produce the greater of the initial target lifetime loss ratio or minimum loss ratio applicable to the form."[6] A key element of "If Knew" rating is that the policies are re-priced so that premiums would have been adequate on a lifetime basis if charged since inception using *current* best-estimate actuarial assumptions. As the Deputy Receiver stated at the rate hearing, this means that the current rates

[6] *See, Long-Term Care Insurance Approached to Reviewing Premium Rate Increases, NAIC LTC Pricing Subgroup – October 2018, at p. 10, available at:* https://www.naic.org/documents/committees_b_ltca_wg_approaches_ltc_rate_increases_final.docx

have been determined by considering all of the actual experience and history for long term care claims experience and then calculating the rates that would have been necessary to achieve a 60% loss ratio had they been charged from inception. The actuarial memorandum did not make an attempt to demonstrate that 60% was "the greater of the initial target lifetime loss ratio or minimum loss ratio applicable to the form," but instead "[f]or the sake of simplicity, under the plan this will be assumed to be 60%."

27. The Actuarial Memorandum states that "[s]ome original policy forms for the policies affected by the proposed rate increase contains language that requires that any requested premium rate change apply to all policies in a given state under the respective policy form." The Memorandum goes on to state that "[t]his requirement is eliminated by the Plan and that "this filing may request different rate increase for policies issued on the same form."

28. A review of several of the policy forms submitted to and approved by the MIA has language similar to what is referenced in the Actuarial Memorandum. For example, Policy Form 10922 states:

> The Company reserves the right, subject to 31 days prior written notice to the Insured, to change the renewal premium rates for the Policy. Any change shall apply to all policies of this form in force in the state of residence of the Insured. The rate change shall be in accordance with the underwriting class of the insured on the Policy Date.

The term "Policy Date" is defined in the policy as "[t]he Policy Date shown on the Schedule. The Policy becomes effective on the Policy Date and shall remain in force for the period for which such premium is paid."

Similarly, Policy Form 10955 states:

> The Company reserves the right to change the renewal premium rates for this Policy. Any change shall apply to all policies of this form in force in the state of residence of the insured. The rate change shall be in accordance with the Underwriting class of the Insured on the Policy Date.

In Policy Form 10955, the term "Policy Date" is defined as [t]he Policy Date shown on the Schedule: provided satisfactory evidence of insurability is accepted by and the required initial premium is paid to the Company. The Policy becomes effective on the Policy Date."

29. The Rate Filing proposes to use gender as a rating factor even though none of the policies subject to a proposed rate increase was underwritten based on gender and gender has never been used as a rating factor in connection with any prior rate increase filed with Maryland for these policies. The Rate Filing also proposes to alter how issue age is used for the applicable policy forms. Under the proposal, the premium rate will now vary within a particular issue age by the issue age month of the policyholder.

30. Section 14 of the Actuarial Memorandum states that if the amount of the increase that is approved is less than the full requested premium rate increase:

> [P]olicyholders will have four options provided to them, as described in the Plan. Depending on the option elected by an affected policyholder, benefits under their policy may be reduced to the amount that can be funded by the effective premium rate on an If Knew Premium rating basis.
> The four options include:
> - Option A: Pay the approved premium rate increase and have policy benefits reduced to the benefit level supported on an If Knew Premium rating basis by the increased rate.
> - Option B: Do not pay the approved premium rate increase, continue paying the current rate, and have policy benefits reduced to the benefit level supported on an If Knew Premium rating basis by the current premium rate.
> - Option C: Elect a reduced paid-up non-forfeiture option.
> - Option D: Voluntarily pay the full If Knew Premium Rate (even if not approved by the state) and maintain the current policy benefits.

31. The Respondents have not filed policy forms with the MIA with regard to the benefit reduction options listed in Section 14 of the Actuarial Memorandum.

Applicable Maryland Law

32. In Maryland, the General Assembly has given the Maryland Insurance Commissioner the exclusive review and determination of rates for those insurers licensed and

doing business in the State. This is a quasi-legislative function. *See e,g. State Ins. Comm'r v. National Bur. of Cas. Underwriters*, 248 Md. 292 (1967). The Insurance Commissioner has "exclusive jurisdiction to enforce by administrative actions the laws of the State that relate to …rate setting practices of an insurer." Md. Code Ann., Ins. Art. § 2-202(a)(1).

33. Long-term care insurance rates specifically must be submitted for review by the Commissioner, which includes an actuarial analysis, and increases may not be implemented unless the Commissioner determines they comply with the applicable standards. Md. Code Ann., Ins. Art. § 11-703(c)(2), § 18-116(b)(relating to across the board increase on policies or contracts of long-term care insurance that the carrier issues or delivers in the state; Code of Maryland Regulations (COMAR) 31.14.01.14(c)(5) (With one exception, an insurer may not charge a renewal premium rate for a long-term care policy which exceeds by more than 15% any premium charged for a policy during the preceding 12 months). Additionally, long-term care insurance forms must comply with § 18-116.1 of the Insurance Article and COMAR 31.14.01.36 and must be submitted to the MIA for approval before they are used. When rates are approved, they are approved with respect to the benefits that are included in the product to which the rates apply. Any changes to the benefits in order to avoid rate increases in whole or in part must be approved by the MIA in advance.

34. The Commissioner is required to disapprove or modify a premium rate filing if the proposed rates appear, based on actuarial analysis and reasonable assumptions, to be inadequate, unfairly discriminatory or excessive in relation to benefits. Md. Code Ann., Ins. Art. § 11-703(c)(2)(i). In considering whether to disapprove or modify a premium rate filing of a carrier, the Commissioner shall consider. To the extent appropriate:

1. past and prospective loss experience in and outside the State;
2. underwriting practice and judgment;
3. a reasonable margin for reserve needs;

4. past and prospective expenses, both countryside and those specifically applicable to the State; and
5. any other relevant factors in and outside of the State.

DISCUSSION

Having heard all of the testimony at the quasi-legislative hearing, reviewed the premium rate filing and all of the supporting information provided on behalf of SHIP, including responses to objections submitted to SHIP by the Office of the Chief Actuary and any documents submitted by consumers or other interested parties, I find that I am not able to approve Respondents request for a rate increase at this time and based on the filing submitted. The proposed increase as filed violates both Maryland and federal law. My reasons follow.

1. The Proposed Rate Increase as Filed Violates Maryland Law and the Policy Forms.

The proposed rate increase as filed by Respondents violates both Maryland law and the contract terms of the policies in question. As guaranteed renewable long-term care policies, the premium may only be increased on a class basis and in accordance with the "underwriting class" of the insureds. *See* COMAR 31.14.01.02.B(16) and Policy Forms 10922 and 10955. Respondents readily admitted at the hearing and in the Actuarial Memorandum that the premium increase is calculated not on a class basis but at the policy level using the If Knew rating methodology, which is dependent on each policyholder's characteristics. Actuarial Memorandum at 5. Further, not all policies in a class or with regard to a particular form are subject to the rate increase. *See* Actuarial Memorandum at 3-4. Thus, the proposed rate increase methodology in inherently at odds with Maryland's requirement that the rating be on a class basis.

Respondents also seek to add gender as a new rating characteristic. *See* Actuarial Memorandum at 5. While it is not normally prohibited to use gender as a rating characteristic for a new long-term care insurance policy, unlike for certain health benefit plans subject to the

Affordable Care Act (*see* §15-1A-07 (b)), in this case, Respondents seek to introduce gender as a rating factor for the first time with regard to the policy forms in question, many of which have been in place for 30 years. Many of the increases that are proposed are significantly higher for certain policyholders, because Respondents have applied gender as a rating characteristic. Of the 100 policyholders with the highest percentage rate increase in the proposal, 93 are women. In contrast, of the 40 policyholders was the lowest premiums increases in the proposal, 23 are men. Given that the policy forms provide that any rate change will "be in accordance with the underwriting class of the insured on the Policy Date (*see* Policy Form 10955), and that gender was not used as a rating characteristic previously, its use here is inconsistent with COMAR 31.14.01.02.B(16).

Similarly, the proposed rate increase seeks to alter the way issue age is used as a rating factor by having rates vary by issue down to the month. An example of this is shown when reviewing policy number 1348023 and 1455980. Although both policyholders were born in 1933, because one was issued the policy at 59 years and 5 months and the other was issued the policy at 59 years and 11 months, there is a 2% difference in the proposed premium for these policyholders. As with the use of gender, the application of the additional rating characteristics based on the month of the person at issue age, rather than the age at the time measured in years, creates new subclasses within each issue age year. Again, this violates COMAR 31.14.01.02.B(16). While the increase is not a large amount (at least in the case cited), it is not permitted. *See* Actuarial Memorandum at 5.

The applicable regulations also generally prohibit a renewal premium rate for a long-term care policy which exceeds by more than 15% any premium charged for the policy during the preceding 12 months. *See* COMAR 31.14.01.04.A(5). However, the Commissioner may approve "a larger increase upon a showing that a larger increase is necessary because of utilization of policy

benefits greatly in excess of the expected rate." COMAR 31.14.01.04.A(6). In this case, the Office of the Chief Actuary of the MIA asked Respondents to provide the showing necessary for the larger than 15% increase. The actuary for Respondents stated it did not have the data to provide the information. Therefore, Respondents have not met their burden for a larger than 15% increase though, if Respondents submit a new rate increase filing consistent with this Order, they will be permitted to supply the necessary information required by the regulation. [7]

2. The Proposed Actions of Respondents in Response to Not Approving the Full Rate Increase Are Illegal Under Maryland Law.

In addition to the proposed rate increase sought by Respondents, the Actuarial Memorandum, and the Plan itself, both state that if the proposed rate increase is not approved in full, policyholders in Maryland will be punished in the form of a unilateral downgrade to and loss of contracted-for benefits without first seeking approval from the MIA. *See* Actuarial Memorandum at 8-9; Plan at 108-118. The Pennsylvania Commonwealth Court Order approving the Plan describes the opt-out process succinctly:

> Alternatively, under an Issued-State Rate Approval Option, a state may opt out of the rate approval section of the Plan. If a state opts out, the Rehabilitator will file an application to increase rates for policies issued in the 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; <u>if it is only partially approved, the Rehabilitator will downgrade the benefits under the affected policies accordingly</u>.

Plan Approval Order at 58 (emphasis added).

[7] With regard to most proposed rate increases, the MIA will engage in discussions with the insurer to see if agreement can be reached regarding the proposed increase. In this case, Respondents have imposed an arbitrary deadline of February 15, 2022, after which it states the filing will be considered denied. While the MIA does not believe it is bound by the February 15 deadline, because it is anticipated that Respondents will attempt to contact policyholders with the alternative options discussed herein shortly after the deadline, the MIA has decided to act based on the information provided at this time and on the filing presented. Should Respondents submit a new filing consistent with the findings in this order, the MIA will consider the appropriateness of a rate increase based on the new filing.

This threatened action violates Maryland law because Respondents, will not first submit to the Commissioner and the MIA the policy downgrades and changes to existing policy forms sought to be imposed on Maryland policyholders. *See* Md. Code Ann. Ins. Art. §§ 2-202(a); 11-703(c)(2); 12-203. Further, Respondents refuse to be bound by any decision made by the Commissioner relating to the appropriate rates applicable to the policy forms in question, subject to their right to appeal to Maryland courts. Indeed, the Rehabilitator plans to offer and charge the rates proposed, even if disapproved, as an alternative to benefit reduction, even though such rates are illegal and cannot be lawfully charged under Maryland law. §11-703(b).

The applicable regulations allow an insurer to offer to policyholders to reduce coverage and lower the policy premium, but this is at the election of the policyholder and still requires approval of the rates. *See* COMAR 31.14.01.36.D (Premium for reduced coverage must be based on the underwriting class used to determine the premium for the coverage currently in force and be consistent with the approved rate table).

The threatened unilateral reduction in benefits also appears to have a potential permanent adverse effect on policyholders' guaranty association benefits in the likely event that SHIP is place into liquidation at a later date. Special Deputy Rehabilitator Cantilo has admitted in previous testimony that "it is not likely that we will magically restore SHIP to solvency, but it is likely that the plan …would substantially reduce the deficit." Transcript of Rehabilitation Plan hearing at 80. In short, the threatened action would impose substantially less benefits than what policyholders are entitled to under their contract.

3. The Authority of Respondents Under Pennsylvania Law.

The Actuarial Memorandum appears to argue that the Plan eliminates the requirement to comply with the Maryland laws and regulations listed above. *See* Actuarial Memorandum at 3

("this requirement is eliminated by the Plan…"). But, it is important to understand what Respondents authority is under Pennsylvania law.

Each jurisdiction has enacted statutes for the rehabilitation and liquidation of insurance companies. *See e.g.* § 9-201 *et. seq.* Under Pennsylvania law, as in all states, the power of the rehabilitator is prescribed and limited by law. The authority of the rehabilitator is circumscribed and limited to control of the assets and business of the insurer and does not extend to regulatory control of the insurer's business. 40 P.S. § 221.16(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 director, officers, and managers, whose authority shall be suspended, except as they are delegated by the rehabilitator.") The statute does not provide authority beyond that of the insurer and its officers and managers.

Under Pennsylvania law, an insurance commissioner acting as a rehabilitator "can only exercise those powers which have been conferred upon it by the Legislature in clear and unmistakable language." *Aetna Cas. And Sur. Co. v. Com., Ins. Dept.,* 638 A.2d 194 (Pa. 1994) quoting *Commonwealth, Human Relations Comm'n v. Transit Casualty Ins. Co*., 831 A.2d 1196 (Pa. Commw. 2003), *aff'd sub nom. Koken v. Villanova Ins. Co*., 878 A.2d 51 (Pa. 2005).

Pennsylvania law authorizes Respondents to manage SHIP. It does not provide, explicitly or implicitly, authority to supplant otherwise applicable regulatory authority over the business of the insurer in rehabilitation, particularly the regulatory authority of other jurisdictions. That 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), does not authorize Respondents to proceed without required regulatory approvals. Nowhere in the text of Pennsylvania's law, or in any model law or NAIC publication) is there "clear and unmistakable language" that allows a

rehabilitator to displace or disregard the regulatory authority of an insurance regulator in another jurisdiction. Indeed, the NAIC states that a receiver in a rehabilitation proceeding should consider "rate increases needed on business and insurer's ability to secure those increases from regulatory authorities." National Association of Insurance Commissioners, *Receiver's Handbook for Insurance Company Insolvencies* at 12 (2021).[8]

4. State and Federal Law Make Clear that the Authority to Approve Rates and Policy Forms in Maryland Rests with the Maryland Insurance Commissioner.

In contrast to the lack of authority granted to Respondents under Pennsylvania law to unilaterally impose rate increases and/or benefit reductions, both federal and State law make clear that insurers licensed in Maryland must obey the laws of this State and that contracts issued in this State are subject to Maryland law.

The primary state regulatory functions remain as they have since the enactment of the McCarran-Fergusson Act in which "Congress …declare[d] that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States." 15 U.S.C. § 1011. "This allows…states to perform solvency oversight of the U.S. insurance industry and to regulate insurer behavior in the marketplace." State Insurance Regulation, National Association of Insurance Commissioner (NAIC), Center for Insurance Policy and Research (CIPR) (2011).[9]

"State legislatures are public policymakers that establish…broad policy for the regulation of insurance by enacting legislation providing the regulatory framework under which insurance

[8] Available at: https://content.naic.org/sites/default/files/publication-rec-bu-receivers-handbook-insolvencies.pdf.

[9] Available at: https://www.naic.org/documents/topics_whiate_paper_hist_ins_reg.pdf.

regulators operate. They establish laws which grant authority to regulators and oversee state insurance departments an approve regulatory budgets." *Id*. "State insurance regulatory systems are accessible and accountable to the public and sensitive to local social and economic conditions." *Id.* Further:

> State regulators protect consumers by ensuring that insurance policy provisions comply with state law, are reasonable and fair, and do not contain major gaps in coverage that might be misunderstood by consumers and leave them unprotected. The nature of regulatory reviews of rates, rating rules and policy forms varies somewhat among the states depending on their laws and regulations.

Id.

As seen above, the Maryland General Assembly has delegated its regulatory authority under the McCarron-Ferguson Act, 15 U.S.C. §§ 1011-1015, to the Maryland Insurance Commissioner and the MIA and has enacted and approved detailed and extensive statutes and regulations governing long-term care insurance policies and rates, including provisions for the approval of rates by the Commissioner. *See State Ins. Comm'r v. National Bur. Of Cas. Underwriters*, 248 Md. 292 (1967); 1 Couch on Ins. § 2:34, Rates –Judicial review ("Ratemaking is generally not a judicial function. Indeed, many jurisdictions have adopted the filed rate doctrine which expressly prohibits courts from imposing rates different than those approved by the state insurance department"). To the extent Respondents are relying on the Pennsylvania court's order approving the Plan and the rate setting scheme within, this would appear to violate the filed rate doctrine.

Further, the Full Faith and Credit Clause of the U.S. Constitution does not require Maryland to obey the Plan approved by the Commonwealth court in Pennsylvania in contravention of its own laws. Indeed, the Pennsylvania court seems to recognize this as its order states "[o]nce this Court renders a judgment on the Second Amended Plan, it is Maine, Massachusetts, and

Washington [the three intervening states] that owe this Court's judgment full faith and credit." Order of Approval at 61.

Additionally, full faith and credit requires only that every state give a foreign judgment the *res judicata* effect that the judgment would be accorded in the state which rendered it. *Durfee v. Duke*, 375 U.S. 106, 109 (1963). Under Pennsylvania law, application of *res judicata* requires that the two relevant proceedings possess several common elements, including identity of the parties. *Robinson Coal Co. v. Goodall*, 72 A.3d 685, 689 (Pa. Super. 2013). Neither the Commissioner nor the MIA were a party in the Pennsylvania proceedings. Rather, Respondents appear to have purposefully decided to supplant the laws of Maryland and other states. As the Supreme Court has said in *Pacific Employers Ins. Co. v. Industrial Accident Comm'n*, 306 U.S. 493, 501 (1939):

> The very nature of the federal union of states, to which are reserved some of the attributes of sovereignty, precludes resort to the full faith and credit clause as means for compelling a state to substitute the statutes of other states for its own statutes dealing with a subject matter concerning which it is competent to legislate.

Here, the Plan specifically is meant to compel states to substitute their laws for that of the order of the Commonwealth court. We decline to do so here.

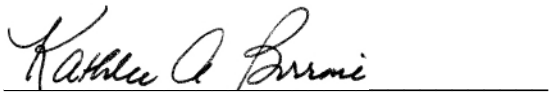
ORDER

Based on the entire record in this matter, including the facts and legal issues discussed in this Order, it is hereby ORDERED this 15th day of February, 2022 that:

A. Respondents request for rate increases on the SHIP policies at issue in this matter is denied. Respondents may file for rate increases consistent with this decision including basing the premium request on a class basis and based on the rating characteristics previously used by SHIP;

B. Respondents are prohibited from communicating, implementing or enforcing the Amended Plan of Rehabilitation in Maryland or otherwise interfering with the rights of

SHIP long-term care insurance policyholders or otherwise violating the insurance laws of this State pertaining to long-term care insurance, including, but not limited to, notifying policyholders of proposed rate or benefit changes or requesting that policyholders select rate or benefits different from those authorized by the Maryland Insurance Administration ("MIA"). Respondents are encouraged to submit to the MIA any benefit option, along with the corresponding rate for each applicable option to the MIA for approval in conformance with Maryland law and regulations.



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Appeal Rights

Pursuant to Title 11, subtitle 5 of the Insurance Article, Annotated Code of Maryland, an order issued after a hearing is subject to judicial review by appeal to the Circuit Court for Baltimore City. Any appeal must be filed within 30 days of the date of this order. An appeal may be commenced by filing a notice of appeal with the Circuit Court for Baltimore City and a copy of the notice of appeal with the Commissioner.

STATE OF OHIO
DEPARTMENT OF INSURANCE
50 WEST TOWN STREET
3rd FLOOR, SUITE 300
COLUMBUS, OHIO 43215

In re:	:	JUDITH L. FRENCH
	:	Superintendent/Director
Senior Health Insurance Company	:	
of Pennsylvania (SHIP)	:	
(in rehabilitation)	:	
	:	

ORDER TO CEASE AND DESIST AND NOTICE OF HEARING

I. INTRODUCTION

Pursuant to R.C. 3901.221, the Superintendent of the Ohio Department of Insurance ("ODI") may issue a cease and desist order to any person engaged in an unfair or deceptive act or practice in the business of insurance that has caused, is causing, or is about to cause substantial and material harm.

The Rehabilitator of Senior Health Insurance Company of Pennsylvania ("SHIP"), SHIP, and SHIP's principals, employees, and agents are a person engaged in an unfair or deceptive act or practice in the business of insurance that is about to cause substantial and material harm. Therefore, consistent with the authority in R.C. 3901.221, and for the reasons explained below, the Superintendent determines a cease and desist order is appropriate.

II. FACTS

On September 9, 1987, ODI issued a certificate of authority for SHIP to conduct the business of insurance in Ohio. SHIP is a stock limited life and health insurance company domiciled in the Commonwealth of Pennsylvania that administers a closed block of long-term care

("LTC") insurance policies. SHIP has issued approximately 1,130 policies in Ohio. At present, the average age of SHIP LTC policyholders in Ohio is approximately 86 years old.

The Pennsylvania Insurance Department ("PID") filed an application to place SHIP into rehabilitation with the Commonwealth Court of Pennsylvania on January 23, 2020. According to the application, as of December 31, 2018, SHIP's reported deficit was approximately a half-billion dollars. SHIP's financial condition has only declined, as a more recent projection estimates a deficit of approximately $1.2 billion. On January 29, 2020, the Commonwealth Court entered an order granting the application of the PID to place SHIP into rehabilitation. The order appointed the Commissioner of the PID, Jessica Altman, and her successors in office as statutory rehabilitator of SHIP pursuant to the provisions of 40 Pa. Stat. 221.14, et seq.

On August 25, 2021, the Commonwealth Court issued its opinion and order approving a rehabilitation plan. The approved rehabilitation plan, as well as all court filings and orders discussed here, are available on the SHIP rehabilitation website, at https://www.shipltc.com/court-documents.

The approved rehabilitation plan provides for a so-called "opt-out" process that violates Ohio law.[1] Approved Rehabilitation Plan ("App. Rehab. P."), p. 108-118. Pursuant to the opt-out process in the approved rehabilitation plan, when a state opts out of the premium rate modification provisions of the plan, the Rehabilitator files a request for approval of rate increases for policies issued in that state. *Id.* at p. 111. If the opt-out state does not approve the rate increases requested

[1] ODI has joined with 26 other departments of insurance as amici curiae in support of the appeal filed in the Supreme Court of Pennsylvania 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. The appeal challenges the legality of the approved rehabilitation plan. The documents related to the appeal in the Supreme Court of Pennsylvania, Docket No. 71 MAP 2021, are available on the SHIP rehabilitation website, at https://www.shipltc.com/court-documents.

by the Rehabilitator in full, the unlawful plan allows for election packages to be sent to Ohio policyholders offering benefits and rates not approved by ODI.

ODI opted out of the premium rate modification provisions of the approved rehabilitation plan. On December 2, 2021, the Rehabilitator filed a request with ODI for approval of rate increases for Ohio policyholders and set a February 15, 2022 deadline for ODI to respond. On February 15, 2022, ODI concluded its review and informed the Rehabilitator of its decision on the requested rate increases.

ODI's review found that some of the Rehabilitator's requested rate increases would result in unreasonable increases. Indeed, some of the Rehabilitator's requested rate increases were well outside the rate increases ODI had traditionally approved. For example, the Rehabilitator's requested rate increases would result in at least one Ohio policyholder receiving a more than 650% rate increase. In these instances, ODI approved a premium rate less than that requested by the Rehabilitator. In other instances, ODI found that the Rehabilitator's requested premium rate increases were reasonable and fully approved them. Nevertheless, the approved rehabilitation plan treats any state not *fully* approving the Rehabilitator's requested rate increases as an opt-out state. *Id.* at p. 108-111.

Consequently, Ohio is an opt-out state. Pursuant to the approved rehabilitation plan, the Rehabilitator will send election packages to Ohio policyholders requiring them to choose between several options. The election packages will offer Ohio policyholders premium rates and benefits not approved by ODI. As discussed in section III, below, offering Ohio policyholders unapproved premium rates and benefits is unlawful.

The approved rehabilitation plan requires the Rehabilitator to send election packages after the passage of the February 15, 2022 deadline. The expectation is that the Rehabilitator will send election packages to Ohio policyholders in the near future.

III. ANALYSIS

Pursuant to R.C. 3901.221 and R.C. 3901.20, the Superintendent of the ODI may issue a cease and desist order to any person engaged in an unfair or deceptive act or practice in the business of insurance that has caused, is causing, or is about to cause substantial and material harm. R.C. 3901.19 defines "person," for purposes of R.C. 3901.221 and R.C. 3901.20, as "any individual, corporation, association, partnership * * * and any other legal entity." The "person" need not be licensed or required to be licensed by the Superintendent of the ODI. R.C. 3901.20.

R.C. 3901.19 through R.C. 3901.23 define an unfair or deceptive act or practice in the business of insurance. Among other provisions, R.C. 3901.21(A) defines an unfair or deceptive act or practice in the business of insurance to include: "Making, issuing, circulating, or causing or permitting to be made, issued, or circulated, or preparing with intent to so use, any estimate, illustration, circular, or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby * * *." R.C. 3901.21(B) further defines an unfair or deceptive act or practice in the business of insurance to include:

> Making, publishing, disseminating, circulating, or placing before the public or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station, or in any other way, or preparing with intent to so use, an advertisement, announcement, or statement containing any assertion, representation, or statement,

with respect to the business of insurance or with respect to any person in the conduct of the person's insurance business, which is untrue, deceptive, or misleading.

Because the Rehabilitator, SHIP, and SHIP's principals, employees, and agents are a person engaged in an unfair or deceptive act or practice in the business of insurance that has caused, is causing, or is about to cause substantial and material harm, the Superintendent of the ODI issues this cease and desist order pursuant to R.C. 3901.221 and R.C. 3901.20.

A. The Rehabilitator, SHIP, and SHIP's principals, employees, and agents are all a "person."

The Rehabilitator, SHIP, and SHIP's principals, employees, and agents are all a "person." R.C. 3901.19 defines "person" to include "any individual, corporation, association, partnership * * * and any other legal entity." Altman, or any successors, as the Rehabilitator, is an "individual." Further, the Rehabilitator is also a "legal entity." *See* 40 Pa. Stat. 221.15, 221.16.

SHIP, as a stock limited life and health insurance company administering a closed block of LTC insurance policies, meets the broad definition of "person." SHIP's certificate of authority from the Superintendent of the ODI further demonstrates it is a "person," as defined in R.C. 3901.19.

SHIP's principals, employees, and agents also meet the broad definition of "person" in R.C. 3901.19. The broad definition of "person" in R.C. 3901.19 includes "any individual."

B. The Rehabilitator, SHIP, and SHIP's principals, employees, and agents are engaged in unfair or deceptive acts or practices in the business of insurance.

The Rehabilitator, SHIP, and SHIP's principals, employees, and agents are engaged in unfair or deceptive acts or practices in the business of insurance. R.C. 3901.19 through R.C.

3901.23 define an unfair or deceptive act or practice. The Rehabilitator, SHIP, as well as SHIP's principals, employees, and agents are engaged in at least two unfair or deceptive acts or practices.

First, the Rehabilitator, SHIP, and SHIP's principals, employees, and agents are engaging in an unfair or deceptive act or practice in the business of insurance, as defined in R.C. 3901.21(A), by "preparing with intent to so use, any * * * statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby * * *."

The approved rehabilitation plan treats any state not fully approving the Rehabilitator's requested rates increases as an opt-out state. App. Rehab. P., p. 108-111. Accordingly, Ohio is an opt-out state. The approved rehabilitation plan permits the Rehabilitator to send election packages to Ohio policyholders. *Id.* at p. 111-114. The expectation is that the Rehabilitator will send election packages to Ohio policyholders in the near future. As a result, the Rehabilitator is "preparing with intent to so use" the election packages for Ohio policyholders.

The election packages contain "statement[s] misrepresenting the terms of any policy * * * to be issued or the benefits or advantages promised thereby * * *." Specifically, by offering Ohio policyholders premium rates and benefits not approved by ODI, the Rehabilitator, through the election packages, distorts the terms of the policies to be issued and the benefits promised.

For example, the Rehabilitator, through the election packages, will offer some Ohio policyholders an option—option four—that ODI has not approved. *See* App. Rehab. P., p. 108-111. Option four of the approved rehabilitation plan states that policyholders may choose this option "even though such a rate increase has not been approved by the [o]pt-out [s]tate." *Id.* at p. 114. Under Ohio law, however, ODI has exclusive jurisdiction to approve and disapprove insurance rates. *Lazarus v. Ohio Cas. Group*, 144 Ohio App.3d 716, 720, 761 N.E.2d 649 (8th Dist.2001). Insurers must file premium rates with ODI prior to issuing new or revised LTC

policies. R.C. 3923.46; R.C. 3923.021. ODI may approve or disapprove the rates. R.C. 3923.021. As a result, the Rehabilitator cannot offer option four or any other option not approved by ODI. Any language in the election packages offering any option not approved by ODI "misrepresent[s] the terms of any policy * * * to be issued or the benefits or advantages promised thereby * * *."

Second, the Rehabilitator, SHIP, as well as SHIP's principals, employees, and agents are engaging in an unfair or deceptive act or practice in the business of insurance, as defined in R.C. 3901.21(B), by "[m]aking, * * * or causing, directly or indirectly, to be made, * * * in a * * * notice, * * * letter, * * * or in any other way, or preparing with intent to so use, [a] * * * statement containing any assertion, representation, or statement, with respect to the business of insurance * * *, which is untrue, deceptive, or misleading."

The Rehabilitator is "preparing with intent to so use" the election packages for Ohio policyholders. The Rehabilitator, through the election packages, will be disregarding Ohio law by offering Ohio policyholders premium rates and benefits not approved by ODI. *See* R.C. 3923.46; R.C. 3923.021. As such, the election packages' offering of unlawful premium rates and benefits, not approved by ODI, constitute a "statement containing any assertion, representation, or statement, with respect to the business of insurance * * *, which is untrue, deceptive, or misleading."

C. The unfair or deceptive acts or practices of the Rehabilitator, SHIP, and SHIP's principals, employees, and agents are about to cause substantial and material harm.

As described in section III, B, above, the Rehabilitator, SHIP, and SHIP's principals, employees, and agents are engaged in unfair or deceptive acts or practices in the business of insurance. The unfair or deceptive acts or practices stem from the Rehabilitator's upcoming issuance of election packages to Ohio policyholders. The expectation is that the Rehabilitator will

send election packages to Ohio policyholders in the near future. As a result, these unfair or deceptive acts or practices are "about to cause" substantial and material harm.

Further, the Rehabilitator's election packages, once issued, will cause "substantial and material harm." First and foremost, the election packages will cause "substantial and material harm" to Ohio's policyholders. The Rehabilitator cannot lawfully offer unapproved rates and benefits, and confusion will result should Ohio policyholders choose one of these unlawful options. SHIP policyholders in Ohio, with an average age of about 86 years old, have the right to know that ODI has reviewed and approved the premium rates and benefits prior to the policyholders accepting them. If the Rehabilitator issues the election packages and offers premium rates and benefits not approved by ODI, "substantial and material harm" will occur.

Second, the Rehabilitator's election packages will cause "substantial and material harm" to ODI. ODI has an interest in protecting its exclusive jurisdiction. If the Rehabilitator issues the election packages and offers unapproved premium rates and benefits, "substantial and material harm" will occur.

Therefore, the Rehabilitator, SHIP, as well as SHIP's principals, employees, and agents are a "person," as defined in R.C. 3901.19. The Rehabilitator, SHIP, and SHIP's principals, employees, and agents are engaged in an unfair or deceptive act or practice in the business of insurance that is about to cause substantial and material harm. The Superintendent of the ODI may issue a cease and desist order pursuant to R.C. 3901.221.

IV. CONCLUSION

Pursuant to R.C. 3901.221, the Superintendent of the Ohio Department of Insurance orders the Rehabilitator, SHIP, and SHIP's principals, employees, and agents to cease and desist the dissemination, implementation, or enforcement in this State of the election

packages to the extent the election packages disregard Ohio law by offering Ohio policyholders premium rates and benefits not approved by ODI.

Pursuant to this order, the Rehabilitator, SHIP, and SHIP's principals, employees, and agents shall send notices to policyholders in Ohio only if the Superintendent has reviewed and approved such notices.

A hearing to determine the continuation or revocation of this cease and desist order shall be held at 1:00 p.m. on March 3, 2022 at the Ohio Department of Insurance, 50 W. Town St., Suite 300, Columbus, Ohio, 43215. At the hearing, the parties may appear in person, by their attorney, or by such other representative as is permitted to practice before the Department, or the parties may present their position, arguments, or contentions in writing and, at the hearing, the parties may present evidence and examine witnesses appearing for and against them.

This Order is effective immediately, signed this 17th day of February, 2022.

Judith L. French

JUDITH L. FRENCH
Director/Superintendent

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true copy of the foregoing Order to Cease and Desist and Notice of Hearing has been sent on this 17 day of February, 2022, by priority mail express with certified service, return receipt requested, to the following:

Commissioner Jessica Altman (as Rehabilitator)
Pennsylvania Insurance Department
901 North 7th St.
Harrisburg, PA 17102

Michael Broadbent
Cozen & O'Connor
1650 Market St., Suite 2800
Philadelphia, PA 19103

Patrick Cantilo (as Special Deputy Rehabilitator)
11401 Century Oaks Terrace, Suite 300
Austin, TX 78758

Senior Health Insurance Company of Pennsylvania (in rehabilitation)
550 Congressional Blvd., Suite 200
Carmel, IN 46032

Senior Health Insurance Company of Pennsylvania (in rehabilitation)
c/o CSC-Lawyers Incorporating Service
50 W. Broad St.
Columbus, OH 43215

And sent via email to:

Michael Broadbent, mbroadbent@cozen.com
Patrick Cantilo, phcantilo@cb-firm.com
Tracy Nave, Office of the Ohio Attorney General, Tracy.Nave@OhioAGO.gov
Amanda Baird, Ohio Department of Insurance, Amanda.Baird@insurance.ohio.gov

Kelly Peters
Kelly Peters
Hearing Administrator

STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

In the Matter of **SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA,** Authorized Insurer.	Order No. 22-0104 WAOIC No. 69145 NAIC 76325 ORDER TO CEASE AND DESIST

Pursuant to RCW 48.02.080(3)(a), the Insurance Commissioner of the state of Washington ("Insurance Commissioner") orders the above-named Respondent, and its officers, directors, trustees, employees, agents, and affiliates to immediately cease and desist from:

A. Disseminating, implementing, or enforcing in Washington the "Coverage Election Package" sent to Respondent's Washington policyholders, described further below;

B. Implementing any election or choice made by a Washington policyholder under the terms of the "Coverage Election Package," or attempting to enforce such election or choice against any Washington policyholder;

C. Requesting that Washington policyholders select rates or benefits different from those authorized by the Insurance Commissioner and called for under the terms of the contract;

D. Charging Washington policyholders additional premium, or withholding, delaying or encumbering benefits in whole or in part, without authorization by the Insurance Commissioner; and

E. Making, issuing, or circulating any "Coverage Election Form" or similar correspondence or communication for Washington policies that is false or deceptive; contains misrepresentations; and/or is untrue, deceptive, or misleading.

BASIS:

1. Senior Health Insurance Company of Pennsylvania ("SHIP") is a Pennsylvania-domiciled life and disability insurance company that became authorized to issue long-term care insurance ("LTC") policies in Washington beginning in 1989.

2. In recent years, SHIP experienced financial distress and faced the possibility of insolvency. SHIP has approximately 1,204 policies remaining in force that were issued in Washington and subject to Washington law.

3. On April 1, 2019, the Insurance Commissioner issued Order No. 19-0154, suspending SHIP's authority to sell, solicit, or issue new policies or certificates of coverage for one year, on the basis that SHIP's reported capital and surplus was below the minimum required in RCW 48.05.340. The Order provides that the continuation of existing coverages to existing members is required during the term of this suspension, and that the Order does not relieve SHIP from any pending or accrued reporting, filing, or fee/tax payment required by Title 48 RCW. SHIP did not appeal or contest this Order.

4. On December 21, 2020, the Insurance Commissioner again suspended SHIP's authority to sell, solicit, or issue policies or certificates of coverage to new members for one year pursuant to Order No. 20-0879. The basis was once more that SHIP's reported capital and surplus was below the minimum required in RCW 48.05.340. The Order provides that the continuation of existing coverages to existing members is required during the term of this suspension, and that the Order does not relieve SHIP from any pending or accrued reporting, filing, or fee/tax payment required by Title 48 RCW. SHIP again did not appeal or contest Order No .20-0879.

5. On January 29, 2020, upon the application of Jessica Altman, the Commissioner of Insurance for the Commonwealth of Pennsylvania, the Commonwealth Court of Pennsylvania, in docket number 1 SHP 2020, entered an Order of Rehabilitation placing SHIP into rehabilitation in accordance with the provisions of Pennsylvania law.

6. The Order of Rehabilitation appointed Commissioner Altman and her successors in office as statutory Rehabilitator of SHIP pursuant to the provisions of 40 P.S. § 221.14, et seq. and required the Rehabilitator to prepare a plan of rehabilitation. Commissioner Altman appointed Patrick Cantilo as Special Deputy Rehabilitator, with the power to act on the Rehabilitator's behalf.

7. On April 22, 2020, the Rehabilitator filed her Application for Approval of the Plan of Rehabilitation for SHIP and contemporaneously filed a Rehabilitation Plan.

8. On September 15, 2020, the Insurance Commissioner was granted intervention as a party in the Rehabilitation Proceeding.

9. The Rehabilitation Plan was approved by a Memorandum Opinion and Order of the Pennsylvania Commonwealth Court on August 24, 2021, as amended on November 4, 2021. However, the Commonwealth Court did not issue any order purporting to approve premium rates under the Rehabilitation Plan until February 2, 2022.

10. The Insurance Commissioner and the other intervening jurisdictions appealed the Rehabilitation Plan to the Pennsylvania Supreme Court (Middle District), No. 71 MAP 201. The appeal challenges the Commonwealth Court's asserted authority to approve premium rates and vary contractual benefits for the policies at issue even if contrary to the statutes and regulations of the states where the policyholders are located.

11. By Order issued January 31, 2022, the Pennsylvania Supreme Court denied the insurance regulators' request for stay pending appeal of the Rehabilitation Plan. The appeal otherwise remains pending before the Pennsylvania Supreme Court. Importantly, the Commonwealth Court has never approved nor ruled on the form the of the Coverage Election Package, nor discussed state laws and regulations regarding false or misleading communications to policyholders in the business of insurance.

12. In late-January 2022, without authorization by the Insurance Commissioner, and prior to any purported approval of premium rates by the Commonwealth Court, the SHIP Rehabilitator mailed a "Coverage Election Package" to Washington policyholders which advises them of purportedly forthcoming premium and/or benefit modifications that would begin as early as April 1, 2022. The "Coverage Election Package" requires Washington policyholders to complete and return their election form with a postmark date of no later than March 15, 2022.

13. The "Coverage Election Package" offers five coverage options to Washington policyholders, including downgrading the policy, converting to a basic policy or to an enhanced basic policy, converting to an enhanced paid-up policy, and keeping their current policy. Each of these benefit changes is also accompanied by premium rate changes relative to the benefits offered under the rates and forms currently approved for such Washington policies. If a Washington policyholder does not make a coverage election by the March 15, 2022, specified postmark date, SHIP will on its own exercise the basic policy coverage option, resulting in a significant benefit reduction under a Washington insurance policy.

14. Certain provisions of the Coverage Election Package are misleading to consumers. Specifically, so-called Option 1 – Downgrade Your Policy, and Option 4 – Keep Your Current Coverage, both advertise that their respective Maximum Lifetime Benefit is "Unlimited." However, other materials explain that "[p]remium rate increases and policy benefit modifications may be required for policyholders who elected Option 1 (Downgrade Your Policy) or Option 4 (Keep Your Current Coverage) in Phase One," making the claim of unlimited lifetime benefits misleading at best. The Coverage Election Package also requires consumers to state that they make any election "voluntarily" even though Option 1 is selected for all consumers who do not select their own option from the package, and when there is uncertainty regarding the legality of the Rehabilitation Plan, as discussed further below.

15. The "Coverage Election Package" fails to advise Washington policyholders that the premium rates and policy modifications under the Rehabilitation Plan are on appeal to the Pennsylvania Supreme Court. SHIP thus is requiring Washington policyholders to make final and binding coverage elections without any explanation to Washington policyholders about how their rates and benefits would be reconfigured if the Rehabilitation Plan is overturned or otherwise modified by the court in a manner that affects rates and benefits.

16. In addition to the pending appeal of the order approving the Rehabilitation Plan before the Pennsylvania Supreme Court, injunctions and administrative cease and desist orders have been issued against SHIP, enjoining the Rehabilitator from implementing the Rehabilitation Plan in multiple jurisdictions. For example, state courts in Louisiana and South Carolina have granted preliminary injunctions against SHIP upon finding that the insurance regulator's challenges to the Rehabilitation Plan demonstrated a likelihood of success on the merits and that a preliminary injunction was necessary to prevent irreparable harm to policyholders. Similar, states such as Maine, Ohio, Connecticut, as well as the District of Columbia, have issued administrative orders to cease and desist to SHIP regarding the same conduct at issue in this matter.

17. Despite the substantial legal uncertainty surrounding these ongoing legal proceedings, the Coverage Election Package fails to disclose to Washington that pending litigation may overturn or modify the Rehabilitation Plan and options afforded to policyholders. Even so, the Coverage Election Package asserts that Washington policyholder elections and SHIP-imposed

elections are deemed irrevocable even if the Rehabilitation Plan is overturned or otherwise modified on appeal.

18. Even if the rates proposed by SHIP are approvable in Washington, the Coverage Election Package fails to adequately inform Washington policyholders that select the policy downgrade, the paid-up policy option, or their current policy terms could face more rate increases during Phase Two of the Rehabilitation Plan.

19. On February 2, 2022, the Rehabilitation Court approved SHIP's use of nationwide premium rates including in Washington. However, SHIP has not submitted to the Insurance Commissioner the premium rates that SHIP intends to use on insurance coverage provided to Washington policyholders, beginning as early as April 1, 2022, nor obtained the Insurance Commissioner's approval to such rates. SHIP has also failed to make all required regulatory filings with the Insurance Commissioner related to SHIP's transaction of insurance in this State, including the required filing of all forms prior to use.

20. Each of the coverage options offered by the Coverage Election Package represents either a reduction in the benefits offered by the Washington policies or an increase in premium rates, or some combination thereof. None of these modifications of the Washington policies for Washington policyholders has been filed with, nor approved by, the Insurance Commissioner for Washington State.

21. The most recent filings by SHIP for Washington included one rate and form filing (state tracking numbers 351565 and 351574, respectively), which were filed with the Insurance Commissioner on September 21, 2018, and subsequently withdrawn. No filings of either rates or forms have been approved for SHIP since at least September 14, 2016, and the five filings since then have either been withdrawn or rejected.

22. Less than one month since the Coverage Election Package was mailed to Washington policyholders, at least eight (8) complaints regarding the Coverage Election Package have been filed with the Insurance Commissioner on behalf of Washington policyholders, either confused by its contents or upset at SHIP's attempt to change contractual benefits, or both.

23. SHIP's effort to change one particular contractual benefit is especially troubling. Certain Washington policyholders have a Lifetime Waiver of Premium for Survivor provision in their contracts, which provides, upon death of a spouse, "the surviving person may continue the

Policy in force for the rest of his or her life and all subsequent premiums will be waived." This provision has been triggered for some of the Washington policyholders in previous years and confirmed by the insurer. SHIP's Coverage Election Package, wherein Option 4 – Keep Your Current Coverage, requires a billable annual premium of $12,199, is fundamentally incompatible with this specific important contractual benefit.

24. RCW 48.19.010(2) provides that every insurer shall, with respect to disability insurance, before using file with the Insurance Commissioner its manual of classification, manual of rules and rates, and any modifications thereof except as provided under RCW 48.43.733 or rate filing requirements established by a specific statute or federal law.

25. RCW 48.18.100(1) provides that no insurance policy form or application form where written application is required and is to be attached to the policy, or printed life or disability rider or endorsement form may be issued, delivered, or used unless it has been filed with and approved by the Insurance Commissioner.

26. RCW 48.02.080(3)(a) provides if the Insurance Commissioner has cause to believe that any person is violating or is about to violate any provision of this code or any regulation or order of the Insurance Commissioner, he or she may issue a cease and desist order.

27. RCW 48.30.040 provides no person shall knowingly make, publish, or disseminate any false, deceptive or misleading representation or advertising in the conduct of the business of insurance, or relative to the business of insurance or relative to any person engaged therein.

28. RCW 48.30.090 provides no person shall make, issue or circulate, or cause to be made, issued or circulated any misrepresentation of the terms of any policy or the benefits or advantages promised thereby, or the dividends or share of surplus to be received thereon, or use any name or title of any policy or class of policies misrepresenting the nature thereof.

29. WAC 284-50-020(1) applies Chapter 284-50 WAC to every "advertisement," as that term is defined in WAC 284-50-030(1), (7), (8) and (9), unless otherwise specified in these rules, intended for presentation distribution, or dissemination in this state when such presentation, distribution, or dissemination is made either directly or indirectly by or on behalf of an insurer, or insurance producer as those terms are defined in the insurance code of this state and these rules.

30. WAC 284-50-020(2) provides that every insurer shall establish and at all times maintain a system of control over the content, form, and method of dissemination of all

advertisements of its policies. All such advertisements, regardless of by whom written, created, designed, or presented, shall be the responsibility of the insurer for whom such advertisements are prepared.

31. WAC 284-50-030(1) provides in relevant part that an advertisement for the purpose of these rules shall include: (a) printed and published material, audio visual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio scripts, television scripts, billboards, and similar displays; and (b) descriptive literature and sales aids of all kinds issued by an insurer, or insurance producer for presentation to members of the insurance buying public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters.

32. WAC 284-50-050(1) provides that the format and content of an advertisement shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the Insurance Commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed.

33. WAC 284-50-050(2) provides that advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used.

34. WAC 284-50-060(1) provides in relevant part that no advertisement shall omit information or use words, phrases, statements, references, or illustrations if the omission of such information or use of such words, phrases, statements, references, or illustrations has the capacity, tendency, or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, or premium payable.

35. WAC 284-50-070(1) provides that when an advertisement which is an invitation to contract refers to either a dollar amount, or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it shall also disclose those exceptions, reductions, and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity or tendency to mislead or deceive.

36. The Respondent's actions described herein violate Insurance Code provisions that include RCW 48.30.040 (false and misleading representations), RCW 48.30.090 (misrepresentation of policy terms and benefits), WAC 284-50-050(1) and (2), WAC 284-50-060(1), WAC 284-50-070(1) (false, misleading, deceptive advertisements), RCW 48.19.010(2) (disability rate filing required), and RCW 48.18.100(1) (form filing required).

NOTICE OF OPPORTUNITY FOR HEARING

Respondents have the right to demand a hearing in accordance with RCW 48.04.010, WAC 284-02-070, and WAC 10-08-110. Respondents have 90 days from the receipt of this Order to demand a hearing. **If the Insurance Commissioner does not receive a hearing demand from Respondent within 90 days from the date Respondent received this Order, Respondent's right to a hearing is conclusively deemed to have been waived.**

This Order shall remain in effect subject to the further order of the Insurance Commissioner.

THIS ORDER IS EFFECTIVE IMMEDIATELY AND IS ENTERED at Tumwater, Washington, this 1st day of March, 2022.

MIKE KREIDLER
Insurance Commissioner

By and through his designee

DocuSigned by:
Darryl E. Colman
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DARRYL E. COLMAN
Attorney Manager
Legal Affairs Division

AMENDED CERTIFICATE OF MAILING

The undersigned certifies under the penalty of perjury under the laws of the State of Washington that I am now and at all times herein mentioned, a citizen of the United States, a resident of the State of Washington, over the age of eighteen years, not a party to or interested in the above-entitled action, and competent to be a witness herein.

On the date given below I caused to be served the foregoing ORDER TO CEASE AND DESIST NO. 22-0104 on the following individuals by depositing in the U.S. Mail via State Consolidated Mail Service with proper postage affixed to:

Senior Health Insurance Company of Pennsylvania
550 Congressional Blvd
Suite 200
Carmel, IN 46032
krickard@shipltc.com

Courtesy Copy To:

Specialty Deputy Rehabilitator for Senior Health Insurance Company of Pennsylvania
Patrick H. Cantilo
Cantilo & Bennett, LLP
11401 Century Oaks Terrace
Suite 300
Austin, TX 78758
phcantilo@cb-firm.com

Counsel for Senior Health Insurance Company of Pennsylvania
Michael John Broadbent
Cozen O'Connor
1900 Market Street
Philadelphia, PA 19103
mbroadbent@cozen.com

Acting Insurance Commissioner for the Commonwealth of Pennsylvania
Michael Humphreys
1326 Strawberry Square
Harrisburg, PA 17120

SIGNED this 1st day of March, 2022, at Tumwater, Washington.

DocuSigned by:
1DEEF54C44F9459...

Kimberly Shoblom
Paralegal
Legal Affairs Division

OFFICE of the INSURANCE COMMISSIONER WASHINGTON STATE

MENU

For Consumers

Kreidler orders Senior Health Insurance Company of Pennsylvania (SHIP) to stop interfering with the rights of Washington policyholders

Listen to this article now 4 min listen

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Contact Public Affairs: 360-725-7055

March 1, 2022

OLYMPIA, Wash. – Insurance Commissioner Mike Kreidler has ordered the insolvent Senior Health Insurance Company of Pennsylvania (SHIP) , of Pennsylvania, to immediately stop soliciting signatures from Washington's 1,200 plus policyholders for unapproved benefit and rate changes.

SHIP's appointed rehabilitator sent letters to policyholders in Washington and other states containing a "Coverage Election Package" that requires they choose a reduced benefit or premium increase by March 15, 2022, with an effective date as soon as April 1. Neither the premium increases nor benefits changes have been approved by Kreidler's office, as required by state law.

SHIP sold long-term care insurance policies to seniors throughout Washington. The financially troubled company was placed into rehabilitation by Pennsylvania's Commissioner of Insurance in

January 2020. A rehabilitation plan for the company was approved by the Pennsylvania Commonwealth Court in August 2021. Kreidler, along with commissioners from Maine and Massachusetts, appealed the rehabilitation plan, claiming it was unfair to policyholders. Their appeal is pending before the Pennsylvania Supreme Court. Twenty-seven other insurance regulators signed an amicus brief in support of the appeal.

In the meantime, any SHIP policyholder who has already received a Coverage Election Package from SHIP must select an option and postmark their response to the company by March 15 if they want to keep the reduced policy.

“I’m hopeful the Pennsylvania Supreme Court will see the facts of this case and grant our appeal,” said Kreidler. “The average SHIP policyholder is 86 years old. It’s critical they have the best option possible in the face of this company’s demise. The rehabilitator’s plan puts the burden of filling a $1.2 billion funding gap entirely on elderly consumers who put their faith in the company to be there when they needed them.”

Individual states have the sole authority to approve or deny rates and forms for companies doing business in their jurisdiction. Kreidler and the other objecting regulators believe the rehabilitation plan disproportionately puts the burden of the company’s insolvency unfairly onto policyholders and ignores their rights under states’ guaranty fund associations. State guaranty associations are set up in each state to pay claims when an insurer is placed in liquidation. Washington’s guaranty association pays claims up to $500,000 for a policyholder of a liquidated insurer. This provides some limited protection for policyholders but is no panacea. SHIP will not recover from its financial insolvency, but liquidating the company and triggering the states’ guaranty associations will offset some of the impact on policyholders. The rehabilitator letter directs SHIP policyholders to select one of five coverage options, with an accompanying premium change:

Downgrading your policy

Converting to a basic policy

Converting to an enhanced basic policy

Converting to an enhanced paid-up policy

Keeping your current policy

But two of the options—downgrading your policy and keeping your current policy—advertise that the Maximum Lifetime Benefit is “unlimited.” Kreidler’s office found this claim to be misleading at best, because the company will not have the funds to fulfill this promise. The package also requires policyholders to attest that any selection they make is voluntary, however if someone does not select an option, one is made for them.

“Given that the March 15 deadline is pending, and we cannot wait for the court to decide, I’m encouraging all SHIP policyholder who have received notice from the company to make the best

decision they can for their own situation," said Kreidler. "If you're confused by the notice you've received, contact your agent or file a complaint with our office."

News from the Commissioner

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The Commissioner in the Media

The Commissioner on social media

Photos and video of Mike Kreidler

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EXHIBIT 13

BEFORE THE UTAH INSURANCE COMMISSIONER	
Utah Insurance Department, Complainant, vs. Jessica K. Altman and her successors in office as Rehabilitator of Senior Health Insurance Company of Pennsylvania, Patrick H. Cantilo, as Special Deputy Rehabilitator of Senior Health Insurance Company of Pennsylvania, and Senior Health Insurance Company of Pennsylvania in Rehabilitation, Respondents.	**EMERGENCY ORDER** Case No. 2022-4377

Pursuant to Utah Code §§ 31A-2-201(4)(a) and 63G-4-502(1), Utah Insurance Commissioner Jonathan T. Pike ("**Commissioner**") hereby issues this emergency order against Jessica K. Altman and her successors in office as Rehabilitator of Senior Health Insurance Company of Pennsylvania ("**Rehabilitator**"), Patrick H. Cantilo, as Special Deputy Rehabilitator of Senior Health Insurance Company of Pennsylvania, and Senior Health Insurance Company of Pennsylvania in Rehabilitation ("**SHIP**"), (together referred to as "**Respondents**"), after determining based on knowledge and belief that Respondents are engaging or are about to engage in conduct prohibited by the Utah Insurance Code, Utah Code Title 31A, and any administrative rule promulgated thereunder, and that immediate action is in the public interest.

In support of this Order, the Commissioner makes the following findings of fact and conclusions of law:

FINDINGS OF FACT

1. SHIP is a Pennsylvania-domiciled life insurance company that became authorized to issue long-term care insurance ("LTCI") policies in the state of Utah as a foreign insurer beginning April 23, 1986 (NAIC Company Code 76325).

2. Between 1994 and 2011, the Commissioner approved multiple rate increases that averaged 127% per policy form. In addition, in 2017 the Commissioner approved a 40% rate increase for policies with 5% compound inflation. SHIP has not requested a rate increase since 2017.

3. In recent years, SHIP experienced financial distress and faced the possibility of insolvency.

4. On January 29, 2020, upon the application of Jessica Altman, the Commissioner of Insurance for the Commonwealth of Pennsylvania, the Commonwealth Court of Pennsylvania entered an Order of Rehabilitation placing SHIP into rehabilitation in accordance with Pennsylvania law.

5. The Order of Rehabilitation appointed Commissioner Altman and her successors in office as statutory rehabilitator of SHIP and required the Rehabilitator to prepare a plan of rehabilitation. Commissioner Altman appointed Patrick Cantilo as Special Deputy Rehabilitator, with the power to act on the Rehabilitator's behalf.

6. SHIP currently has 298 policies issued in Utah and subject to Utah law, with the average age of Utah policyholders being 84 years old.

7. On April 22, 2020, the Rehabilitator filed her Application for Approval of the Plan of Rehabilitation for SHIP with a Rehabilitation Plan.

8. The Rehabilitation Plan was approved in a Memorandum Opinion and Order of the

Pennsylvania Commonwealth Court on August 24, 2021, as amended on November 4, 2021.

9. State insurance regulators from Massachusetts, Maine and Washington intervened in rehabilitation proceedings and appealed the Order approving Rehabilitation Plan to the Pennsylvania Supreme Court (Middle District), No. 71 MAP 201. Approximately, 32 state insurance regulators, including the Commissioner, have requested leave to support the intervening regulators as amici curie. The appeal remains pending before the Pennsylvania Supreme Court.

10. Under the Rehabilitation Plan:

a. SHIP unilaterally, and without a factual or legal basis, determined that the Commissioner has agreed to SHIP's proposed premium rate plan for Utah.

b. The proposed premium rate increases average 75%.

c. The Rehabilitator will send or has sent to each Utah policyholder a "Coverage Election Package" that notifies them of the new premium rates and instructs them to select among coverage options that increase or reduce premium and reduce or maintain benefits under their policies.

11. Under Utah law, a premium rate for a LTCI policy and its related forms must be filed with the Commissioner before the rates and forms take effect. Utah Code §§ 31A-2-201.1, 31A-21-201, and 31A-22-1404; Utah Admin Code, Rules R 590-85, R590-148, and R590-220.

12. Utah law gives the Commissioner authority to disapprove a filed rate or form. Utah Code §§ 31A-21-201 and 31A-22-602.

13. SHIP's premium rate plan and its assumptions, methodology and related forms have not been filed with the Commissioner.

14. Because SHIP has not complied with Utah's rate and form filing requirements,

SHIP has violated or will violate Utah law by notifying Utah policyholders of the new rates and instructing them to select among coverage options based on those rates.

15. SHIP's notice to Utah policyholders is or will be deceptive because it constitutes a false representation that its rates and forms have met legal filing requirements. Utah Code §§ 31A-21-201(3) and 31A-23a-402.

16. SHIP's notice to Utah policyholders will cause immediate and significant danger to them. After receiving the notice, Utah policyholders will be compelled to make final and binding premium and coverage elections. Those elections will affect the availability of coverage for long-term care services in the future. Additionally, the elections will affect the policyholders' benefits from Utah's guaranty association if SHIP is later placed in liquidation, a likely occurrence due to SHIP's plans for future rate increases and benefit reductions.

17. Other jurisdictions, including Louisiana, Maine, South Carolina, North Dakota, Ohio, Maryland, and the District of Columbia, have enjoined SHIP's similar conduct in their states.

18. Based on the foregoing, there is substantial cause to believe that an immediate and significant danger to the public health, safety and welfare of Utah policyholders requires immediate action.

CONCLUSIONS OF LAW

19. The Commissioner regulates the business of insurance in Utah pursuant to Title 31A of the Utah Code.

20. Pursuant to Utah Code § 31A-2-201(4)(a), the Commissioner is authorized to issue prohibitory orders to secure compliance with Title 31A.

21. Pursuant to Utah Code § 63G-4-502, the Commissioner is authorized to issue an

order on an emergency basis if the facts known by or presented to the Commissioner show that an immediate and significant danger to the public health, safety, or welfare exists that requires the Commissioner's immediate action.

22. Pursuant to Utah Code §§ 31A-2-201.1, 31A-21-201, and 31A-22-1404 and Utah Admin. Code Rules R590-85, R590-148 and R590-220, every LTCI insurer shall file with the Commissioner the classification of risks and their related premium rates and policy forms. Respondents violated this provision of law by not filing proposed rates and forms with the Commissioner.

23. Pursuant to Utah Code § 31A-23a-402, no person shall engage in an unfair or deceptive act or practice in the business of insurance in Utah. Respondents violated or will violate this law by falsely notifying Utah policyholders that their rates have been legally and appropriately changed.

ORDER

Based upon the Findings of Fact, Conclusions of Law, it is ordered that:

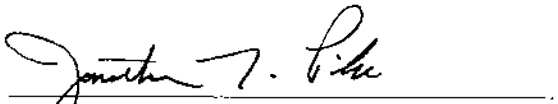
1. Respondents and any of their principals, agents, employees, successors, and assigns shall cease and desist from implementing the Rehabilitation Plan in Utah or otherwise interfering with the rights of SHIP's Utah policyholders or violating the insurance laws and regulations of Utah, including by mailing "Coverage Election Packages" and notifying Utah policyholders of proposed rate or benefit modifications SHIP intends use in place of the policyholders' existing rates and benefits, none of which has been authorized by the Commissioner.

2. For the duration of this emergency order, SHIP shall continue to abide by the current policy terms, benefits, and premium levels for Utah policyholders in effect prior to the adoption of the Rehabilitation Plan.

3. SHIP is not prohibited from curing any of its form or rate filing deficiencies or from filing their form and rate filings, including resolution of any objections issued by the Commissioner.

4. Pursuant to Utah Code § 63G-4-502 this Emergency Order is effective immediately and the Utah Insurance Department shall commence a formal adjudicative proceeding.

DATED this 22nd day of February, 2022.



JONATHAN T. PIKE
Utah Insurance Commissioner
Utah Insurance Department
4315 S. 2700 W., Suite 2300
Taylorsville, UT 84129
Telephone: 801-957-9321
Email: uidadmincases@utah.gov

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing Emergency Order was mailed to:

Jessica K. Altman, and her successors in office
Rehabilitator
Pennsylvania Insurance Department
1326 Strawberry Square
Harrisburg, PA 17120

Patrick H. Cantilo
Cantilo & Bennett, L.L.P.
Special Deputy Rehabilitator
550 Congressional Boulevard, Suite 200
Carmel, IN 46032

Senior Health Insurance Companyof
Pennsylvania (In Rehabilitation)
550 Congressional Boulevard, Suite 200
Carmel, IN 46032

DATED this 23rd day of February, 2022.

Jeanine Couser

Jeanine Couser
Utah Insurance Department
4315 S. 2700 W., Suite 2300
Taylorsville, UT 84129801-957-9321

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STATE OF SOUTH CAROLINA

RICHLAND COUNTY

IN THE COURT OF COMMON PLEAS

FIFTH JUDICIAL CIRCUIT

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

Plaintiffs,

vs.

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

Defendants.

Civil Action No. 2020-CP-40-05802

ORDER GRANTING PLAINTIFFS' MOTION FOR A TEMPORARY INJUNCTION

This matter comes before the Court pursuant to a motion for temporary injunction filed on November 12, 2021, by the Plaintiffs, Raymond G. Farmer, as Director of the South Carolina Department of Insurance, and the South Carolina Department of Insurance. The motion seeks to enjoin the Defendants, Jessica K. Altman, as Rehabilitator of Senior Health Insurance Company of Pennsylvania, Patrick H. Cantilo, as Special Deputy Rehabilitator of Senior Health Insurance, Company of Pennsylvania, and Senior Health Insurance Company of Pennsylvania in Rehabilitation, from taking any action in furtherance of their expressed plans to, without first obtaining required regulatory approval from the State, raise premium rates, reduce benefits, or both under certain binding contracts of insurance issued in the State of South Carolina or held by residents of this State, including, but not limited to, notifying policyholders of proposed rate or benefit changes or requesting that they select rates or benefits different from those authorized by

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the appropriate state regulator and called for under the terms of the contract, charging additional premium, or withholding, delaying or encumbering benefits in whole or in part. Notice duly having been provided to all parties, a hearing was held before the undersigned at 10:30 a.m. on December 15, 2021, in the Court of Common Pleas for Richland County. Geoffrey R. Bonham, Associate General Counsel for the South Carolina Department of Insurance, appeared for the Plaintiffs. Tracy L. Eggleston, Esq. and Michael J. Broadbent, Esq., both of Cozen O'Connor P.C., appeared for the Defendants.

FINDINGS OF FACT

After consideration of Plaintiffs' motion and the arguments presented by the parties at the hearing, I find as follows:

1. All parties were properly served notice of the hearing.

2. Plaintiff Raymond G. Farmer is the Director of the South Carolina Department of Insurance (the "Director").

3. Plaintiff South Carolina Department of Insurance (the "Department") is an agency of the State of South Carolina created and charged by the South Carolina General Assembly to regulate the business of insurance in this State. *See generally* S.C. Code Ann. §§ 38-1-10 *et seq*. ("The Insurance Law").

4. Defendant Jessica K. Altman is the Commissioner of Insurance for the Commonwealth of Pennsylvania and has been appointed Rehabilitator of Senior Health Insurance Company of Pennsylvania (the "Rehabilitator") by order of the Commonwealth Court of Pennsylvania ("Commonwealth Court") dated January 29, 2020 (the "Rehabilitation Order"). (Defs. Exh. 1.)

5. Defendant Patrick H. Cantilo was appointed by the Rehabilitator as Special Deputy

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Rehabilitator (the "SDR") of Senior Health Insurance Company of Pennsylvania. He generally has the power to act on behalf of the Rehabilitator, subject to the control and direction of the Rehabilitator. (Defs. Exh. 1 at ¶¶ 2, 14; Decl. of Cantilo at ¶¶ 2, 9.)

6. Defendant Senior Health Insurance Company of Pennsylvania ("SHIP") is a life and health insurance company domiciled in the Commonwealth of Pennsylvania that administers a closed block of long-term care insurance policies issued in over forty states. A fraction of its business remains. (Defs. Exh. 3 at p. 2-3.)

7. SHIP was issued a certificate of authority to conduct the business of insurance in South Carolina on April 8, 1988. (Ver. Mot. at ¶ 6.) It is undisputed that, like all long-term care insurers licensed in this State, SHIP has previously submitted proposed rate increases to the South Carolina Department of Insurance for review and approval in accordance with South Carolina law. (Ver. Mot. at ¶¶ 6, 18.)

8. The average SHIP policyholder age is approximately 87 years of age and the average policyholder on claim is approximately 90 years old. At present, there are approximately 300 policies issued in South Carolina by SHIP, and there are other SHIP policyholders residing in South Carolina whose policies were issued in other states. (Defs. Exh. 3 at p. 4; Ver. Mot. at ¶ 7.)

9. SHIP has been insolvent[1] since at least December 31, 2018, having reported a deficit of approximately a half-billion dollars as of that date; and, SHIP's financial condition has continued to deteriorate, with a current deficit of approximately $1.2 billion. (Pls. Exh. A at p. 45 ln. 2-5, p. 46 ln. 9-10, p. 240 ln. 17-25, p. 292 ln. 11-12.; Defs. Exh. 3 at p. 1.)

10. The Pennsylvania Insurance Department (the "PID") has not sought a declaration

1 *Compare* 40 Pa. Stat. § 221.3 (defining "Insolvency" within context of receivership) *with, e.g.*, 40 Pa. Stat. § 991.1702 (defining "Insolvent insurer" in the context of guaranty association coverage).

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of insolvency, which would have triggered guaranty association coverage in the affected states; however, it did file an application to place SHIP into rehabilitation in the Commonwealth Court of Pennsylvania on January 23, 2020. (*See generally* http://www. https://www.shipltc.com/court-documents.)

11. That application was granted by the Rehabilitation Order entered on January 29, 2020. The Rehabilitation Order is not a subject of dispute between the parties. (Defs. Exh. 1.)

12. Plaintiffs are not parties to the Pennsylvania rehabilitation proceedings, nor are SHIP policyholders represented by class representatives or legal counsel in those proceedings. (*See* Defs. Exh. 3.) Policyholders were also not provided formal legal process or service of process. (*See* Defs. Exh. 2.)

13. SHIP was the sole respondent in the Pennsylvania proceedings. (*See* Defs. Exh. 3.)

14. Three states, Massachusetts, Maine and Washington, intervened in those proceedings. (*Id.* at p. 6.)

15. A Second Amended Rehabilitation Plan (the "Plan") was filed on or about May 3, 2021 and approved by a single judge of the Commonwealth Court of Pennsylvania by order filed on August 24, 2021, which was amended by order entered on November 4, 2021. (Defs. Exh. 3.)

16. An appeal by the intervening three states is pending before the Pennsylvania Supreme Court, as is an application for stay. Approximately twenty (20) other state insurance regulators have expressed their support for the stay as *amici curiae*. (Defs. Exh. 6.)

17. Several large insurers -- Anthem, Inc., Health Care Service Corporation, Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey, and UnitedHealthcare Insurance Company -- appeared as intervenors in the proceedings and were represented by counsel. These companies fully support the Plan and oppose a stay in the

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Pennsylvania proceedings. (Defs. Exh. 3 at p. 6; *see generally* http://www.https://www.shipltc.com/court-documents.)

18. Under the Plan, Defendants will impose nationwide rates without filing those rates with state regulators for review and approval in accordance with each state's insurance laws. In some cases, the rate imposed will be more than double the amount of premium currently paid and can reasonably be expected to force policy lapses. Policyholders may be able to avoid some of the increases, but only if they agree to a decrease in benefits currently provided under their policies. (Pls. Exh. B.)

19. The Plan contains a so-called "opt-out" process under which SHIP submits rates to individual states that "opt-out" of the nationwide rate under those states' respective rate approval statutes. However, it also provides that if an "opt-out" state does not approve the rate demanded, that state's policyholders will incur a further downgrade to their benefits. The Rehabilitator "DOES NOT recommend that states opt out because that is generally expected to be disadvantageous to affected policyholders." (Pls. Exh. B at p. 108-118 & Pls. Exh. C, FAQ. 9.)

20. Under the Plan, Defendants gave states until November 15, 2021, to provide written notice, under oath, of their decision to "opt-out." (Pls. Exh. C.) Plaintiffs maintain that they are not subject to nor bound by the Plan.

21. Defendants do not dispute that the changes to rates, benefits or both will reduce the insurer's shortfall and that this in turn would reduce the burden of a declared insolvency on guaranty associations. (Pls. Exh. A at p.78 ln. 19-23, p. 79 ln. 4, p. 83-84 ln. 20-18, p. 289 ln. 9-18 & p. 292 ln. 11-25; Pls. Exh. B at p. 19.).

22. The rate increases and reductions in benefits would also appear to have a permanent adverse effect on policyholders' guaranty association benefits in the likely event that SHIP is

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placed into liquidation at a later date: the Defendant Cantilo has admitted in previous testimony that "it is not likely that we will magically restore SHIP to solvency, but it is likely that the plan . . . would substantially reduce the deficit." (Pls. Exh. A at p. 80 ln. 6-12; Pls. Exh. B at p. 14.)

23. Plaintiffs are concerned that, despite SHIP being inevitably headed for liquidation, or perhaps because of it, Defendants are attempting to use the rehabilitation proceedings to (1) coerce vulnerable elderly policyholders into paying exceptionally high rates, accepting substantially less benefits than what they are entitled to under their contracts, or even lapsing on their policies altogether, and (2) avoid state law, specifically restraints on premium increases and changes to policy forms, in an effort to permanently reduce the amount of guaranty association protection benefits each policyholder would receive in a liquidation, resulting in savings to large insurers in the form of substantially smaller guaranty association assessments. They are concerned that this aspect of the Plan violates the law and elevates the interests of large insurers over the rights of policyholders under their insurance contracts and applicable State law.

24. Plaintiffs seek an order temporarily enjoining Defendants from taking any measure that purports to bypass, impede, supersede, diminish or interfere in any manner with the State of South Carolina's laws or regulatory authority over changes to the terms of policies and review and approval of insurance rates in this State, and further temporarily enjoining Defendants from communicating in any form or manner with South Carolina policyholders regarding proposed changes to policy terms or rates without required approval by the State.

CONCLUSIONS OF LAW

I. JURISDICTION

The question of personal jurisdiction over a nonresident defendant is one that must be resolved upon the facts of each particular case. *State v. NV Sumatra Tobacco Trading, Co.*, 379

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S.C. 81, 88, 666 S.E.2d 218, 221 (2008) (citing *Cockrell v. Hillerich & Bradsby Co.*, 363 S.C. 485, 611 S.E.2d 505 (2005)). At the pretrial stage, the burden of proving personal jurisdiction over a nonresident is met by a prima facie showing of jurisdiction either in the complaint or in affidavits. *Moosally v. W.W. Norton & Co., Inc.*, 358 S.C. 320, 328, 594 S.E.2d 878, 882 (Ct. App. 2004). Because South Carolina treats its long-arm statute as coextensive with the due process clause, the sole question is whether the exercise of personal jurisdiction would violate due process. *Cockrell*, 363 S.C. at 491, 611 S.E.2d at 508. Determining whether the requirements of due process are satisfied involves a two-prong analysis: (1) the "power" prong, in which minimum contacts provide courts the "power" to adjudicate the action; and (2) the "fairness" prong, which requires the exercise of jurisdiction to be "reasonable" or "fair." *Moosally*, 358 S.C. at 331, 594 S.E.2d at 884.

Under the power prong, minimum contacts analysis requires a finding that the defendant directed its activities to residents of South Carolina and that the cause of action arises out of or relates to those activities. *Id.* at 331-332, 594 S.E.2d at 884. It is essential that there be some act by which the defendant purposefully avails itself of the privilege of conducting activities within the forum state, thus invoking the benefits and protections of its laws. *Id.* This "purposeful availment" element ensures that a defendant will not be haled into a jurisdiction solely as a result of random, fortuitous, or attenuated contacts. *Id.*

The individual Defendants authored, presented and are implementing the Plan, under which they avail themselves of the privilege of conducting activities in the State. They have sought not merely to invoke the benefits and protections of South Carolina's laws, but to supplant them, undermining the authority of the General Assembly and Plaintiffs. By directing their activities to

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South Carolina residents under the Plan that gives rise to this action, they have established sufficient contacts with the State to invoke the power of this Court.

In order to determine whether the exercise of jurisdiction over a foreign defendant meets the "fairness" prong, a court must consider the following: (1) the duration of the activity of the nonresident within the state; (2) the character and circumstances of the commission of the nonresident's acts; (3) the inconvenience resulting to the parties by conferring or refusing to confer jurisdiction over the nonresident; and (4) the State's interest in exercising jurisdiction. *Cockrell*, 363 S.C. at 492, 611 S.E.2d at 508; *see also Leggett v. Smith*, 386 S.C. 63, 76, 686 S.E.2d 699, 706 (Ct. App. 2009). Which state's law controls is also a factor to be considered under the fairness prong. *Moosally*, 358 S.C. at 332, 594 S.E.2d at 885.

Under the Plan, the Defendants intend to communicate with South Carolina policyholders regarding their insurance contracts and propose to establish new policy rates and benefits. These actions would appear to affect permanently policyholders' rights under South Carolina law, both immediately and in the event of a liquidation. It is their specific decisions and actions with regard to rates and policy benefits that have prompted the dispute between the parties. Without them, there is no Plan, and it is the unique aspects of that Plan that form the basis for Plaintiffs' lawsuit. It would be no less inconvenient for the Plaintiffs to bring suit in Pennsylvania than for Defendants to defend their actions here; and, the State has an obvious interest in defending its sovereignty and laws, and of course its citizens. Finally, Plaintiffs' action itself is for a declaration of South Carolina law. Under these circumstances, the Court's exercise of jurisdiction over the individual Defendants would also be fair. Accordingly, I find that the requisite prima facie showing of personal jurisdiction over the individual Defendants has been made. *See Moosally*, 358 S.C. at 328, 594 S.E.2d at 882.

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The Court clearly has personal jurisdiction of the insurer, which as a condition of its licensure has appointed the Director as its agent for service, *see* S.C. Code Ann. § 38-5-70 (2015), and has conducted the business of insurance in this State for many years.

The Court also has jurisdiction over the subject matter. No state's rehabilitation proceedings grant that state jurisdiction over "the whole field." *Smalls v. Weed*, 293 S.C. 364, 360 S.E.2d 531 (Ct. App. 1987). Although the Pennsylvania Commonwealth Court exercises *in rem* jurisdiction in the rehabilitation proceedings, the res over which that jurisdiction is exercised is the corporation itself, the fictitious entity, not all of the corporation's property for all purposes and certainly not the rights of all persons wherever situated. *See Matter of Rehabilitation of Nat'l Heritage Life Ins. Co.*, 656 A.2d 252 (Del. Ch. 1994). It does not appear that the Commonwealth Court may, simply by reason of the *in rem* nature of the Pennsylvania rehabilitation proceedings, abrogate the power and duties of Plaintiffs or adjudicate the rights of South Carolina policyholders and claimants who are neither parties in the Pennsylvania proceedings nor subject to the jurisdiction of the Commonwealth Court. *See Thormann v. Frame*, 176 U.S. 350 (1900) (judgment *in rem* binds only property within the control of the court).

II. GROUNDS FOR A TEMPORARY INJUNCTION

A preliminary injunction should issue where necessary to preserve the *status quo ante*, upon a showing by the moving party that (1) without such relief it will suffer irreparable harm, (2) it has a likelihood of success on the merits, and (3) there is no adequate remedy at law. *Poynter Invs., Inc. v. Cent. Builders of Piedmont, Inc.*, 387 S.C. 583, 694 S.E.2d 15 (2010) (citing *AJG Holdings, LLC v. Dunn*, 382 S.C. 43, 674 S.E.2d 505 (Ct. App. 2009). "'When a prima facie showing has been made entitling plaintiff to injunctive relief, a temporary injunction will be granted without regard to the ultimate termination of the case on the merits.'" *Columbia*

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Broadcasting System, Inc. v. Custom Recording Co., 258 S.C. 465, 471-472, 189 S.E.2d 305, 308 (1972) (quoting *Transcontinental Gas Pipe Line Corp. v. Porter*, 252 S.C. 478, 167 S.E.2d 313 (1969) (citing *D.W. Alderman & Sons Co. v. Wilson*, 69 S.C. 156, 48 S.E. 85 (1904)).

III. A PRELIMINARY INJUNCTION PURSUANT TO RULE 65, SCRCP IS WARRANTED UNDER THE CIRCUMSTANCES.

A. Plaintiffs have shown a likelihood of success on the merits.

Based on the foregoing, I find Plaintiffs have shown a likelihood of success on the merits. Defendants' Plan appears to be founded on a clearly erroneous reading of the law and appears likely to be overturned on appeal. Regardless, the order approving that Plan is not binding on Plaintiffs or policyholders. Both federal and State law support Plaintiffs' position that insurers licensed by Plaintiffs must obey the laws of this State and that contracts issued in this state are subject to South Carolina law.

The primary state insurance regulatory functions remain as they have been since the enactment of the McCarran-Ferguson [Act], in which "Congress . . . declare[d] that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States." 15 U.S.C. § 1011. "This allows . . . states to perform solvency oversight of the U.S. insurance industry and to regulate insurer behavior in the marketplace." *State Insurance Regulation*, National Association of Insurance Commissioners (NAIC), Center for Insurance Policy and Research (CIPR) (2011), https://www.naic.org/documents/topics_white_paper_hist_ins_reg.pdf.

"State legislatures are the public policymakers that establish . . . broad policy for the regulation of insurance by enacting legislation providing the regulatory framework under which insurance regulators operate. They establish laws which grant regulatory authority to regulators

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and oversee state insurance departments and approve regulatory budgets." *Id.* "State insurance regulatory systems are accessible and accountable to the public and sensitive to local social and economic conditions." *Id.* "State regulators protect consumers by ensuring that insurance policy provisions comply with state law, are reasonable and fair, and do not contain major gaps in coverage that might be misunderstood by consumers and leave them unprotected. The nature of the regulatory reviews of rates, rating rules and policy forms varies somewhat among the states depending on their laws and regulations." *Id.*

The South Carolina General Assembly has delegated its regulatory authority under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, to the Department. Pursuant to S.C. Code Ann. § 38-3-10 (2015), the General Assembly "established a separate and distinct department of this State, known as the Department of Insurance. The department must be managed and operated by a director appointed by the Governor upon the advice and consent of the Senate." Pursuant to S.C. Code Ann. § 38-3-60 (2015), "The director or his designee must follow the general policies and broad objectives enacted by the General Assembly regarding the operation of the insurance industry in this State." S.C. Code Ann. § 38-3-110 (2015) sets forth the Director's responsibilities, which include the duty to:

> (1) supervise and regulate the rates and service of every insurer in this State and fix just and reasonable standards, classifications, regulations, practices, and measurements of service to be observed and followed by every insurer doing business in this State. Nothing contained in this title authorizes or requires a review by the department or the director of any order of the director's designee or the deputy director under the Administrative Procedures Act. This item does not grant any additional authority to the director or his designee with regard to insurance rates other than the ratemaking authority specifically granted to the director or his designee, or the Department of Insurance for certain kinds of insurance in other provisions of this title;
>
> and to:

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> (2) see that all laws of this State governing insurers or relating to the business of insurance are faithfully executed and make regulations to carry out this title and all other insurance laws of this State, the enforcement or administration of which is not otherwise specifically provided for.

The legislature has also provided, pursuant to S.C. Code Ann. § 38-61-10 (2015), "All contracts of insurance on property, lives, or interests in this State are considered to be made in the State and all contracts of insurance the applications for which are taken within the State are considered to have been made within this State and are subject to the laws of this State." It has enacted and approved detailed and extensive statutes and regulations governing long-term care insurance policies and rates, including provisions for the approval of rates by the Department. *See* S.C. Code Ann. §§ 38-72-10 *et seq.*; S.C. Code Regs. § 69-44. Under the Long-Term Care Insurance Act, S.C. Code Ann. §§ 38-72-10 *et seg.*, "All premium rate schedules for long-term care insurance must be filed with the [South Carolina Department of Insurance] and are subject to the prior approval of the director or his designee." S.C. Code Ann. § 38-72-75(A) (2019); *see also* Act No. 6 of 2019. An insurer may not charge a premium to an insured under a policy or contract of long-term care insurance before the applicable premium rate is filed and approved, and an insurer may not change the premium charged to an insured under a policy or contract of long-term care insurance until the applicable premium rate change has been filed with and approved by the Director or his designee. *Id.* "The director or his designee may hold a public hearing or solicit public comments as a part of the process to review long-term care insurance rate filings received by the director or his designee." S.C. Code Ann. § 38-72-75(C) (2019). Each decision of the Director or his designee about premium rates is subject to review under the Administrative Procedures Act (APA). S.C. Code Ann. § 38-72-75(D) (2019). S.C. Code Regs. 69-44 also provides for the comprehensive regulation of long-term care insurance policies, including rates, forms and required market practices.

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In addition, our Supreme Court has held that because the authority to determine what insurance premium rates are just and reasonable is vested in the Department, not even courts should adjudicate what a reasonable rate might be in a collateral proceeding. *Cf. Temporary Services, Inc. v. American Intern. Group, Inc.*, 388 S.C. 348, 351, 697 S.E.2d 527, 529 (2010); § 2:34. Rates—Judicial review, 1 Couch on Ins. § 2:34 ("Ratemaking is generally not a judicial function. Indeed, many jurisdictions have adopted the filed rate doctrine which expressly prohibits courts from imposing rates different than those approved by the state insurance department.") To the extent Defendants might rely on the Pennsylvania court's order approving the Plan and the rate-setting scheme within, this would appear to violate the filed rate doctrine. This doctrine preserves the stability, uniformity, and finality inherent in rates filed with the regulatory agency and what has been determined to be a reasonable rate by that agency. *Edge v. State Farm Mut. Auto. Ins. Co.*, 366 S.C. 511, 623 S.E.2d 387 (2005).

Pennsylvania law also appears to militate in favor of Plaintiffs' motion. That state's highest court has made clear that as a creature of statute, an insurance commissioner acting as a rehabilitator "'can only exercise those powers which have been conferred upon it by the Legislature in clear and unmistakable language.'" *Aetna Cas. and Sur. Co. v. Com., Ins. Dept.*, 638 A.2d 194 (Pa. 1994) (quoting *Com., Human Relations Commission v. Transit Cas. Ins. Co.*, 387 A.2d 58, 62 (Pa. 1978)). *See also Koken v. Legion Ins. Co.*, 831 A.2d 1196 (Pa. Commw. 2003), *aff'd sub nom. Koken v. Villanova Ins. Co.*, 878 A.2d 51 (Pa. 2005). Defendants Rehabilitator and SDR have only those powers conferred upon them by 40 Pa. Stat. Ann. § 221.16. This statute prescribes the powers and duties of the rehabilitator, who has "all the powers of the directors, officers and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator" and "full power to direct and manage, to hire and discharge employees subject to

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any contract rights they may have, and to deal with the property and business of the insurer." *Id.* These powers are limited and equivalent to those of new management, and rehabilitators and insurance companies in rehabilitation, including SHIP, must therefore obey the insurance laws of each the states in which they conduct the business of insurance. *See id.* (rehabilitator has "full power to direct and manage" the insurer). The rehabilitation statutes do not appear to contain "clear and unmistakable language" permitting a rehabilitator to unilaterally set new rates and policy terms nationwide. Under Pennsylvania law, a rehabilitator's powers are sufficiently limited as to prevent her from even amending an insurer's bylaws. *See Koken*, 831 A.2d at 1227.

In maintaining that South Carolina is bound by the Plan, Defendants appear to rely on the Full Faith and Credit Clause of the U.S. Constitution. Assuming, *arguendo*, that the Pennsylvania approval order is a "judgment" for purposes of full faith and credit, South Carolina does not appear obligated to obey it in contravention of its own laws. As noted, the jurisdiction of the Pennsylvania court and the extraterritorial reach of the rehabilitation proceedings is limited. *See, e.g., Smalls*, 293 S.C. at 371, 360 S.E.2d at 534; *see also Heritage Life*, 656 A.2d at 259-260. Even the Pennsylvania court seems to indicate that its order is binding only on those who appeared before it. Although that order is in places ambiguous as to its intended reach, the court does plainly state, "Once this Court renders a judgment on the Second Amended Plan, it is Maine, Massachusetts, and Washington [the three intervening regulators] that owe this Court's judgment full faith and credit." (Defs. Exh. 3 at p. 61.)

Moreover, full faith and credit requires only that every state give a foreign judgment the *res judicata* effect which that judgment would be accorded in the state which rendered it. *Durfee v. Duke*, 375 U.S. 106 (1963). Under Pennsylvania law, application of *res judicata* requires that the two relevant proceedings possess several common elements, including identity of the parties.

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Robinson Coal Co. v. Goodall, 72 A.3d 685 (Pa. Super. 2013). Plaintiffs were not parties to the Pennsylvania proceedings. The constitutional command of full faith and credit does not compel South Carolina to defer to a Pennsylvania court where the matter was neither fully and fairly litigated nor involved the relevant parties: "Before a court is bound by the judgment rendered in another State, it may inquire into the jurisdictional basis of the foreign court's decree" and "[i]f that court did not have jurisdiction over the subject matter or the relevant parties, full faith and credit need not be given." *Underwriters Nat'l Assurance Co. v. N.C. Life & Accident & Health Ins. Guar. Ass'n.*, 455 U.S. 691, 705 (1982).

To the contrary, enforcing Defendants' apparent attempt to supplant the laws of South Carolina and other states risks adoption of a "policy of hostility to the public Acts" of each of the forty-plus affected states, resulting in a direct injury to their sovereignty in violation of the Full Faith and Credit Clause. *See Franchise Tax Bd. v. Hyatt*, 578 U.S. 171 (2016); *Allstate Ins. Co. v. Hague*, 449 U.S. 302 (1981); *Carroll v. Lanza*, 349 U.S. 408 (1955). "The very nature of the federal union of states, to which are reserved some of the attributes of sovereignty, precludes resort to the full faith and credit clause as the means for compelling a state to substitute the statutes of other states for its own statutes dealing with a subject matter concerning which it is competent to legislate." *Pacific Employers Ins. Co. v. Industrial Accident Comm'n*, 306 U.S. 493, 501 (1939); *see also Alaska Packers Ass'n v. Indus. Accident Comm'n.*, 294 U.S. 532, 547 (1935).

Full faith and credit also need not be granted a judgment obtained in violation of procedural due process. *Purdie v. Smalls*, 293 S.C. 216, 359 S.E.2d 306 (Ct. App. 1987). An insurance policy is a contract between the insured and the insurance company. *Coakley v. Horace Mann Ins. Co.*, 376 S.C. 2, 656 S.E.2d 17 (2007). Statutes governing an insurance contract are part of the contract as a matter of law. *See Williams v. Government Employees Ins. Co. (GEICO)*, 409 S.C. 586, 762

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S.E.2d 705 (2014). Here, policyholders appear to have had their contract rights, including the statutory rights that are part of their policies, stripped of them without the benefit of due process. There is no evidence that policyholders, who were not respondents in the Pennsylvania proceedings, received proper service of process or were represented by class representatives or independent legal counsel. Defendants have yet to offer a justification for why policyholders, who Defendants would have bound by the Plan, were not afforded the process apparently due them. *Cf. Underwriters Nat. Assur. Co.*, 455 U.S. at 712 (example of policyholders being represented by legal counsel and class representatives who engaged in "extensive negotiations" with the insurer and the receiver).

Moreover, the Defendants in their own filings appear to concede that the Pennsylvania order is not a final order, but temporary or interlocutory, and thus not entitled to full faith and credit: "Even after approval . . . the Rehabilitator and the Commonwealth Court of Pennsylvania 'are obligated to interact in order to supervise, implement and regulate equitably the process engaged to rehabilitate an insolvent or financially hazardous insurer.' Thus, plan approval and implementation remain in the jurisdiction of the Commonwealth Court of Pennsylvania and within its supervision throughout the proceedings." (Defendants' Memorandum of Law in Support of their Motion to Dismiss at 6.) *See Purdie*, 293 S.C. at 220, 359 S.E.2d at 308 (temporary or interlocutory order not entitled to full faith and credit).

B. Plaintiffs have shown that a preliminary injunction is necessary to prevent irreparable harm and that there is no adequate remedy at law.

A temporary injunction to preserve *the status quo ante* is necessary to prevent irreparable harm. Plaintiffs are specifically charged by the South Carolina General Assembly to uphold the insurance laws of this State. Those laws are designed to protect the policyholders, whose contracts were formed in this State and are subject to its laws and regulations. Notwithstanding the clear

EXHIBIT 1

(PART 5)

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mandate of South Carolina law, the insurer's past compliance with that law, the limited reach of the Pennsylvania proceedings, and the apparent defects in those proceedings, Defendants have made clear their position that SHIP is no longer subject to South Carolina law and have manifested their intention to not obey it and to move forward immediately with implementing changes to South Carolina policies and rates.

The State has a strong interest in protecting policyholders and ensuring that its laws are enforced. If those laws are not enforced, and Defendants are permitted to implement their Plan immediately, Plaintiffs will have not upheld their statutory duty and policyholders will be permanently denied basic rights and suffer permanent and substantial economic harm. In short, Plaintiffs would not have performed the very functions delegated to them by the General Assembly.

Even if Plaintiffs were to fine SHIP or suspend or revoke its license, such after-the-fact measures would not reinstate any permanent or temporary loss of benefits or premium overcharges. The same is true of any lawsuit to recover damages for lost benefits or premium overcharges, which would also be impracticable given the advanced age and typically limited means of the victims. Similarly, a suit by Plaintiffs for damages arising out of violation of this State's laws seems implausible, if not infeasible. An action at law by either Plaintiffs or policyholders would also not undo the substantial confusion and disruption of the marketplace that would have occurred. *See Nutt Corp. v. Howell Rd., LLC*, 396 S.C. 323, 328, 721 S.E.2d 447, 450 (Ct. App. 2011) ("adequate" remedy at law is one that is as certain, practical, complete and efficient to attain the ends of justice and its administration as the remedy in equity). Conversely, Defendants need do no more than refrain from violating South Carolina law. If they wish to file for a rate increase in accordance with the laws of this State, they have done so in the past and may

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do so again.

On the basis of the pleadings and papers in this matter and the arguments of the parties, it appears to the Court that Plaintiffs have shown a likelihood of success on the merits, and that they will suffer immediate, irreparable injury, with no adequate means of redress at law, in that, *inter alia*, without a temporary injunction, the *status quo* would be irretrievably altered with respect to the enforcement of the insurance laws, the order and stability of the insurance marketplace and the rights of policyholders Plaintiffs have the statutory duty to protect. Plaintiffs have therefore made the necessary showing that they are entitled to a temporary injunction - irreparable harm, likelihood of success on the merits, and no adequate remedy at law - thereby establishing grounds for relief pursuant to Rule 65, SCRCP.

IT IS THEREFORE ORDERED THAT:

1. Plaintiffs' Motion for Temporary Injunction is hereby GRANTED;

2. Defendants are hereby enjoined from communicating, implementing or enforcing in this State the Plan, otherwise interfering with the rights of SHIP long-term care insurance policyholders or otherwise violating the insurance laws of this State pertaining to long-term care insurance, including, but not limited to, notifying policyholders of proposed rate or benefit changes or requesting that they select rates or benefits different from those authorized by the appropriate state regulator and called for under the terms of the contract, charging additional premium, or withholding, delaying or encumbering benefits in whole or in part, until such time as specified herein;

3. The temporary injunction granted is binding upon the Defendants, their officers, agents, servants, employees, and attorneys, and upon those persons in active concert or

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participation with them who receive actual notice of this Order for Temporary Injunction by personal service or otherwise;

4. This temporary injunction is to remain in effect for no more than thirty (30) days after there has been a final adjudication on the merits of the proceedings pending in Pennsylvania, with leave granted to Plaintiffs to apply for an extension; and

5. Pursuant to Rule 65(c), SCRCP, no bond or other security shall be required of Plaintiffs as an officer and agency of the State as a result of the granting of a temporary injunction in this case.

AND IT IS SO ORDERED.

L. Casey Manning
Chief Administrative Judge
Fifth Judicial Circuit

JAN 20, 2022
~~December~~ __, 2021
Columbia, South Carolina

EAST BATON ROUGE PARISH
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C-713794
22

NINETEENTH JUDICIAL DISTRICT COURT

PARISH OF EAST BATON ROUGE

STATE OF LOUISIANA

JAMES J. DONELON IN HIS OFFICIAL CAPACITY AS COMMISSIONER OF INSURANCE FOR THE STATE OF LOUISIANA AND THE LOUISIANA DEPARTMENT OF INSURANCE

Plaintiff

VERSUS

JESSICA K. ALTMAN, IN HER CAPACITY AS STATUTORY REHABILITATOR OF SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA AND SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, IN REHABILITATION

Defendant

NUMBER: 713794

SECTION: 22

ORDER GRANTING PRELIMINARY INJUNCTION

THIS MATTER came for hearing before the Court on January 25, 2022 on the request contained in the petition of James J. Donelon, in his official capacity as Commissioner of Insurance for the State of Louisiana, and the Louisiana Department of Insurance (collectively, Plaintiffs) for issuance of a preliminary injunction against Defendants Jessica K. Altman, in her capacity as Statutory Rehabilitator of Senior Health Insurance Company of Pennsylvania (the Rehabilitator), and Senior Health Insurance Company of Pennsylvania, In Rehabilitation (SHIP) (collectively, Defendants).

Present in Court: David S. Rubin, counsel for the Plaintiffs; and Brandon K. Black and Michael J. Broadbent, counsel for the Defendants.

CONSIDERING the pleadings of the parties, the record of this matter, the evidence introduced, the arguments of counsel, for reasons orally assigned on the record of this matter in open court,

IT IS HEREBY ORDERED, ADJUDGED, AND DECREED as follows:

1. A preliminary injunction is issued in this matter as set forth herein.

NINETEENTH JUDICIAL DISTRICT COURT

PARISH OF EAST BATON ROUGE

STATE OF LOUISIANA

JAMES J. DONELON
IN HIS OFFICIAL CAPACITY
AS COMMISSIONER OF INSURANCE
FOR THE STATE OF LOUISIANA AND
THE LOUISIANA DEPARTMENT OF
INSURANCE

Plaintiff

VERSUS

JESSICA K. ALTMAN, IN HER CAPACITY AS STATUTORY
REHABILITATOR
OF SENIOR HEALTH INSURANCE COMPANY OF
PENNSYLVANIA
AND
SENIOR HEALTH INSURANCE COMPANY OF
PENNSYLVANIA, IN REHABILITATION

Defendant

NUMBER: 713794

SECTION: 22

ORDER GRANTING PRELIMINARY INJUNCTION (continued)

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2. The Rehabilitator and SHIP are each preliminarily enjoined from (a) attempting to enforce against any Louisiana policyholders of SHIP any increase in premium rates paid on policies issued in Louisiana based on the Approved Plan of Rehabilitation currently being implemented by the Rehabilitator without compliance with all applicable provisions of Louisiana law and regulations identified in Plaintiffs' Petition for Preliminary Injunction, Permanent Injunction, and Declaratory Judgment filed December 3, 2021, and (b) soliciting any Louisiana policyholders of SHIP to select one of the options made available under that Approved Plan without compliance with all applicable provisions of Louisiana law and regulations identified in Plaintiffs' Petition for Preliminary Injunction, Permanent Injunction, and Declaratory Judgment filed December 3, 2021.

NINETEENTH JUDICIAL DISTRICT COURT

PARISH OF EAST BATON ROUGE

STATE OF LOUISIANA

JAMES J. DONELON
IN HIS OFFICIAL CAPACITY
AS COMMISSIONER OF INSURANCE
FOR THE STATE OF LOUISIANA AND
THE LOUISIANA DEPARTMENT OF
INSURANCE

Plaintiff

VERSUS

JESSICA K. ALTMAN, IN HER CAPACITY AS STATUTORY
REHABILITATOR
OF SENIOR HEALTH INSURANCE COMPANY OF
PENNSYLVANIA
AND
SENIOR HEALTH INSURANCE COMPANY OF
PENNSYLVANIA, IN REHABILITATION

Defendant

NUMBER: 713794

SECTION: 22

ORDER GRANTING PRELIMINARY INJUNCTION (continued)

Notwithstanding the foregoing, SHIP may (a) send communications and information to such policyholders in the ordinary course of business concerning claims under or premium payments due under policies held by such policyholders, (b) comply with any Pennsylvania statutes or orders of the Commonwealth Court of Pennsylvania regarding benefit reductions or other policy modifications that do not require premium rate increases for such policyholders, subject to (i) Defendants' agreement to provide notice to Plaintiffs at least twenty-one days before any such benefit reductions or other policy modification(s) is/are made effective and (ii) Plaintiffs' reservation of their right to return to this Court and assert that any such benefit reductions or other policy modification(s) is/are within the scope of this injunction, and (c) offer and effect for such policyholders any policy modification available in the ordinary course of business and that are unrelated to the Approved Plan that is in compliance with all applicable provisions of Louisiana law and regulations.

NINETEENTH JUDICIAL DISTRICT COURT

PARISH OF EAST BATON ROUGE

STATE OF LOUISIANA

JAMES J. DONELON
IN HIS OFFICIAL CAPACITY
AS COMMISSIONER OF INSURANCE
FOR THE STATE OF LOUISIANA AND
THE LOUISIANA DEPARTMENT OF
INSURANCE

Plaintiff

VERSUS

JESSICA K. ALTMAN, IN HER CAPACITY AS STATUTORY
REHABILITATOR
OF SENIOR HEALTH INSURANCE COMPANY OF
PENNSYLVANIA
AND
SENIOR HEALTH INSURANCE COMPANY OF
PENNSYLVANIA, IN REHABILITATION

Defendant

NUMBER: 713794

SECTION: 22

ORDER GRANTING PRELIMINARY INJUNCTION (continued)

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3. IT IS FURTHER ORDERED that no security is required for issuance of this preliminary injunction because the Plaintiffs are the Commissioner of Insurance for the State of Louisiana and the Louisiana Department of Insurance and as such are exempt from any requirement to post security as provided by La. Rev. Stat. 13:4581.

4. IT IS FURTHER ORDERED that this preliminary injunction shall remain in effect until further order of the Court.

5. IT IS FURTHER ORDERED that Defendants shall pay all court costs actually incurred by Plaintiffs as related to the preliminary injunction filed by Plaintiffs.

SO ORDERED at Baton Rouge, Louisiana, this ____ day of **February 03 2022**, 2022, at **10:55** o'clock **a** m.

HONORABLE TIMOTHY KELLEY
JUDGE, 19th JUDICIAL DISTRICT COURT

I HEREBY CERTIFY THAT ON THIS DAY A COPY OF THE WRITTEN REASONS FOR JUDGMENT / JUDGMENT / ORDER / COMMISSIONER'S RECOMMENDATION WAS MAILED BY ME WITH SUFFICIENT POSTAGE AFFIXED.
SEE ATTACHED LETTER FOR LIST OF RECIPIENTS.

DONE AND MAILED ON February 07, 2022

DEPUTY CLERK OF COURT

STATE OF NORTH DAKOTA

COUNTY OF BURLEIGH

IN DISTRICT COURT

SOUTH CENTRAL JUDICIAL DISTRICT

Jon Godfread, in his capacity as the North Dakota Commissioner of Insurance, and the North Dakota Insurance Department,

Plaintiffs

vs.

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

Defendants.

TEMPORARY RESTRAINING ORDER

Civil No. 08-2022-CV-00293

[¶ 1] On February 7, 2022, Plaintiffs Jon Godfread, in his capacity as the Commissioner of the North Dakota Department of Insurance ("Commissioner"), and the North Dakota Insurance Department ("Department"), filed an Motion for Temporary Restraining Order and a Complaint seeking a temporary restraining order, a preliminary injunction, and a permanent injunction against Defendants Jessica K. Altman, as Rehabilitator of Senior Health Insurance Company of Pennsylvania ("Rehabilitator"), Patrick H. Cantilo, as Special Deputy Rehabilitator of Senior Health Insurance Company of Pennsylvania ("SDR"), and Senior Health Insurance Company of Pennsylvania ("SHIP"). Based on Plaintiffs' motion for a temporary restraining order, temporary injunction, and permanent injunction, including the brief, declarations and exhibits submitted in support of the motion, and upon the other files, records, and proceedings herein, which I have fully reviewed:

IT IS ORDERED that Plaintiffs Motion for Temporary Restraining Order is GRANTED.

Defendants and any of their agents, servants, employees, successors, assigns, and those persons in active concert and participation therewith from taking any action in furtherance of their expressed plans to, without first obtaining required regulatory approval from the State of North Dakota, raise premium rates and/or reduce benefits under certain binding contracts of insurance issued in the State of North Dakota or held by residents of this State, including, but not limited to, notifying policy holders of proposed rate or benefit changes or requesting that they select rates or benefits different from those authorized by the Department and called for under the terms of the contact, charging additional premium or withholding, delaying or encumbering benefits in whole or in part.

IT IS FURTHER ORDERED that this Temporary Restraining Order expires no later than 28 days after issuance or until earlier amended by Order of the Court, whichever occurs first.

Dated this _____ day of February, 2022.

Signed: 2/8/2022 2:35:12 PM

District Court Judge

ELECTRONICALLY FILED - 2022 Jan 20 11:36 AM - RICHLAND - COMMON PLEAS - CASE#2020CP4005802

STATE OF SOUTH CAROLINA **RICHLAND COUNTY**	**IN THE COURT OF COMMON PLEAS** **FIFTH JUDICIAL CIRCUIT**
Raymond G. Farmer, as Director of the South Carolina Department of Insurance, and the South Carolina Department of Insurance, Plaintiffs, vs. Jessica K. Altman, as Rehabilitator of Senior Health Insurance Company of Pennsylvania, Patrick H. Cantilo, as Special Deputy Rehabilitator of Senior Health Insurance, Company of Pennsylvania, and Senior Health Insurance Company of Pennsylvania in Rehabilitation, Defendants.	Civil Action No. 2020-CP-40-05802 **ORDER GRANTING PLAINTIFFS' MOTION FOR A TEMPORARY INJUNCTION**

This matter comes before the Court pursuant to a motion for temporary injunction filed on November 12, 2021, by the Plaintiffs, Raymond G. Farmer, as Director of the South Carolina Department of Insurance, and the South Carolina Department of Insurance. The motion seeks to enjoin the Defendants, Jessica K. Altman, as Rehabilitator of Senior Health Insurance Company of Pennsylvania, Patrick H. Cantilo, as Special Deputy Rehabilitator of Senior Health Insurance, Company of Pennsylvania, and Senior Health Insurance Company of Pennsylvania in Rehabilitation, from taking any action in furtherance of their expressed plans to, without first obtaining required regulatory approval from the State, raise premium rates, reduce benefits, or both under certain binding contracts of insurance issued in the State of South Carolina or held by residents of this State, including, but not limited to, notifying policyholders of proposed rate or benefit changes or requesting that they select rates or benefits different from those authorized by

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the appropriate state regulator and called for under the terms of the contract, charging additional premium, or withholding, delaying or encumbering benefits in whole or in part. Notice duly having been provided to all parties, a hearing was held before the undersigned at 10:30 a.m. on December 15, 2021, in the Court of Common Pleas for Richland County. Geoffrey R. Bonham, Associate General Counsel for the South Carolina Department of Insurance, appeared for the Plaintiffs. Tracy L. Eggleston, Esq. and Michael J. Broadbent, Esq., both of Cozen O'Connor P.C., appeared for the Defendants.

FINDINGS OF FACT

After consideration of Plaintiffs' motion and the arguments presented by the parties at the hearing, I find as follows:

1. All parties were properly served notice of the hearing.

2. Plaintiff Raymond G. Farmer is the Director of the South Carolina Department of Insurance (the "Director").

3. Plaintiff South Carolina Department of Insurance (the "Department") is an agency of the State of South Carolina created and charged by the South Carolina General Assembly to regulate the business of insurance in this State. *See generally* S.C. Code Ann. §§ 38-1-10 *et seq.* ("The Insurance Law").

4. Defendant Jessica K. Altman is the Commissioner of Insurance for the Commonwealth of Pennsylvania and has been appointed Rehabilitator of Senior Health Insurance Company of Pennsylvania (the "Rehabilitator") by order of the Commonwealth Court of Pennsylvania ("Commonwealth Court") dated January 29, 2020 (the "Rehabilitation Order"). (Defs. Exh. 1.)

5. Defendant Patrick H. Cantilo was appointed by the Rehabilitator as Special Deputy

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Rehabilitator (the "SDR") of Senior Health Insurance Company of Pennsylvania. He generally has the power to act on behalf of the Rehabilitator, subject to the control and direction of the Rehabilitator. (Defs. Exh. 1 at ¶¶ 2, 14; Decl. of Cantilo at ¶¶ 2, 9.)

6. Defendant Senior Health Insurance Company of Pennsylvania ("SHIP") is a life and health insurance company domiciled in the Commonwealth of Pennsylvania that administers a closed block of long-term care insurance policies issued in over forty states. A fraction of its business remains. (Defs. Exh. 3 at p. 2-3.)

7. SHIP was issued a certificate of authority to conduct the business of insurance in South Carolina on April 8, 1988. (Ver. Mot. at ¶ 6.) It is undisputed that, like all long-term care insurers licensed in this State, SHIP has previously submitted proposed rate increases to the South Carolina Department of Insurance for review and approval in accordance with South Carolina law. (Ver. Mot. at ¶¶ 6, 18.)

8. The average SHIP policyholder age is approximately 87 years of age and the average policyholder on claim is approximately 90 years old. At present, there are approximately 300 policies issued in South Carolina by SHIP, and there are other SHIP policyholders residing in South Carolina whose policies were issued in other states. (Defs. Exh. 3 at p. 4; Ver. Mot. at ¶ 7.)

9. SHIP has been insolvent[1] since at least December 31, 2018, having reported a deficit of approximately a half-billion dollars as of that date; and, SHIP's financial condition has continued to deteriorate, with a current deficit of approximately $1.2 billion. (Pls. Exh. A at p. 45 ln. 2-5, p. 46 ln. 9-10, p. 240 ln. 17-25, p. 292 ln. 11-12.; Defs. Exh. 3 at p. 1.)

10. The Pennsylvania Insurance Department (the "PID") has not sought a declaration

1 *Compare* 40 Pa. Stat. § 221.3 (defining "Insolvency" within context of receivership) *with, e.g.*, 40 Pa. Stat. § 991.1702 (defining "Insolvent insurer" in the context of guaranty association coverage).

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of insolvency, which would have triggered guaranty association coverage in the affected states; however, it did file an application to place SHIP into rehabilitation in the Commonwealth Court of Pennsylvania on January 23, 2020. (*See generally* http://www. https://www.shipltc.com/court-documents.)

11. That application was granted by the Rehabilitation Order entered on January 29, 2020. The Rehabilitation Order is not a subject of dispute between the parties. (Defs. Exh. 1.)

12. Plaintiffs are not parties to the Pennsylvania rehabilitation proceedings, nor are SHIP policyholders represented by class representatives or legal counsel in those proceedings. (*See* Defs. Exh. 3.) Policyholders were also not provided formal legal process or service of process. (*See* Defs. Exh. 2.)

13. SHIP was the sole respondent in the Pennsylvania proceedings. (*See* Defs. Exh. 3.)

14. Three states, Massachusetts, Maine and Washington, intervened in those proceedings. (*Id.* at p. 6.)

15. A Second Amended Rehabilitation Plan (the "Plan") was filed on or about May 3, 2021 and approved by a single judge of the Commonwealth Court of Pennsylvania by order filed on August 24, 2021, which was amended by order entered on November 4, 2021. (Defs. Exh. 3.)

16. An appeal by the intervening three states is pending before the Pennsylvania Supreme Court, as is an application for stay. Approximately twenty (20) other state insurance regulators have expressed their support for the stay as *amici curiae*. (Defs. Exh. 6.)

17. Several large insurers -- Anthem, Inc., Health Care Service Corporation, Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey, and UnitedHealthcare Insurance Company -- appeared as intervenors in the proceedings and were represented by counsel. These companies fully support the Plan and oppose a stay in the

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Pennsylvania proceedings. (Defs. Exh. 3 at p. 6; *see generally* http://www. https://www.shipltc.com/court-documents.)

18. Under the Plan, Defendants will impose nationwide rates without filing those rates with state regulators for review and approval in accordance with each state's insurance laws. In some cases, the rate imposed will be more than double the amount of premium currently paid and can reasonably be expected to force policy lapses. Policyholders may be able to avoid some of the increases, but only if they agree to a decrease in benefits currently provided under their policies. (Pls. Exh. B.)

19. The Plan contains a so-called "opt-out" process under which SHIP submits rates to individual states that "opt-out" of the nationwide rate under those states' respective rate approval statutes. However, it also provides that if an "opt-out" state does not approve the rate demanded, that state's policyholders will incur a further downgrade to their benefits. The Rehabilitator "DOES NOT recommend that states opt out because that is generally expected to be disadvantageous to affected policyholders." (Pls. Exh. B at p. 108-118 & Pls. Exh. C, FAQ. 9.)

20. Under the Plan, Defendants gave states until November 15, 2021, to provide written notice, under oath, of their decision to "opt-out." (Pls. Exh. C.) Plaintiffs maintain that they are not subject to nor bound by the Plan.

21. Defendants do not dispute that the changes to rates, benefits or both will reduce the insurer's shortfall and that this in turn would reduce the burden of a declared insolvency on guaranty associations. (Pls. Exh. A at p.78 ln. 19-23, p. 79 ln. 4, p. 83-84 ln. 20-18, p. 289 ln. 9-18 & p. 292 ln. 11-25; Pls. Exh. B at p. 19.).

22. The rate increases and reductions in benefits would also appear to have a permanent adverse effect on policyholders' guaranty association benefits in the likely event that SHIP is

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placed into liquidation at a later date: the Defendant Cantilo has admitted in previous testimony that "it is not likely that we will magically restore SHIP to solvency, but it is likely that the plan . . . would substantially reduce the deficit." (Pls. Exh. A at p. 80 ln. 6-12; Pls. Exh. B at p. 14.)

23. Plaintiffs are concerned that, despite SHIP being inevitably headed for liquidation, or perhaps because of it, Defendants are attempting to use the rehabilitation proceedings to (1) coerce vulnerable elderly policyholders into paying exceptionally high rates, accepting substantially less benefits than what they are entitled to under their contracts, or even lapsing on their policies altogether, and (2) avoid state law, specifically restraints on premium increases and changes to policy forms, in an effort to permanently reduce the amount of guaranty association protection benefits each policyholder would receive in a liquidation, resulting in savings to large insurers in the form of substantially smaller guaranty association assessments. They are concerned that this aspect of the Plan violates the law and elevates the interests of large insurers over the rights of policyholders under their insurance contracts and applicable State law.

24. Plaintiffs seek an order temporarily enjoining Defendants from taking any measure that purports to bypass, impede, supersede, diminish or interfere in any manner with the State of South Carolina's laws or regulatory authority over changes to the terms of policies and review and approval of insurance rates in this State, and further temporarily enjoining Defendants from communicating in any form or manner with South Carolina policyholders regarding proposed changes to policy terms or rates without required approval by the State.

CONCLUSIONS OF LAW

I. JURISDICTION

The question of personal jurisdiction over a nonresident defendant is one that must be resolved upon the facts of each particular case. *State v. NV Sumatra Tobacco Trading, Co.*, 379

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S.C. 81, 88, 666 S.E.2d 218, 221 (2008) (citing *Cockrell v. Hillerich & Bradsby Co.*, 363 S.C. 485, 611 S.E.2d 505 (2005)). At the pretrial stage, the burden of proving personal jurisdiction over a nonresident is met by a prima facie showing of jurisdiction either in the complaint or in affidavits. *Moosally v. W.W. Norton & Co., Inc.*, 358 S.C. 320, 328, 594 S.E.2d 878, 882 (Ct. App. 2004). Because South Carolina treats its long-arm statute as coextensive with the due process clause, the sole question is whether the exercise of personal jurisdiction would violate due process. *Cockrell*, 363 S.C. at 491, 611 S.E.2d at 508. Determining whether the requirements of due process are satisfied involves a two-prong analysis: (1) the "power" prong, in which minimum contacts provide courts the "power" to adjudicate the action; and (2) the "fairness" prong, which requires the exercise of jurisdiction to be "reasonable" or "fair." *Moosally*, 358 S.C. at 331, 594 S.E.2d at 884.

Under the power prong, minimum contacts analysis requires a finding that the defendant directed its activities to residents of South Carolina and that the cause of action arises out of or relates to those activities. *Id.* at 331-332, 594 S.E.2d at 884. It is essential that there be some act by which the defendant purposefully avails itself of the privilege of conducting activities within the forum state, thus invoking the benefits and protections of its laws. *Id.* This "purposeful availment" element ensures that a defendant will not be haled into a jurisdiction solely as a result of random, fortuitous, or attenuated contacts. *Id.*

The individual Defendants authored, presented and are implementing the Plan, under which they avail themselves of the privilege of conducting activities in the State. They have sought not merely to invoke the benefits and protections of South Carolina's laws, but to supplant them, undermining the authority of the General Assembly and Plaintiffs. By directing their activities to

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South Carolina residents under the Plan that gives rise to this action, they have established sufficient contacts with the State to invoke the power of this Court.

In order to determine whether the exercise of jurisdiction over a foreign defendant meets the "fairness" prong, a court must consider the following: (1) the duration of the activity of the nonresident within the state; (2) the character and circumstances of the commission of the nonresident's acts; (3) the inconvenience resulting to the parties by conferring or refusing to confer jurisdiction over the nonresident; and (4) the State's interest in exercising jurisdiction. *Cockrell*, 363 S.C. at 492, 611 S.E.2d at 508; *see also Leggett v. Smith*, 386 S.C. 63, 76, 686 S.E.2d 699, 706 (Ct. App. 2009). Which state's law controls is also a factor to be considered under the fairness prong. *Moosally*, 358 S.C. at 332, 594 S.E.2d at 885.

Under the Plan, the Defendants intend to communicate with South Carolina policyholders regarding their insurance contracts and propose to establish new policy rates and benefits. These actions would appear to affect permanently policyholders' rights under South Carolina law, both immediately and in the event of a liquidation. It is their specific decisions and actions with regard to rates and policy benefits that have prompted the dispute between the parties. Without them, there is no Plan, and it is the unique aspects of that Plan that form the basis for Plaintiffs' lawsuit. It would be no less inconvenient for the Plaintiffs to bring suit in Pennsylvania than for Defendants to defend their actions here; and, the State has an obvious interest in defending its sovereignty and laws, and of course its citizens. Finally, Plaintiffs' action itself is for a declaration of South Carolina law. Under these circumstances, the Court's exercise of jurisdiction over the individual Defendants would also be fair. Accordingly, I find that the requisite prima facie showing of personal jurisdiction over the individual Defendants has been made. *See Moosally*, 358 S.C. at 328, 594 S.E.2d at 882.

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The Court clearly has personal jurisdiction of the insurer, which as a condition of its licensure has appointed the Director as its agent for service, *see* S.C. Code Ann. § 38-5-70 (2015), and has conducted the business of insurance in this State for many years.

The Court also has jurisdiction over the subject matter. No state's rehabilitation proceedings grant that state jurisdiction over "the whole field." *Smalls v. Weed*, 293 S.C. 364, 360 S.E.2d 531 (Ct. App. 1987). Although the Pennsylvania Commonwealth Court exercises *in rem* jurisdiction in the rehabilitation proceedings, the res over which that jurisdiction is exercised is the corporation itself, the fictitious entity, not all of the corporation's property for all purposes and certainly not the rights of all persons wherever situated. *See Matter of Rehabilitation of Nat'l Heritage Life Ins. Co.*, 656 A.2d 252 (Del. Ch. 1994). It does not appear that the Commonwealth Court may, simply by reason of the *in rem* nature of the Pennsylvania rehabilitation proceedings, abrogate the power and duties of Plaintiffs or adjudicate the rights of South Carolina policyholders and claimants who are neither parties in the Pennsylvania proceedings nor subject to the jurisdiction of the Commonwealth Court. *See Thormann v. Frame*, 176 U.S. 350 (1900) (judgment *in rem* binds only property within the control of the court).

II. GROUNDS FOR A TEMPORARY INJUNCTION

A preliminary injunction should issue where necessary to preserve the *status quo ante*, upon a showing by the moving party that (1) without such relief it will suffer irreparable harm, (2) it has a likelihood of success on the merits, and (3) there is no adequate remedy at law. *Poynter Invs., Inc. v. Cent. Builders of Piedmont, Inc.*, 387 S.C. 583, 694 S.E.2d 15 (2010) (citing *AJG Holdings, LLC v. Dunn*, 382 S.C. 43, 674 S.E.2d 505 (Ct. App. 2009). "'When a prima facie showing has been made entitling plaintiff to injunctive relief, a temporary injunction will be granted without regard to the ultimate termination of the case on the merits.'" *Columbia*

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Broadcasting System, Inc. v. Custom Recording Co., 258 S.C. 465, 471-472, 189 S.E.2d 305, 308 (1972) (quoting *Transcontinental Gas Pipe Line Corp. v. Porter*, 252 S.C. 478, 167 S.E.2d 313 (1969) (citing *D.W. Alderman & Sons Co. v. Wilson*, 69 S.C. 156, 48 S.E. 85 (1904)).

III. A PRELIMINARY INJUNCTION PURSUANT TO RULE 65, SCRCP IS WARRANTED UNDER THE CIRCUMSTANCES.

A. Plaintiffs have shown a likelihood of success on the merits.

Based on the foregoing, I find Plaintiffs have shown a likelihood of success on the merits. Defendants' Plan appears to be founded on a clearly erroneous reading of the law and appears likely to be overturned on appeal. Regardless, the order approving that Plan is not binding on Plaintiffs or policyholders. Both federal and State law support Plaintiffs' position that insurers licensed by Plaintiffs must obey the laws of this State and that contracts issued in this state are subject to South Carolina law.

The primary state insurance regulatory functions remain as they have been since the enactment of the McCarran-Ferguson [Act], in which "Congress . . . declare[d] that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States." 15 U.S.C. § 1011. "This allows . . . states to perform solvency oversight of the U.S. insurance industry and to regulate insurer behavior in the marketplace." *State Insurance Regulation*, National Association of Insurance Commissioners (NAIC), Center for Insurance Policy and Research (CIPR) (2011), https://www.naic.org/documents/topics_white_paper_hist_ins_reg.pdf.

"State legislatures are the public policymakers that establish . . . broad policy for the regulation of insurance by enacting legislation providing the regulatory framework under which insurance regulators operate. They establish laws which grant regulatory authority to regulators

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and oversee state insurance departments and approve regulatory budgets." *Id.* "State insurance regulatory systems are accessible and accountable to the public and sensitive to local social and economic conditions." *Id.* "State regulators protect consumers by ensuring that insurance policy provisions comply with state law, are reasonable and fair, and do not contain major gaps in coverage that might be misunderstood by consumers and leave them unprotected. The nature of the regulatory reviews of rates, rating rules and policy forms varies somewhat among the states depending on their laws and regulations." *Id.*

The South Carolina General Assembly has delegated its regulatory authority under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, to the Department. Pursuant to S.C. Code Ann. § 38-3-10 (2015), the General Assembly "established a separate and distinct department of this State, known as the Department of Insurance. The department must be managed and operated by a director appointed by the Governor upon the advice and consent of the Senate." Pursuant to S.C. Code Ann. § 38-3-60 (2015), "The director or his designee must follow the general policies and broad objectives enacted by the General Assembly regarding the operation of the insurance industry in this State." S.C. Code Ann. § 38-3-110 (2015) sets forth the Director's responsibilities, which include the duty to:

> (1) supervise and regulate the rates and service of every insurer in this State and fix just and reasonable standards, classifications, regulations, practices, and measurements of service to be observed and followed by every insurer doing business in this State. Nothing contained in this title authorizes or requires a review by the department or the director of any order of the director's designee or the deputy director under the Administrative Procedures Act. This item does not grant any additional authority to the director or his designee with regard to insurance rates other than the ratemaking authority specifically granted to the director or his designee, or the Department of Insurance for certain kinds of insurance in other provisions of this title;
>
> and to:

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> (2) see that all laws of this State governing insurers or relating to the business of insurance are faithfully executed and make regulations to carry out this title and all other insurance laws of this State, the enforcement or administration of which is not otherwise specifically provided for.

The legislature has also provided, pursuant to S.C. Code Ann. § 38-61-10 (2015), "All contracts of insurance on property, lives, or interests in this State are considered to be made in the State and all contracts of insurance the applications for which are taken within the State are considered to have been made within this State and are subject to the laws of this State." It has enacted and approved detailed and extensive statutes and regulations governing long-term care insurance policies and rates, including provisions for the approval of rates by the Department. *See* S.C. Code Ann. §§ 38-72-10 *et seq.*; S.C. Code Regs. § 69-44. Under the Long-Term Care Insurance Act, S.C. Code Ann. §§ 38-72-10 *et seg.*, "All premium rate schedules for long-term care insurance must be filed with the [South Carolina Department of Insurance] and are subject to the prior approval of the director or his designee." S.C. Code Ann. § 38-72-75(A) (2019); *see also* Act No. 6 of 2019. An insurer may not charge a premium to an insured under a policy or contract of long-term care insurance before the applicable premium rate is filed and approved, and an insurer may not change the premium charged to an insured under a policy or contract of long-term care insurance until the applicable premium rate change has been filed with and approved by the Director or his designee. *Id.* "The director or his designee may hold a public hearing or solicit public comments as a part of the process to review long-term care insurance rate filings received by the director or his designee." S.C. Code Ann. § 38-72-75(C) (2019). Each decision of the Director or his designee about premium rates is subject to review under the Administrative Procedures Act (APA). S.C. Code Ann. § 38-72-75(D) (2019). S.C. Code Regs. 69-44 also provides for the comprehensive regulation of long-term care insurance policies, including rates, forms and required market practices.

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In addition, our Supreme Court has held that because the authority to determine what insurance premium rates are just and reasonable is vested in the Department, not even courts should adjudicate what a reasonable rate might be in a collateral proceeding. *Cf. Temporary Services, Inc. v. American Intern. Group, Inc.*, 388 S.C. 348, 351, 697 S.E.2d 527, 529 (2010); § 2:34. Rates—Judicial review, 1 Couch on Ins. § 2:34 ("Ratemaking is generally not a judicial function. Indeed, many jurisdictions have adopted the filed rate doctrine which expressly prohibits courts from imposing rates different than those approved by the state insurance department.") To the extent Defendants might rely on the Pennsylvania court's order approving the Plan and the rate-setting scheme within, this would appear to violate the filed rate doctrine. This doctrine preserves the stability, uniformity, and finality inherent in rates filed with the regulatory agency and what has been determined to be a reasonable rate by that agency. *Edge v. State Farm Mut. Auto. Ins. Co.*, 366 S.C. 511, 623 S.E.2d 387 (2005).

Pennsylvania law also appears to militate in favor of Plaintiffs' motion. That state's highest court has made clear that as a creature of statute, an insurance commissioner acting as a rehabilitator "'can only exercise those powers which have been conferred upon it by the Legislature in clear and unmistakable language.'" *Aetna Cas. and Sur. Co. v. Com., Ins. Dept.*, 638 A.2d 194 (Pa. 1994) (quoting *Com., Human Relations Commission v. Transit Cas. Ins. Co.*, 387 A.2d 58, 62 (Pa. 1978)). *See also Koken v. Legion Ins. Co.*, 831 A.2d 1196 (Pa. Commw. 2003), *aff'd sub nom. Koken v. Villanova Ins. Co.*, 878 A.2d 51 (Pa. 2005). Defendants Rehabilitator and SDR have only those powers conferred upon them by 40 Pa. Stat. Ann. § 221.16. This statute prescribes the powers and duties of the rehabilitator, who has "all the powers of the directors, officers and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator" and "full power to direct and manage, to hire and discharge employees subject to

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any contract rights they may have, and to deal with the property and business of the insurer." *Id.* These powers are limited and equivalent to those of new management, and rehabilitators and insurance companies in rehabilitation, including SHIP, must therefore obey the insurance laws of each the states in which they conduct the business of insurance. *See id.* (rehabilitator has "full power to direct and manage" the insurer). The rehabilitation statutes do not appear to contain "clear and unmistakable language" permitting a rehabilitator to unilaterally set new rates and policy terms nationwide. Under Pennsylvania law, a rehabilitator's powers are sufficiently limited as to prevent her from even amending an insurer's bylaws. *See Koken*, 831 A.2d at 1227.

In maintaining that South Carolina is bound by the Plan, Defendants appear to rely on the Full Faith and Credit Clause of the U.S. Constitution. Assuming, *arguendo*, that the Pennsylvania approval order is a "judgment" for purposes of full faith and credit, South Carolina does not appear obligated to obey it in contravention of its own laws. As noted, the jurisdiction of the Pennsylvania court and the extraterritorial reach of the rehabilitation proceedings is limited. *See, e.g., Smalls*, 293 S.C. at 371, 360 S.E.2d at 534; *see also Heritage Life*, 656 A.2d at 259-260. Even the Pennsylvania court seems to indicate that its order is binding only on those who appeared before it. Although that order is in places ambiguous as to its intended reach, the court does plainly state, "Once this Court renders a judgment on the Second Amended Plan, it is Maine, Massachusetts, and Washington [the three intervening regulators] that owe this Court's judgment full faith and credit." (Defs. Exh. 3 at p. 61.)

Moreover, full faith and credit requires only that every state give a foreign judgment the *res judicata* effect which that judgment would be accorded in the state which rendered it. *Durfee v. Duke*, 375 U.S. 106 (1963). Under Pennsylvania law, application of *res judicata* requires that the two relevant proceedings possess several common elements, including identity of the parties.

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Robinson Coal Co. v. Goodall, 72 A.3d 685 (Pa. Super. 2013). Plaintiffs were not parties to the Pennsylvania proceedings. The constitutional command of full faith and credit does not compel South Carolina to defer to a Pennsylvania court where the matter was neither fully and fairly litigated nor involved the relevant parties: "Before a court is bound by the judgment rendered in another State, it may inquire into the jurisdictional basis of the foreign court's decree" and "[i]f that court did not have jurisdiction over the subject matter or the relevant parties, full faith and credit need not be given." *Underwriters Nat'l Assurance Co. v. N.C. Life & Accident & Health Ins. Guar. Ass'n.*, 455 U.S. 691, 705 (1982).

To the contrary, enforcing Defendants' apparent attempt to supplant the laws of South Carolina and other states risks adoption of a "policy of hostility to the public Acts" of each of the forty-plus affected states, resulting in a direct injury to their sovereignty in violation of the Full Faith and Credit Clause. *See Franchise Tax Bd. v. Hyatt,* 578 U.S. 171 (2016)*; Allstate Ins. Co. v. Hague*, 449 U.S. 302 (1981); *Carroll v. Lanza*, 349 U.S. 408 (1955). "The very nature of the federal union of states, to which are reserved some of the attributes of sovereignty, precludes resort to the full faith and credit clause as the means for compelling a state to substitute the statutes of other states for its own statutes dealing with a subject matter concerning which it is competent to legislate." *Pacific Employers Ins. Co. v. Industrial Accident Comm'n*, 306 U.S. 493, 501 (1939); *see also Alaska Packers Ass'n v. Indus. Accident Comm'n.*, 294 U.S. 532, 547 (1935).

Full faith and credit also need not be granted a judgment obtained in violation of procedural due process. *Purdie v. Smalls*, 293 S.C. 216, 359 S.E.2d 306 (Ct. App. 1987). An insurance policy is a contract between the insured and the insurance company. *Coakley v. Horace Mann Ins. Co.*, 376 S.C. 2, 656 S.E.2d 17 (2007). Statutes governing an insurance contract are part of the contract as a matter of law. *See Williams v. Government Employees Ins. Co. (GEICO)*, 409 S.C. 586, 762

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S.E.2d 705 (2014). Here, policyholders appear to have had their contract rights, including the statutory rights that are part of their policies, stripped of them without the benefit of due process. There is no evidence that policyholders, who were not respondents in the Pennsylvania proceedings, received proper service of process or were represented by class representatives or independent legal counsel. Defendants have yet to offer a justification for why policyholders, who Defendants would have bound by the Plan, were not afforded the process apparently due them. *Cf. Underwriters Nat. Assur. Co.*, 455 U.S. at 712 (example of policyholders being represented by legal counsel and class representatives who engaged in "extensive negotiations" with the insurer and the receiver).

Moreover, the Defendants in their own filings appear to concede that the Pennsylvania order is not a final order, but temporary or interlocutory, and thus not entitled to full faith and credit: "Even after approval . . . the Rehabilitator and the Commonwealth Court of Pennsylvania 'are obligated to interact in order to supervise, implement and regulate equitably the process engaged to rehabilitate an insolvent or financially hazardous insurer.' Thus, plan approval and implementation remain in the jurisdiction of the Commonwealth Court of Pennsylvania and within its supervision throughout the proceedings." (Defendants' Memorandum of Law in Support of their Motion to Dismiss at 6.) *See Purdie*, 293 S.C. at 220, 359 S.E.2d at 308 (temporary or interlocutory order not entitled to full faith and credit).

B. Plaintiffs have shown that a preliminary injunction is necessary to prevent irreparable harm and that there is no adequate remedy at law.

A temporary injunction to preserve *the status quo ante* is necessary to prevent irreparable harm. Plaintiffs are specifically charged by the South Carolina General Assembly to uphold the insurance laws of this State. Those laws are designed to protect the policyholders, whose contracts were formed in this State and are subject to its laws and regulations. Notwithstanding the clear

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mandate of South Carolina law, the insurer's past compliance with that law, the limited reach of the Pennsylvania proceedings, and the apparent defects in those proceedings, Defendants have made clear their position that SHIP is no longer subject to South Carolina law and have manifested their intention to not obey it and to move forward immediately with implementing changes to South Carolina policies and rates.

The State has a strong interest in protecting policyholders and ensuring that its laws are enforced. If those laws are not enforced, and Defendants are permitted to implement their Plan immediately, Plaintiffs will have not upheld their statutory duty and policyholders will be permanently denied basic rights and suffer permanent and substantial economic harm. In short, Plaintiffs would not have performed the very functions delegated to them by the General Assembly.

Even if Plaintiffs were to fine SHIP or suspend or revoke its license, such after-the-fact measures would not reinstate any permanent or temporary loss of benefits or premium overcharges. The same is true of any lawsuit to recover damages for lost benefits or premium overcharges, which would also be impracticable given the advanced age and typically limited means of the victims. Similarly, a suit by Plaintiffs for damages arising out of violation of this State's laws seems implausible, if not infeasible. An action at law by either Plaintiffs or policyholders would also not undo the substantial confusion and disruption of the marketplace that would have occurred. *See Nutt Corp. v. Howell Rd., LLC*, 396 S.C. 323, 328, 721 S.E.2d 447, 450 (Ct. App. 2011) ("adequate" remedy at law is one that is as certain, practical, complete and efficient to attain the ends of justice and its administration as the remedy in equity). Conversely, Defendants need do no more than refrain from violating South Carolina law. If they wish to file for a rate increase in accordance with the laws of this State, they have done so in the past and may

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do so again.

On the basis of the pleadings and papers in this matter and the arguments of the parties, it appears to the Court that Plaintiffs have shown a likelihood of success on the merits, and that they will suffer immediate, irreparable injury, with no adequate means of redress at law, in that, *inter alia*, without a temporary injunction, the *status quo* would be irretrievably altered with respect to the enforcement of the insurance laws, the order and stability of the insurance marketplace and the rights of policyholders Plaintiffs have the statutory duty to protect. Plaintiffs have therefore made the necessary showing that they are entitled to a temporary injunction - irreparable harm, likelihood of success on the merits, and no adequate remedy at law - thereby establishing grounds for relief pursuant to Rule 65, SCRCP.

IT IS THEREFORE ORDERED THAT:

1. Plaintiffs' Motion for Temporary Injunction is hereby GRANTED;

2. Defendants are hereby enjoined from communicating, implementing or enforcing in this State the Plan, otherwise interfering with the rights of SHIP long-term care insurance policyholders or otherwise violating the insurance laws of this State pertaining to long-term care insurance, including, but not limited to, notifying policyholders of proposed rate or benefit changes or requesting that they select rates or benefits different from those authorized by the appropriate state regulator and called for under the terms of the contract, charging additional premium, or withholding, delaying or encumbering benefits in whole or in part, until such time as specified herein;

3. The temporary injunction granted is binding upon the Defendants, their officers, agents, servants, employees, and attorneys, and upon those persons in active concert or

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participation with them who receive actual notice of this Order for Temporary Injunction by personal service or otherwise;

4. This temporary injunction is to remain in effect for no more than thirty (30) days after there has been a final adjudication on the merits of the proceedings pending in Pennsylvania, with leave granted to Plaintiffs to apply for an extension; and

5. Pursuant to Rule 65(c), SCRCP, no bond or other security shall be required of Plaintiffs as an officer and agency of the State as a result of the granting of a temporary injunction in this case.

AND IT IS SO ORDERED.

L. Casey Manning
Chief Administrative Judge
Fifth Judicial Circuit

JAN 20, 2022
~~December~~ __, 2021
Columbia, South Carolina

EXHIBIT 14

pennsylvania
INSURANCE DEPARTMENT

March 8, 2022

VIA E-MAIL

Re: Senior Health Insurance Plan of Pennsylvania ("SHIP")

Dear Esteemed Colleagues and Friends,

As you know, Jessica Altman recently moved on to another important position in the health insurance public policy world and, as a result, I now serve as the Acting Commissioner of Insurance for the Commonwealth of Pennsylvania. This letter is written to you by me; not by my outside consultants or attorneys, or the Insurance Department legal team, in an effort to catch you up on the status of the SHIP rehabilitation plan that has been subject to much discussion at the NAIC. It is my hope that you receive this letter and my plans for next steps as constructive in seeking as much consensus as possible to resolve a highly contentious debate.

Following our February Commissioners Conference, on February 11, a number of you formally wrote to Jessica asking Pennsylvania to withdraw or suspend our efforts to implement our plan to rehabilitate SHIP ("Plan") while the Pennsylvania Supreme Court considers the appeal of three states opposing the Court-approved Plan. Together, Jessica and I responded on February 18 declining to withdraw the plan but offering, as part of a consensual resolution, to delay implementation of the modification of SHIP policies under the plan until a tolling date of the earlier of October 1, 2022, or the date of the final order of the Pennsylvania Supreme Court. Unfortunately, Pennsylvania received only an informal response from an attorney representing the three states essentially saying that a majority of states on the February 11 letter would neither agree to our offer nor provide a counteroffer as a way to resolve SHIP.

In the spirit of camaraderie and consensus-building, and despite no agreement to our offer, ***I have directed Pennsylvania's team to delay implementation of plan modifications until the earlier of October 1, 2022, or the date of the final order of our Supreme Court.*** This delay will apply to all states—opt-in states, opt-out states, and states that have brought their own legal actions against the Plan, and provides a uniform, national implementation date. We will continue to prepare for the modifications, including through the collection of policyholder election information, in the meantime.

That said, I have also directed Pennsylvania's team to oppose any and all state administrative and/or legal actions directed against Pennsylvania and the Plan. Pennsylvania courts have jurisdiction over actions the Pennsylvania Insurance Department takes against Pennsylvania's domestic companies. This position of domestic deference is central to our state-based system of insurance regulation, most clearly evidenced in the NAIC Financial Regulation Standards and Accreditation Program and has historically been part of our message to Congress when threats to the state-based system have surfaced.

It is no secret that the SHIP Plan has been controversial, but we have been collaborative throughout. The Pennsylvania Insurance Department and our outside attorneys and advisors (including individuals that have helped many states work through complicated rehabilitations and receiverships over the years)

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provided access to our thinking and plans long before we brought the first Plan to our Commonwealth Court. We have modified the Plan in important ways in response to regulator feedback and we continue to provide updates and information on the status of the Plan.

We believe strongly that the best path forward for SHIP policyholders is the path identified in the Plan. It is consistent with the lessons learned in this organization's important LTC workstreams (RBOs and national rate approach). The only other alternative that has been suggested is an immediate path to liquidation. For reasons that Jessica discussed in a December statement on SHIP, I am convinced that at this time Rehabilitation, not Liquidation, is best for SHIP policyholders. **Let me be very clear, though, on one point: Liquidation at some future time is not off the table.** We have said time and again that after Phase One of the Plan, we will undergo a deep dive of the results before determining our next steps. In fact, we have previously committed, and I do so again today, that we will have discussions with you and approach the Court again, before moving on to any possible Phase Two.

We are in the midst of Phase One and have proceeded with the Plan's implementation. That implementation included distribution of election packages to around 20,000 policyholders thus far, with more to come. Remarkably, around two thirds of the almost half who have already responded have selected options that would not have been available to them in liquidation based on applicable law and our experience with Penn Treaty.[1]

Long-term care insurance solutions are not easy. The SHIP Rehabilitation Plan was not an easy or quick decision. But it was the right one. SHIP policyholders deserve options, and the Plan provides several quality options that would not be otherwise available to our constituencies. I'm hopeful that this letter helps explain the thought process behind the Plan, its current implementation stages, and our plan forward over the next several months as we seek expedited Supreme Court review that we hope and expect will be a final arbiter of SHIP's future.

We thank you for the attention you have given to this matter.

Sincerely,

Mike Humphreys
Acting Insurance Commissioner

[1] Some have suggested that guaranty associations would offer policyholders better options than the SHIP Plan provides. I do not believe this to be the case because they did not offer better options in the Penn Treaty liquidation.

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Attorneys for Plaintiffs

MARLENE CARIDE, As Commissioner of the New Jersey Department of Banking and Insurance, and THE NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE, Plaintiffs, v. JESSICA K. ALTMAN, as Rehabilitator of Senior Health Insurance Company of Pennsylvania and her successors in office, in their capacity as Rehabilitator of SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, PATRICK H. CANTILO, as Special Deputy Rehabilitator of Senior Health Insurance Company of Pennsylvania, MICHAEL HUMPHREYS, as Successor Rehabilitator of Senior Health Insurance Company of Pennsylvania, and SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, Defendants.	SUPERIOR COURT OF NEW JERSEY CHANCERY DIVISION GENERAL EQUITY PART MERCER COUNTY DOCKET NO. MER-C-_____22 Civil Action **CERTIFICATION OF ASSISTANT COMMISSIONER GALE SIMON IN SUPPORT OF ORDER TO SHOW CAUSE**

I, GALE SIMON, hereby certify as follows:

1. I am the Assistant Commissioner, Consumer Protection Services, for the New Jersey Department of Banking and Insurance ("DOBI").

2. I am fully familiar with the facts as set forth below, unless otherwise indicated.

3. I submit this Certification in support of the order to show cause filed on behalf of DOBI and Commissioner Marlene Caride ("Commissioner Caride") in the above-captioned matter.

A. **SHIP – Long-term Care Business**

4. SHIP is a life and health insurance company domiciled in the Commonwealth of Pennsylvania that administers a closed block of long-term care insurance policies. SHIP commenced business on July 5, 1887, as the Home Beneficial Society. By the 1980s, SHIP was known as American Travelers Insurance Company and was primarily writing long-term care insurance policies. It was then acquired by, and merged into, CIHC, Inc., which was a wholly-owned subsidiary of Conseco, Inc. Ex. 1. [1]

5. Upon information and belief, in 2002, Conseco filed a petition for bankruptcy protection, emerged from bankruptcy as CNO Financing Group. By 2003, CNO Financial Group's successor, Conseco Senior Health Insurance Company, ceased writing long-term care insurance policies. Conseco Senior Health Insurance Company has not sold any new policies since 2003. Ibid.

6. In October 2008, Conseco Senior Health Insurance Company changed its name to Senior Insurance Company of Pennsylvania (*i.e.* "SHIP"), and its ownership was transferred from CNO Financial Group to the newly-formed nonprofit Senior Health Care Oversight Trust, which

[1] Reference herein to numbered Exhibits (e.g., "Ex. 1"), are attached to the Troublefield Cert., which is filed simultaneously herewith.

has managed the run-off of SHIP's long-term care insurance business since 2008. At the time SHIP was transferred to the Senior Oversight Trust, SHIP had approximately 165,000 policyholders and approximately $3.2 billion in assets. Ibid.

7. SHIP was licensed in 46 states, including the State of New Jersey. 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. SHIP's policies are approximately thirteen percent (13%) home health care coverage, eighteen percent (18%) facility care coverage (inclusive of nursing homes and/or assisted living facilities), and sixty-nine percent (69%) comprehensive coverage. Upon information and belief, the average age of a SHIP long-term care policy holder is 89 and the average age of a policyholder claim is 89 years old. Ibid.

8. SHIP's financial condition deteriorated and required rehabilitation. By 2020, SHIP's assets were $1.4 billion and its liabilities were $2.6 billion, which created the Funding Gap.

B. SHIP's Rehabilitation Proceeding

9. On January 23, 2020, pursuant to Article V of the Insurance Department Act of 1921, Act of May 17, 1921, P.L. 789, as amended, ("Article V"), 40 P.S. § 221.1-221.63, and Rule 3774(c) of the Pennsylvania Rules of Appellate Procedure, Pa. R.A.P. 3774(c), the Rehabilitator filed an application for an order placing SHIP in rehabilitation. The application was filed in the Commonwealth Court of Pennsylvania and titled Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania v. Senior Health Insurance Company of Pennsylvania, Docket No. 1 SHP 2020, (the "Rehabilitation Proceeding"). See Certification of G. Glennon Troublefield, Esq., Dated March 8, 2022, Ex. 1.

10. Among other grounds, the Rehabilitator asserted that SHIP committed one or more acts which constitute grounds for rehabilitation as set forth in 40 P.S. § 221.14 and 221.15, in that

SHIP'S most recent annual statement demonstrated that it is statutorily insolvent as defined by 40 P.S. § 221.3 and that its most recent risk-based capital report ("RBC"), indicated that its total adjusted capital is substantially below its mandatory control level RBC, which triggered a "mandatory control level event" as that term is defined in 40 P.S. § 221.1A. SHIP's directors consented to being placed in rehabilitation. Ibid.

11. On January 29, 2020, the Commonwealth Court in the Rehabilitation Proceeding entered an Order of Rehabilitation and appointed the Rehabilitator. The Rehabilitator appointed Patrick H. Cantilo ("Cantilo") as Special Deputy Rehabilitator. Ex. 2.

12. On April 22, 2020, the Rehabilitator filed a proposed plan of rehabilitation and over the course of several months proposed two amended plans. Ex. 3.

13. On August 24, 2021, the Commonwealth Court in the Rehabilitation Proceeding entered a Memorandum Opinion and Order approving the Plan. Exs. 4 and 5.

14. On September 21, 2021, the State Insurance Regulators filed a direct appeal to the Supreme Court of Pennsylvania of the Commonwealth Court's order approving the Plan. The appeal is titled In re: Senior Health Insurance Company of Pennsylvania (In Rehabilitation) - Appeal of: The Superintendent of Insurance of the State of Maine, Commissioner of Insurance of the Commonwealth of Massachusetts, and Insurance Commissioner of the State of Washington, Docket No. 71 MAP 2021. Ex. 6.

15. On October 1, 2021, the State Insurance Regulators filed a motion in the Rehabilitation Proceeding to stay implementation of the Plan pending the appeal. Ex. 7. The motion was denied.

16. On November 8, 2021, the State Insurance Regulators filed a motion in the Supreme Court of Pennsylvania for a stay pending appeal of, inter alia the Commonwealth Court's order approving the Plan. Ex. 8.

17. On December 22, 2021, Amici Curiae filed a brief in support of the State Insurance Regulators' appeal of the Commonwealth Court's order approving the Plan. Ex. 9.

18. On January 31, 2022, the Pennsylvania Supreme Court denied the State Insurance Regulator's motion for a stay pending appeal. Ex. 10.

C. Commissioner Caride's Authority

19. The New Jersey Legislature has expressly authorized the commissioner of insurance to be the administrator and chief executive officer of DOBI. N.J.S.A. 17:1-2 and 17:1-15. Among other duties and responsibilities, the commissioner of insurance has the exclusive authority to "perform, exercise, and discharge the functions, powers, and duties of the department through these divisions established by law or as the commissioner deems necessary." N.J.S.A. 17:1-15(c).

20. The New Jersey Legislature has also expressly authorized the commissioner of insurance to "determine all matters of policy within the commissioner's jurisdiction" and to "institute or cause to be instituted the legal proceedings or process necessary to enforce properly and give effect to any of the commissioner's powers or duties; and perform such other functions as may be prescribed by law in this act or by another other law." N.J.S.A. 17:1-15(f) and (g).

21. As to long-term care insurance, the New Jersey Legislature enacted the New Jersey Long-Term Care Insurance Act, N.J.S.A. 17B:27E-1, et seq. (the "Act"). The stated purpose of the Act is to "promote the public interest, to promote the availability of long-term care insurance policies, to protect applications for long-term care insurance from unfair or deceptive sales or

enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage." N.J.S.A. 17B:27E-1.

22. Commissioner Caride is empowered to enforce the Act in New Jersey.

E. Required Filing and Approval

23. Under Section 10 of the Act, long-term care policies, certificates, riders, or endorsements are required be filed with Commissioner Caride for approval. Section 10 of the Act provides:

> Every long-term care insurance policy or contract, including any application, certificate, rider, or endorsement to be issued or delivered in this State shall be filed with the commissioner for prior approval as provided in this section.
>
> [(N.J.S.A. 17B:27E-10.)]

24. Similarly, Section 11 of the Act provides:

> An insurer providing long-term care insurance issued on an individual basis in this State shall file, for the commissioner's approval, its rates, rating schedule, and supporting documentation demonstrating that it is in compliance with the applicable loss ratio standards of this State. All filings of rates and rating schedules shall demonstrate that the benefits are reasonable in relation to the premium charged and that the rates are not excessive, inadequate, or unfairly discriminatory.
>
> [(N.J.S.A. 17B:27E-11).]

25. Under N.J.A.C. 11:4-34.17, premium and benefits under long-term care policies that are subject to the Act are required to be reviewed by Commissioner Caride:

> (a) This section applies to all rates for individual long-term care policies except those covered pursuant to N.J.A.C. 11:4–34.8 and 34.18.

> (b) Premiums and benefits under long-term care insurance policies whose rates are subject to this section shall meet the loss ratio requirements of N.J.A.C. 11:4–18.5.
>
> (c) Carriers shall include with each submission of new or revised rates for individual long-term care insurance an actuarial memorandum which includes anticipated loss ratio, methodology for calculating gross premiums, an explanation and documentation supporting the premium assumptions and the objective basis for any rate differentials. . . .
>
> [N.J.A.C. 11:4-34.17.]

F. SHIP's policies in New Jersey

26. As of January 12, 2021, SHIP has approximately 592 active long-term care policies in New Jersey. Of that group of policies, 17 policies were terminated, 523 policies are still in force, and approximately 49 policies are identified as being "NFO" – which means non-forfeiture option and no premium is due.

27. From approximately 2003 to 2019, either SHIP or one its successors and/or assigns submitted requests for rate increases for its long-term care policies issued to New Jersey policyholders. SHIP's requests were either approved, denied or withdrawn. On August 26, 2019, SHIP filed its last application for a rate increase with DOBI. On March 13, 2020, SHIP withdrew that request. See Exhibit A annexed hereto.

F. SHIP, The Rehabilitator and The Plan

28. SHIP is insolvent. Because SHIP is insolvent, a liquidation would inevitably result in the triggering of the state life and health insurance guaranty associations ("GA's") if SHIP cannot be successfully rehabilitated. Mandatory triggers of guaranty association benefits include an insurer being placed in liquidation with a finding of insolvency. Once "triggered", GA's commence the payment of policy benefits. The GA's generally provide for the continuation of insurance coverage provided by the failed insurer, up to the statutory maximum coverage amounts.

Unlike GA's in other states, New Jersey does not have a limit or "cap" on what benefits will be paid to health insurance policyholders, including long-term care insurance policyholders. The benefits recoverable from LHIGA are subject to the policy limits. In addition, under the LHIGA, each provider receiving payments from the guaranty association must agree to a 20% discount pursuant to N.J.S.A. 17B:32A-3(e) as follows:

> A provider of health care services, in order to receive payment directly from the association upon a claim of the provider against an insured, shall agree to forgive the insured of 20% of the obligation which would otherwise be paid by the insurer had it not been insolvent. The obligations of solvent insurers to pay all or part of the covered claim are not diminished by the forgiveness provided in this paragraph. The association is not bound by an assignment of benefits executed with respect to the coverage provided by the insolvent insurer. The association may aggregate all claims owed health care providers when negotiating direct payment of claims of all covered individuals.

29. After the GA's are triggered, the liquidator and the GA's work together to make loss adjustment on claims. The GA's becomes a creditor of the liquidation estate and can submit a claim to the liquidation estate for the loss adjustment expense. GA's also receive all ongoing policy premiums once triggered. See N.J.S.A. 17B:32A-7(g). The GA's use the premium and estate assets to fulfill, in part, their obligations to policyholders. The GA's supplement those amounts by making assessments on their member insurance companies.

30. In a liquidation, virtually all of SHIP's long-term care insurance policies would be covered by the state guaranty association system, subject to the individual state statutory conditions and limits. Thus, if SHIP is placed into liquidation because of its insolvency, the SHIP long-term care policies purchased by New Jersey residents would be covered by New Jersey's guaranty association. Because New Jersey does not have statutory limits on its guaranty association with respect to benefits paid to health insurance policyholders, New Jersey

policyholders would be in a better position if SHIP is liquidated than they would be if the plan of rehabilitation is implemented.

31. Rather than deem SHIP insolvent, the Rehabilitator has proposed the Plan as a means of curing SHIP's insolvency. Through the Plan, the burden of reducing the Funding Gap rests exclusively on SHIP's current policyholders who have not taken non-forfeiture options, i.e. the premium paying policyholders. The Plan does not involve any financial assistance from guaranty associations. This strategy reflects a policy judgment by the Rehabilitator not to spread the burden of SHIP's insolvency through the guaranty association system but rather to place the burden solely on the backs of elderly policyholders through higher premiums or reduced benefits. The Rehabilitator has chosen to burden the elderly policyholders even though they paid premiums for years, which contractually guaranty their benefits under their policy and are supposed to be protected by guaranty association support in the event of company insolvency.

32. The Rehabilitator knows or should have known that implementation of the Plan has left the elderly policyholders with no options. Because of their age, the elderly policyholders do not have the option to obtain a new long-term care policy from a different carrier. Their advanced age makes them uninsurable based on present industry standards associated with long-term care policy products offered in the life and health insurance market. As a result, the elderly policyholders have no choice but to either accept paying increased premiums or accept reduce benefits if they want to keep their long-term care policy from SHIP. That is patently unfair to the elderly policyholders. They faithfully paid their premiums over 20 years and, frankly, did nothing wrong. Now, at the time when they will need their contractually guaranteed long-term care policy, that have to accept less than what they paid for because of SHIP's insolvency. . Worst yet, even though the guaranty association system exists in each state, including New Jersey, to protect the

interests of the elderly policyholders, the Rehabilitator has chosen to ignore that option. The Rehabilitator would rather require the elderly policyholders to pay more money or receive less premiums under the Plan for the sole purpose of curing the Funding Gap. That is unfair to the elderly policyholders who have timely paid their premiums for over 20 years and unacceptable to DOBI.

33. The Plan is implemented in three phases. Phase One, which began immediately upon the Commonwealth Court's approval of the Plan, is the principal phase through which the Rehabilitator seeks to reduce or eliminate the Funding Gap. Ex. 5.

34. In Phase One, policyholders whose premiums are below the "If Knew" premium level will be required to elect among options to modify premiums and/or benefits. 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. Policyholders whose current premium (including the premium they would be paying but for a premium waiver) falls below the If Knew Premium rate for the policy's benefits are required to select among five options. Option 1 ("downgrade") reduces benefits to the level supported by current premium on an If Knew Premium basis. Option 2 is a "basic policy endorsement" with reduced benefits. Option 2(a) is an "enhanced basic policy" with somewhat smaller benefit reductions. Option 3 is "non-forfeiture option" or "NFO" with reduced benefits and no future premium. Option 4 is the current policy with premiums increased to If Knew levels.

35. Phase Two is intended to address the Funding Gap remaining after Phase One through further premium increases or benefit cuts largely based on Self-sustaining Premium. Phase Two will not affect policyholders who selected Options 2 or 3 in Phase One. Policyholders who choose Options 1 or 4 in Phase One face the possibility of additional substantial rate increases or

benefit reductions in Phase Two. The substance of Phase Two is otherwise unknown, as the Plan does not specify all remedial measures that may be applied to policyholders in Phase Two and provides for an "alternative premium structure." The alternative premium structure is a "placeholder," and the Rehabilitator does not know what it would be.

36. Phase Three will run-off the long-term care business in force.

37. Policyholder elections under the Plan will be permanent. If SHIP is placed in liquidation after the Plan is implemented, the policies to which the guaranty association coverage will apply will be those as modified under the Plan. The modified policies will also be the basis for distribution from the liquidation estate. Accordingly, the total policy obligations will be reduced by the elections made by policyholders during implementation of the Plan.

38. State insurance regulators other than Pennsylvania were given the option under the Plan to either 'opt in' or 'opt out'. By letter dated September 30, 2021, the Rehabilitator communicated this option to Commissioner Caride. See Ex. B attached hereto. A state which opts out is one that elects to make its own determinations as to modifications of premium rates. Id. If a state opts in, the state agrees that the Rehabilitator may make rate increases and benefit changes to that state's policyholders (pursuant to the Plan). If a state opts out, then the Rehabilitator will file a premium rate application for all policies below the If Knew premium. If a state denies the requested premium or approves only a lower premium, the Rehabilitator will then unilaterally adjust the benefits to the level that is determined to be appropriate.

39. Commissioner Caride disagreed that the Rehabilitator had the unilateral right or ability to alter benefits or premium rates for New Jersey policyholders without her approval. By letter dated November 9, 2021, Commissioner Caride rejected the options presented to her by the

Rehabilitator in the September 20, 2021 letter. See Ex. C annexed hereto. In her letter, Commissioner Caride stated:

> "[G]iven that rate regulation has long been reserved to the insurance commissioners of each state, the purpose of this letter is to notify you that (a) the Department will not respond to the Notice, and (b) the Department does not believe the Rehabilitator has authority to impose rate increases on our policyholders without the Department's approval." Id.

40. Commissioner Caride further stated to the Rehabilitator that DOBI objects to the Plan, as expressed by State Insurance Regulators. Ibid.

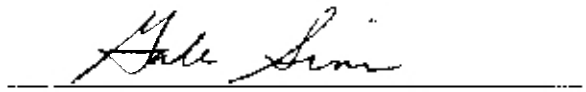
41. In late January 2022, the Rehabilitator mailed "Coverage Election Packages" to New Jersey policyholders which contained the options referred to in the Plan.

42. On February 2, 2022, the Rehabilitation Court approved SHIP's use of nationwide-premium rates including New Jersey. The "Coverage Election Packages" do not provide legally sufficient notice to New Jersey policyholders of SHIP's proposed rate increases, which have not been approved by Commissioner Caride. If a New Jersey policyholder does not make an option election by March 15, 2022, SHIP will on its own elect the basic policy coverage option for the non-responding policyholder, resulting in a significant benefit reduction under a New Jersey insurance policy. Ex. 11.

43. Neither the laws of Pennsylvania, nor proceedings under the laws, nor the full faith and credit clause of the United States Constitution supersede or nullify the Constitution and laws of New Jersey. Nor do they command that New Jersey, DOBI or Commissioner Caride implement any rehabilitation plan which violates or contravenes New Jersey law.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Dated: March 9, 2022



GALE SIMON

EXHIBIT A

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

New Jersey Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625

August 21, 2019

NAIC No: 76325 FEIN No: 29-0704970
Rate Revision Filing on Long Term Care Insurance

To Whom It May Concern:

The purpose of this letter is to introduce offers that Senior Health Insurance Company of Pennsylvania (SHIP) is filing in your state to assist in maintaining the solvency of SHIP so that future policyholder obligations can be met.

The enclosed actuarial memorandum provides details of a request for approval of rate actions that would require policyholders with certain benefits to choose the following options, depending on their policy:

For policyholders that have purchased individual policies with a 5% compound lifetime inflation benefit:

1. A 40% reduction in premium in exchange for a discontinuance of future inflationary daily benefit increases,

2. A Non-forfeiture Option ("NFO") under which the lifetime maximum benefit would be reduced to an amount equal to the sum of all premiums paid less all claims that have been paid, or

3. A 145% premium rate increase.

For policyholders that have purchased individual Limited Benefit policies with a 5% compound lifetime inflation benefit:

1. A 40% reduction in premium in exchange for a discontinuance of future inflationary daily benefit increases,

2. A Non-forfeiture Option ("NFO") under which the lifetime maximum benefit would be reduced to an amount equal to the sum of all premiums paid less all claims that have been paid, or

3. A 96% premium rate increase.

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

For policyholders that have purchased individual policies with zero-day elimination periods:

1. A 30% reduction in premium in exchange for an increase in elimination period from 0 days to 110 days.

2. A Non-Forfeiture Option ("NFO") under which the lifetime maximum benefit would be reduced to an amount equal to the sum of all premiums paid less all claims that have been paid, or

3. A 30% premium rate increase to maintain the current elimination period of 0 days.

For policyholders that have purchased Individual policies with non-zero day elimination periods and without 5% compound lifetime inflation benefit, the offer below would apply:

1. A 25% rate increase to maintain the current elimination period.

2. A Non-Forfeiture Option ("NFO") under which the lifetime maximum benefit would be reduced to an amount equal to the sum of all premiums paid less all claims that have been paid.

3. Policyholders may choose to reduce certain, available benefits in their policy, with a corresponding reduction of their premium. Policyholders will have the option of changing the following features of coverage as they are available: daily benefit amount, elimination period, benefit period, and inflation protection.

The actuarial memorandum attached under Supporting Documentation provides details of a request for approval for each of these rate actions.

We have also attached for your review and approval; the policy amendment forms that will be used with the rate offers referenced above. These are new forms and do not replace any previously approved forms currently on file with your Division. These amendments will be used with closed blocks of business and with policies previously approved/filed with your Division. This amendment submission does not contain any provisions, conditions, or concepts that are uncommon, unusual, or possibly controversial from the standpoint of normal company or industry standards. The forms comply with all laws, rules, bulletins and published guidelines applicable to Long Term Care amendments to policy forms.

The rates will be effective upon approval and will apply to all existing policyholders with the benefits listed above. The rate increases will apply to in-force business only as SHIP no longer markets these policy forms.

The development of these offers involved the study of many combinations of benefit downgrades, rate increases, and rate decreases. The offers proposed were determined to be the set of options most effective in balancing policyholder premium and benefit interests with SHIP's long-term solvency interests. Because inflated daily benefit amounts exceed the daily cost of care on most of the affected policies, an election of the premium reduction/downgrade option is expected to have a minimal impact on policyholders' ability to meet care needs.

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

Reasons for Downgrade Action

While the long-term care business is complex with many factors affecting results, two key factors have led to the current need for an offer: premiums have been less than originally projected and morbidity has been greater than projected.

• Premiums have been lower because (i) on historical rate filings, approved rates have been lower than filed rates, (ii) planned premium rate increase filings were discontinued prior to a manifestation of increased morbidity, and (iii) NFOs were elected by a significant number of policyholders on historical rate actions.

• Morbidity has been greater than projected because of anti-selection arising from (i) imposition of rate increases, (ii) NFO elections, and (iii) indemnity daily benefit levels on certain policy forms that have inflated to amounts in excess of the daily cost of care.

We trust that you will find our filing to be in order and hope that you will grant your Division's approval to this submission.

Sincerely,

8/31/19

Duane L. Anderson
Chief Technology Officer
danderson@shipltc.com

EXHIBIT B

SHIP
SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
IN REHABILITATION

September 30, 2021

Via U.S. Mail and Email

Commissioner Marlene Caride
State of New Jersey
Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

Opt-Out Election Notice for Senior Health Insurance Company of Pennsylvania (In Rehabilitation) - Deadline: November 15, 2021

Dear Commissioner Caride:

This communication provides important information on a decision available to each state's Commissioner (or chief insurance regulator) affecting holders of long-term care insurance policies issued in their states by Senior Health Insurance Company of Pennsylvania ("SHIP") or its predecessors.

Background

As you are already aware, SHIP was placed in statutory rehabilitation on January 29, 2020, at the request of the Pennsylvania Insurance Commissioner, Jessica K. Altman (the "Commissioner"). On that day she appointed me Special Deputy Rehabilitator of SHIP. On April 22, 2020, the Commissioner as Rehabilitator filed a proposed Rehabilitation Plan with the Commonwealth Court of Pennsylvania ("Court"). Subsequently, on October 21, 2020, the Rehabilitator filed a proposed Amended Rehabilitation Plan and on May 3, 2021, she filed a proposed Second Amended Rehabilitation Plan ("Second Amended Plan"). A hearing on the Second Amended Plan was conducted by the Court the week of May 17, 2021. On August 25, 2021, the Court filed her Memorandum Opinion and Order approving the Plan. In accordance with its Order, an Approved Rehabilitation Plan (the "Approved

Plan" or "Plan") was filed with the Court on September 24, 2021. The Order approving the Plan and the Approved Plan can be found on the SHIP website ("Website"), www.shipltc.com/court-documents.

Issue-State Rate Approvals Introduction

The Approved Plan contains a section providing a rate approval alternative for states that object to the Rehabilitator and the Court modifying premium rates for SHIP long-term care insurance policies issued in those states, and which elect to make their own determinations as to such rate modification themselves. A state electing this alternative will be considered an Opt-out State. The process and additional information for the issue-state rate approval is provided in more detail in the Approved Plan beginning on page 108. **While this notice summarizes some aspects of that provision, the Plan and especially that section, must be read in its entirety to understand its requirements and consequences. In addition, we provide after this letter some frequently asked questions and their answers.**

The Opt-out deadline is November 15, 2021.

As described in that section of the Plan, the Rehabilitator has undertaken the development of a model that allows her to address each policy individually in a seriatim fashion. Most, if not all, material policyholder calculations under the Plan (including premium rate and benefit adjustments) are performed individually for each long-term care policy. This is a key component of the Plan's mechanism for eliminating discriminatory or inequitable premium rates and policyholder subsidization prospectively. In determining whether or not to "opt out" a state should carefully consider its ability to address the circumstances of each policy individually, as does the Rehabilitator under the Plan. As explained in the Plan, setting rates in cohorts or groups could work to the disadvantage of some policyholders.

Process to Opt-Out of the Plan

Every state in which there are long-term care insurance policies in force issued by SHIP or its predecessors has the opportunity to opt out of the rate approval provision of the Plan. States may, but are not required to, affirmatively opt into the Plan. States that wish to opt out of the Plan must make an Opt-out Election as described below.

The Opt-out Election must be signed and sworn by the Commissioner, Director, Superintendent, or other senior insurance regulatory official of the state. The communication must contain the following statement, also found on the attached Opt-out Form:

> *On behalf of the State [or Commonwealth] of [X], and in the exercise of my authority as [X's] senior insurance regulatory official I hereby elect to withdraw from the premium rate increase approval provisions of the Rehabilitation Plan for Senior Health Insurance Company of Pennsylvania (SHIP) all of the in force long-term care insurance policies currently held by SHIP and first issued by SHIP or its predecessors in [X]. I have read the Plan and understand the consequences of this election.*

As noted, November 15, 2021, is the Opt-out Deadline. All original signed and sworn Opt-out Elections must be received by the Rehabilitator at the following address by the Opt-out Deadline.

> Senior Health Insurance Company of Pennsylvania (In Rehabilitation)
> Attn: Administrator of State Opt-out Elections
> 550 Congressional Boulevard, Suite 200, Carmel, IN 46032

Alternatively, the Opt-out Election will be effective if an electronic form of the Opt-out Election is received by the Rehabilitator via email at rehabilitation@shipltc.com (or via facsimile at (317) 566-7588) on or before the Opt-out Deadline. The physical original signed and sworn Opt-out Election must be received by the Rehabilitator no later than ten days after the Opt-out Deadline, i.e., by November 25, 2021. **Every state that does not communicate to the Rehabilitator a proper election to opt out by the Opt-out Deadline will be deemed to have opted into the Plan. The Rehabilitator will not assert that submitting an Opt-out Election in accordance with the Plan constitutes an appearance in the Rehabilitation proceeding or submission to the Court's jurisdiction.**

The Rehabilitator will acknowledge every Opt-out Election in writing. An Opt-out Election sent in advance of the Opt-out Deadline may be canceled by the Opt-out State in a communication sent in the same manner as the Opt-out Election, received by the Rehabilitator no later than the Opt-out Deadline. It must contain the following language:

> *On behalf of State [or Commonwealth] of [X], and in the exercise of my authority as [X]'s senior insurance regulatory official, having first elected by communication dated [*Opt-out Election date*] to withdraw from the premium rate increase approval provisions of the Rehabilitation Plan for Senior Health Insurance Company of Pennsylvania (SHIP) as to all of the in force long-term care insurance policies currently held by SHIP and first issued by SHIP or its predecessors in [X], I hereby revoke the Opt-out Election. Accordingly, I request*

that all of the SHIP long-term care insurance policies issued in [X] be included in the premium rate increase approval provisions of SHIP's Rehabilitation Plan. I have read the Plan and understand the consequences of this revocation.

After the Opt-out Deadline, Opt-out Elections may only be revoked with the Rehabilitator's written consent. Generally, such consent will be provided unless the revocation will have an adverse effect on the Plan or opt-in policyholders.

After receiving an Opt-out Election, the Rehabilitator will file a premium rate application in the Opt-out state for all of the Opt-out Policies on an if knew premium basis (defined and explained in the Approved Plan). However, no rate increases will be sought for policyholders on premium waiver or, in Phase One, for those whose premium is at or above if knew premium.

If a state submits (and the Rehabilitator acknowledges) an Opt-out Election, and that state subsequently and timely approves the rate increases requested by the Rehabilitator in full for all Opt-out Policies, the state will be treated as if it had not opted out of the Plan. It will be deemed to be an Opt-in State, and its policyholders will be included in the Plan just as those whose policies were issued in states that did not opt out (Opt-in States).

Policyholder Data Available to Assist in Making Your Decision

A file of policyholder data has been prepared to assist in your decision about participation in the Plan's premium rate modification provisions. This policyholder file provides liabilities, premium, and Rehabilitation Plan coverage options information for individual policies in each state. Access to this file is available on the SHIP Rehabilitation Plan secure data site.

Please note that this policyholder file contains data as of July 31, 2021. This is the data the Rehabilitator will use in implementing the Plan. If you previously requested and reviewed policyholder files for your state as of June 30, 2021, or an earlier date, the July 31, 2021, policyholder file is intended to replace those earlier files.

Access to the SHIP Rehabilitation Plan Secure Data Site

In February 2021, information was provided to you regarding the creation of a SHIP Rehabilitation Plan secure data site. If you do not already have access to this site, please send an email requesting access to rehabilitation@shipltc.com and access will be granted. As the chief insurance regulator in your state,

you are authorized to have access to the secure data site which is being provided as a regulator-to-regulator confidential communication under the auspices of applicable NAIC confidentiality provisions. Please do not hesitate to contact us if you have any questions about these confidentiality provisions or about obtaining access to the secure data site.

Updated Information

SHIP's website will continue to be updated regularly with Court documents and related rehabilitation materials. You are encouraged to visit the website regularly for updated information.

The Rehabilitator, the Court, and other interested parties are aware that the effect of this Amended Plan may be substantial for some policyholders and creditors. Every reasonable effort has been made to design a plan that is consistent with the best interests of policyholders, consistent with applicable law, and in compliance with the orders of the Court.

We strongly encourage you to contact us if you have any questions about these matters. You can reach me at phcantilo@cb-firm.com and Robert L. Robinson, SHIP's chief rehabilitation officer, at rrobinson@shipltc.com and (609) 670-2367.

Thank you for your patience and cooperation during the rehabilitation process.

Sincerely yours,

Patrick H. Cantilo

Patrick H. Cantilo
Special Deputy Rehabilitator

Enclosures

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA IN REHABILITATION

Frequently Asked Questions about Issue-State Rate Approval Alternative ("Opt-Out Election")

Q1. What does opting out of the rate approval provisions of the Approved Plan mean for my policyholders?

If a state opts-out of the rate setting provisions of the Approved Plan, policyholders with SHIP long-term care insurance policies issued in that state will not be eligible to participate in the rate approval and certain other provisions of the Plan. Premium rates will be set by the Opt-out state and the Rehabilitator will adjust benefits accordingly to avoid requiring other policyholders to subsidize Opt-out policyholders. In other respects, those policies will be administered under the Plan. Opt-out policyholders will not have the same options as opt-in policyholders. In particular, they will not be able to select the basic policy endorsement, enhanced basic policy endorsement, or enhanced NFO. As explained in the Plan, under some circumstances Opt-out policyholders may end up paying a higher premium than they would have if the state had not opted out. Note also that, if after opting out a state approves in full the Rehabilitator's requested premium rate increases, the policies issued in that state will be treated as if the state had never opted out. See Q11, below.

Q2. How does a state opt-out of the Plan?

To opt out, the chief insurance regulator of a state must make an Opt-out Election using the attached form entitled "State Opt-out Election Form" or its own form containing the requisite provision, which will be signed and sworn by the chief insurance regulatory official of the state. The form must be mailed to the following address:

Senior Health Insurance Company of Pennsylvania (In Rehabilitation)
Attn: Administrator of State Opt-out Elections
550 Congressional Boulevard, Suite 200, Carmel, IN 46032

The form must be received by the Rehabilitator at the above address by the Opt-out Deadline, which is November 15, 2021. More detailed instructions can be found in the cover letter of this Notice and on pages 109 - 110 of the Approved Plan.

Q3. Will submitting an Opt-out Election subject a state to the jurisdiction of the rehabilitation court?

While the Rehabilitator obviously cannot predict what the Court will decide in cases that have not yet arisen, she hereby assures all the commissioners and chief insurance regulators that neither the Pennsylvania Insurance Commissioner, nor the Rehabilitator, will take the position with the Court that submitting an Opt-Out Election subjects a state to the jurisdiction of the Rehabilitation Court.

Q4. What happens when a state opts out of the Plan?

An Opt-out Election will be effective as to all the SHIP LTC policies issued in the Opt-out State. A state may not opt out as to only some of SHIP's policies issued in that state. The Rehabilitator will file a premium rate modification application in the Opt-out State and benefits will be adjusted depending on that state's decision in response to that application.

Additional details for the Premium Rate Increase Application begin on page 111 of the Approved Plan, including details of the treatment of opt-out policies in Phase One and Phase Two.

Q5. On what basis will the Rehabilitator file a rate modification application for Opt-out Policies?

The Rehabilitator's application will be on an if knew premium basis and submitted seriatim – policy-by-policy.

Q6. What will the Rehabilitator do if an Opt-out State rejects part or all of the requested premium rate modifications?

In that case, the Rehabilitator will adjust the affected premium rates to the amount approved by the Opt-out State. Depending on the option elected by the affected policyholder, benefits under the policy may be reduced to the amount that can be funded by the approved rate on an if knew basis. This is necessary to avoid forcing other policyholders to subsidize the Opt-out Policies prospectively. This matter is discussed in more detail in the Plan.

Q7. What will happen if an Opt-out State makes a rate decision for Opt-out Policies in groups rather than on a policy-by-policy basis?

In that case, the Rehabilitator will apply the new rates to the affected policies individually. Note that the result may be that some policyholders will get a larger rate increase than sought by the Rehabilitator without getting any additional benefits. For other policyholders this may result in an unintended mandatory downgrade. By way of illustration, assume that the Rehabilitator seeks a rate increase of 5% for Policyholder 1, 10% for Policyholder 2, and 15% for Policyholder 3. If the state approves a flat 10% increase for all three, Policyholder 1 will end up paying 5% more than he or she would have if the state had opted in and Policyholder 3 will face a 5% benefit reduction he or she would not have if the state had approved the 15% requested increase.

Q8. Will Opt-out Policies have the same options as Opt-in Policies?

No. While the Plan must be read in detail to understand this, in general three options available to Opt-in Policyholders will not be available to Opt-out Policyholders: (1) the basic policy endorsement, (2) the enhanced basic policy endorsement, and (3) the enhanced non-forfeiture option. These are described on pages 24, 48, 49 and 50 of the Plan. As noted above, if the state approves the Rehabilitator's rate increase in full after opting out, the policyholders will be treated as if the state had not opted out and will have all the options available under the Plan.

Q9. How will states opting out affect the Plan?

It is difficult to predict future results but, in general, the Rehabilitator believes that states opting out is likely to help reduce SHIP's deficit more that states opting in. This is because it is anticipated that Opt-out States will approve lower rate increases than the Rehabilitator seeks. This will result in additional downgrades which reduce the deficit faster than additional premium. However, the Rehabilitator DOES NOT recommend that states opt out because that is generally expected to be disadvantageous to affected policyholders.

Q10. What policies will be affected by a state's opt-out decision?

The Opt-out Election only affects policies **issued** in the Opt-out State, not those **residing** in that state. On average, 15% of the policyholders reside in states other than the issue state. For some states, this percentage is as high as 40%. That means that the Opt-out State's rate decision will affect a significant number of policyholders residing in other states. Conversely, on average that rate decision will not affect 15% of SHIP's policyholders in the Opt-out State (because they were issued in other states), although this percentage is as high as 57% in some states.

Q11. What happens if a state that opts out of the Plan subsequently and timely approves the requested rate increases in full for all Opt-out Policies?

If a state submits and the Rehabilitator acknowledges an Opt-Out Election, then subsequently and timely approves the requested rate increases in full for all Opt-out Policies, it will be treated as if it had not opted out of the Plan. It will be deemed to be an Opt-in State, and for functional purposes its policyholders will be included in the Plan just as those whose policies were issued in states that did not opt out (Opt-in States). Additional information about the Premium Rate Increase Application following the receipt of a valid Opt-out Election can be found in the Approved Plan.

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)

This form must be received by the Opt-out Deadline – November 15, 2021

STATE OPT-OUT ELECTION FORM

Senior Health Insurance Company of Pennsylvania (In Rehabilitation)

If you desire to opt-out of the rate modification provisions of the Approved Plan, please fill in the blanks with the name of your state in the paragraph below, sign your name, and include your title and date in the blanks below the paragraph. The form must be notarized and received by the deadline.

> *On behalf of the State (or Commonwealth) of _____, and in the exercise of my authority as [_____'s] senior insurance regulatory official I hereby elect to withdraw from the premium rate increase approval provisions of the Rehabilitation Plan for Senior Health Insurance Company of Pennsylvania (SHIP) all of the in force long-term care insurance policies currently held by SHIP and first issued by SHIP or its predecessors in [_____]. I have read the Plan and understand the consequences of this election.*

Printed Name:_____

Signature:_____

Title:_____

Date:_____

State of _____

County of _____

BEFORE ME appeared on the ___day of _____, 2021 _____, known to me to be the person who signed the foregoing form and upon [his/her] oath stated that [he/she] executed the same for the purposes therein stated.

_____

Notary public in and for _____ [NOTARY SEAL]

My commission expires _____

This form should be returned to:

Senior Health Insurance Company of Pennsylvania (In Rehabilitation)
Attn: Administrator of State Opt-out Elections
550 Congressional Boulevard, Suite 200, Carmel, IN 46032

EXHIBIT C

State of New Jersey
DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF THE COMMISSIONER
PO BOX 325
TRENTON, NJ 08625-0325
TEL (609) 292-7272

PHIL MURPHY
Governor

SHEILA OLIVER
Lt. Governor

MARLENE CARIDE
Commissioner

November 9, 2021

Commissioner Jessica Altman
Statutory Rehabilitator, Senior Health Insurance Company of Pennsylvania
Pennsylvania Insurance Department
1341 Strawberry Square
Harrisburg, PA 17120

Senior Health Insurance Company of Pennsylvania (in Rehabilitation)
Attn: Mr. Patrick H. Cantilo
Special Deputy Rehabilitator
c/o Administrator of SHIP Opt-out Elections
550 Congressional Boulevard
Suite 200
Carmel, In 46032

RE: Senior Health Insurance Company of Pennsylvania (SHIP)
Second Amended Rehabilitation Plan (Plan)
Opt-Out Election Notice

Dear Commissioner Altman and Mr. Cantilo:

This letter is in response to your letter of September 30, sent to the New Jersey Department of Banking and Insurance (the Department) regarding the "Opt-Out Election Notice" (Notice) under the SHIP Plan.

The Department objects to the Plan for the reasons set forth by the Maine Superintendent of Insurance, the Massachusetts Commissioner of Insurance, and the Washington Insurance Commissioner at the trial held on the approval of the Plan and their pending appeal.

Given that rate regulation has long been reserved to the insurance commissioners of each state, the purpose of this letter is to notify you that (a) the Department will not respond to the Notice, and (b) the Department does not believe the Rehabilitator has

RE: Senior Health Insurance Company of Pennsylvania (SHIP)
Second Amended Rehabilitation Plan (Plan)
Opt-Out Election Notice

authority to impose rate increases on our policyholders without the Department's approval. The Department reserves all of its rights in this regard.

Respectfully,

Marlene Caride, Commissioner
New Jersey Department of Banking and Insurance
Via electronic mail (Rehabilitation@shiplte.com and phcantilo@cb-firm.com)
and regular mail

EXHIBIT 2

MERCER COUNTY COURTHOUSE
CIVIL CASE MANAGMENT OFFICE
175 SOUTH BROAD ST P O BOX 8068
TRENTON NJ 08650-0068

TRACK ASSIGNMENT NOTICE

COURT TELEPHONE NO. (609) 571-4200
COURT HOURS 8:30 AM - 4:30 PM

DATE: MARCH 09, 2022
RE: MARLENE CARIDE, COMM . DOBI VS COMM. JESSICA K.
DOCKET: MER L -000448 22

THE ABOVE CASE HAS BEEN ASSIGNED TO: TRACK 1.

DISCOVERY IS 150 DAYS AND RUNS FROM THE FIRST ANSWER OR 90 DAYS FROM SERVICE ON THE FIRST DEFENDANT, WHICHEVER COMES FIRST.

THE PRETRIAL JUDGE ASSIGNED IS: HON R BRIAN MCLAUGHLIN

IF YOU HAVE ANY QUESTIONS, CONTACT TEAM 008 AT: (609) 571-4200 EXT 74314.

IF YOU BELIEVE THAT THE TRACK IS INAPPROPRIATE YOU MUST FILE A CERTIFICATION OF GOOD CAUSE WITHIN 30 DAYS OF THE FILING OF YOUR PLEADING.
PLAINTIFF MUST SERVE COPIES OF THIS FORM ON ALL OTHER PARTIES IN ACCORDANCE WITH R.4:5A-2.

ATTENTION:
ATT: SEAN M. KILEY
CARELLA BYRNE CECCHI OLSTEIN B
5 BECKER FARM RD
ROSELAND NJ 07068-1738

ECOURTS

JS 44 (Rev. 04/21)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

(see attachment)

(b) County of Residence of First Listed Plaintiff Mercer County, NJ
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*

(see attachment)

DEFENDANTS

(see attachment)

County of Residence of First Listed Defendant Dauphin County, PA
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

Michael J. Broadbent, Cozen O'Connor, 1650 Market Street, Suite 2800, Phila, PA 19103. 215-665-4732

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☐ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☒ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*

(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☒ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☒ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT
- ☒ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

INTELLECTUAL PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent - Abbreviated New Drug Application
- ☐ 840 Trademark
- ☐ 880 Defend Trade Secrets Act of 2016

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit (15 USC 1681 or 1692)
- ☐ 485 Telephone Consumer Protection Act
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

- ☐ 1 Original Proceeding
- ☒ 2 Removed from State Court
- ☐ 3 Remanded from Appellate Court
- ☐ 4 Reinstated or Reopened
- ☐ 5 Transferred from Another District *(specify)*
- ☐ 6 Multidistrict Litigation - Transfer
- ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
Section 1332 and Sections 1441 and 1446

Brief description of cause:
Plaintiff seeks injunction regarding Def. Senior Health Ins. Co.'s rehabilitation plan

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:

JURY DEMAND: ☐ Yes ☒ No

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE _____ DOCKET NUMBER _____

DATE
03/11/2022

SIGNATURE OF ATTORNEY OF RECORD
/s/Michael J. Broadbent

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

Michael J. Broadbent (No. 043992010)
COZEN O'CONNOR
1650 Market Street, Suite 2800
Philadelphia, PA 19103
Telephone: (215) 665-4732
Facsimile: (215) 701-2288
Email: mbroadbent@cozen.com
Attorneys for Defendants

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

MARLENE CARIDE, as Commissioner of the New Jersey Department of Banking and Insurance, and THE NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE, Plaintiffs, vs. JESSICA K. ALTMAN, as Rehabilitator of Senior Health Insurance Company of Pennsylvania and her successors in office, in their capacity as Rehabilitator of Senior Health Insurance Company of Pennsylvania, PATRICK H. CANTILO, as Special Deputy Rehabilitator of Senior Health Insurance Company of Pennsylvania, MICHAEL HUMPHREYS, as Successor Rehabilitator of Senior Health Insurance Company of Pennsylvania, and SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, Defendants.	Case No. _____ [formerly Superior Court of New Jersey, Law Division, Civil Part, Mercer County, Docket No. MER-L-000448-22]

ATTACHMENT TO CIVIL COVER SHEET

I. (a) PLAINTIFFS

Marlene Caride, as Commissioner of the New Jersey Department of Banking and Insurance
20 W State Street, Trenton, NJ 08625

The New Jersey Department of Banking and Insurance
20 W State Street, Trenton, NJ 08625

I. (c) PLAINTIFFS Attorneys *(Firm name, Address, and Telephone Number)*

CARELLA, BYRNE, CECCHI, OLSTEIN, BRODY & AGNELLO, P.C.
G. Glennon Troublefield
Brian H. Fenlon
Sean M. Kiley
5 Becker Farm Road
Roseland, New Jersey 07068
(973) 994-1700
Counsel for all Plaintiffs

I. (a) DEFENDANTS

Defendant Michael Humphreys, Acting Insurance Commissioner and Rehabilitator of Senior Health Insurance Company of Pennsylvania, *and* Defendant Jessica K. Altman, former Insurance Commissioner of Pennsylvania and former Rehabilitator of Senior Health Insurance Company of Pennsylvania
1326 Strawberry Square
Harrisburg, PA 17120

Patrick Cantilo, as Special Deputy Rehabilitator of Senior Health Insurance Company of Pennsylvania
Cantilo & Bennett, L.L.P.
11401 Century Oaks Terrace #300
Austin, TX 78758

Senior Health Insurance Company of Pennsylvania in Rehabilitation
Attention: Rehabilitation Administrator
550 Congressional Boulevard, Suite 200
Carmel, IN 46032