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71 MAP 2021

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

On Direct Appeal from Orders of the Commonwealth Court
Entered August 24, 2021, May 21, 2021, and August 25, 2021, at 1 SHP 2020

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INTRODUCTION

This appeal arises out of the rehabilitation of Senior Health Insurance Company of Pennsylvania ("SHIP"). SHIP issued long-term care ("LTC") insurance policies, which provide coverage to individuals when they become unable to perform certain acts of daily living.

SHIP is insolvent. The Pennsylvania Insurance Department commenced rehabilitation proceedings for SHIP in January 2020, and the Insurance Commissioner was appointed rehabilitator. Op. 5. In August 2020, the Commonwealth Court entered an order approving the Second Amended Plan of Rehabilitation (the "Plan") for SHIP over the objection of the Appellants, who are the insurance regulators of Massachusetts, Maine, and Washington (the "Intervening Regulators"). R.203a, 284a. The undersigned are health insurance companies that supported confirmation of the Plan (the "Health Insurers"). R.224a.

The Intervening Regulators and a larger group of insurance regulators, as amici curiae ("Amici"), seek to overturn the Commonwealth Court's order approving the Plan and force SHIP into liquidation. They assign seven errors in the Commonwealth Court's decision to approve the Plan, which they characterize as errors of law. But these purported errors are principally disagreements over public policy, and as this Court held in *Foster v. Mut. Fire, Marine & Inland Ins. Co*., 614 A.2d 1086 (Pa. 1992) ("*Mutual Fire II*"):

> [I]t is not the function of the courts to reassess the determinations of fact and public policy made by the Rehabilitator. Rather, the involvement of the judicial process is limited to the safeguarding of the plan from any potential abuse of the Rehabilitator's discretion.

614 A.2d at 1091. Accordingly, this Court should affirm the Commonwealth Court's decision approving the Plan.

STATEMENT OF THE SCOPE AND STANDARD OF REVIEW

Pennsylvania law requires "great deference in favor of the Insurance Commissioner," and so the courts employ a "narrow scope of review" under an abuse-of-discretion standard. *Mutual Fire II*, 614 A.2d at 1093. Indeed, review of the Plan is doubly deferential: the Commonwealth Court itself must greatly defer to the rehabilitator's expertise, and this Court's review "must be equally specific and limited in order to remain consistent with the principles . . . that restrict judicial discretion to those instances where the agency has abused its discretion." *Id*. at 1092. The Intervening Regulators' attempt to procure plenary review contradicts this guidance and finds no support in Pennsylvania decisions involving insurer rehabilitations or liquidations.

Employing a "three part standard," the Court will:

> (1) examin[e] … whether the Commonwealth Court exceeded its statutory authority to approve, disapprove or modify the rehabilitation plan; (2) determine whether the Commonwealth Court substituted any of its own beliefs into the rehabilitation process; and (3) if so, whether the exercise of such discretion was for the prevention of further abuse by the Rehabilitator, and not to change the substance of the plan.

Id. "[T]his limited scope of review is especially appropriate in a highly specialized industry such as insurance, where the skill, judgment and expertise of the Insurance Commissioner are statutorily recognized and deferred to, resulting in a broad scope of discretionary powers." *Id*. In this case, the Commonwealth Court did not exercise its discretion in modifying any provisions of the Plan, and so the scope of review is limited to whether the Commonwealth Court abused its discretion in reviewing the rehabilitator's exercise of discretion.

The Intervening Regulators acknowledge that this Court reviews "the Commonwealth Court's approval of a plan of rehabilitation under 40 P.S. § 221.16 for abuse of discretion" (Br. 2), yet in the next breath, contend that the "questions presented regarding the Plan are questions of law," so "the standard of review is *de novo* and the scope of review is plenary." Br. 3. This is incorrect. In the rehabilitation context, this Court has expressly rejected the "traditional appellate review" standard that would "[o]rdinarily" apply in "determining questions of law and whether sufficient competent evidence exists to support the exercise of discretion engaged below." *Mutual Fire II*, 614 A.2d at 1092 (citation omitted). Unsurprisingly, none of the cases the Intervening Regulators cite in support of this supposed de novo standard involve court approval of an insurance rehabilitation plan. *See* Br. 3–4.

The proper standard of review—an abuse-of-discretion standard that greatly defers to agency expertise—has long been "established as an elementary principle of law" in this jurisdiction. *Mutual Fire II*, 614 A.2d at 1092 (quoting *Norfolk & Western Railway Co. v. Pennsylvania Public Utility Comm.*, 413 A.2d 1037, 1047 (Pa. 1980) (internal citation omitted)); *In re Penn Treaty Network Am. Ins. Co.*, 119 A.3d 313, 320–22 (Pa. 2015) (rejecting trial court's use of de novo review and reaffirming *Mutual Fire II*'s "narrow scope of review" and "great deference in favor of the Insurance Commissioner").[1]

COUNTER-STATEMENT OF THE CASE

I. Statutory background

Statutory law across many jurisdictions has long provided for "the rehabilitation of insurance companies that are experiencing financial difficulties." 1 *Couch on Insurance* 3d § 5:18. In Pennsylvania, rehabilitation and liquidation of insolvent insurers is governed by Article V of The Insurance Department Act of 1921 ("Article V"), Act of May 17, 1921, P.L. 789, *added by* Section 2 of the Act of December 14, 1977, P.L. 280, *as amended*, 40 P.S. §§ 221.1–221.63. Article V's purpose is to further "the protection of the interests of insureds, creditors, and the public generally." 40 P.S. § 221.1(c).

[1] The amici acknowledge that an abuse-of-discretion standard applies even while contending that Commonwealth Court "erred as a matter of law in approving the plan." Amici Br. 11 (capitalization altered).

Rehabilitation may be warranted on a number of grounds, including if "[t]he insurer is insolvent, or is in such condition that the further transaction of business would be hazardous, financially, to its policyholders, creditors or the public." 40 P.S. § 221.14. If there are grounds for rehabilitation, the Insurance Commissioner will petition the Commonwealth Court for an order authorizing it to rehabilitate a struggling insurer. 40 P.S. §§ 221.3, 221.15(a). As rehabilitator, the Insurance Commissioner "may appoint a special deputy" and "may take such action as [s]he deems necessary or expedient to correct the" conditions that necessitated the rehabilitation. 40 P.S. § 221.16(a), (b). In doing so, "[t]he rehabilitator may prepare a plan for the reorganization . . . or other transformation of the insurer." 40 P.S. § 221.16(d).

The rehabilitator has "broad discretion" in formulating and proposing a rehabilitation plan. Op. 50; *see also Mutual Fire II*, 614 A.2d at 1086 (observing that a statutory rehabilitator has broader discretion than a statutory liquidator). A rehabilitation plan may "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 Am. Ins. Co*., 63 A.3d 368, 452 (Pa. Commw. Ct. 2012) (citing *Mutual Fire II*, 614 A.2d at 1094). Once presented with the plan, "the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified." 40 P.S. § 221.16(d).

The statutory scheme also provides for liquidation. *See* 40 P.S. §§ 221.19–52. The rehabilitator has discretion regarding when to seek liquidation but can be forced to seek liquidation only if "*further attempts* to rehabilitate an insurer would substantially increase the risk of loss to creditors, policy and certificate holders, or the public, or would be futile." 40 P.S. § 221.18(a) (emphasis added); *Penn Treaty*, 119 A.3d at 322.

II. Procedural background

In early 2020, Insurance Commissioner Jessica K. Altman requested that the Commonwealth Court "enter an Order placing SHIP in rehabilitation, enabling her to develop a rehabilitation plan for [the Commonwealth] Court's approval, modification, or rejection after notice and hearing, and providing her the tools necessary for the development of that plan." R.70a. The Commonwealth Court, with Judge Leavitt presiding, granted that request and placed SHIP in rehabilitation. R.73a. Months later, the Insurance Commissioner returned with a proposed plan of rehabilitation. R.78a. The Commonwealth Court ordered that the rehabilitator provide notice to potential interested parties and solicited comments on the proposed plan. R.197a.

The Intervening Regulators intervened to oppose the Plan. The Health Insurers intervened to support it. The National Organization of Life and Health

Insurance Guaranty Associations, acting in its associational capacity, intervened but neither supported nor opposed the Plan. Op. 6; *see also* 2890a–2940a.

The intervenors and others provided formal and informal comments, leading the rehabilitator to amend the proposed rehabilitation plan. Op. 6. After a second comment period and extensive pre-hearing briefing, the rehabilitator submitted the second amended Plan for court approval. *Id*.

The Commonwealth Court held a week-long hearing on the Plan in May 2021. R.1618a–2621a. The rehabilitator put on three witnesses. Op. 11–31. Special Deputy Rehabilitator Patrick Cantilo provided the bulk of the testimony. Op. 11–26. He testified as an expert witness on insurer insolvency matters and walked through the details of the Plan. *Id.* The rehabilitator also proffered two actuarial consultants as witnesses. Op. 27–31. Vincent Bodnar testified as an expert witness on LTC insurance, including product development and sales practices, the rate-setting and approval process for insurers, and the liquidation of financially troubled insurers. *Id*. The other actuarial consultant, Marc Lambright, testified as a fact witness. *Id*. For their part, the Intervening Regulators offered just one witness, Frank Edwards, an actuary who testified as fact witness. Op. 31–33. Edwards compared the 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." Op. 33. The Intervening Regulators did not proffer an expert witness. Op. 31–33.

The parties engaged in post-hearing briefing and submitted proposed findings of fact and conclusions of law. R.2622a–3314a. Months later, the Commonwealth Court issued a memorandum opinion and order approving the Plan. Op. 1–82; *see also In Re Senior Health Ins. Co. of Pennsylvania In Rehab.*, No. 1 SHP 2020, 2021 WL 5119358 (Pa. Commw. Ct. Aug. 24, 2021). This appeal followed.

In this appeal, insurance regulators from twenty-seven states have submitted a brief as amici curiae. *See* Amici Br. 1. Their amici brief was prepared by and paid for by South Carolina and Louisiana. *Id.* at 2. All of the Amici had the opportunity participate in the proceedings below but declined to do so. In fact, rather than participate in the proceedings before the Commonwealth Court, South Carolina and Louisiana sued SHIP and the rehabilitator in courts in their jurisdictions to attack the Plan.[2] Their amici brief does not attempt to explain or justify this flank attack on the rehabilitation process, but instead tracks the arguments made by the Intervening Regulators. They fail for the same reasons. *Cf. Wert v. Manorcare of Carlisle PA, LLC*, 124 A.3d 1248, 1252 (Pa. 2015) (considering "[a]rguments of [a]mici … to the

[2] Dockets for the South Carolina and Louisiana actions can be accessed at https://www.shipltc.com/related-proceedings (last visited Jan. 31, 2022).

extent they are non-duplicative of the parties' arguments" and relevant) (citation and emphasis omitted).

III. Factual background

A. SHIP faces a $1.2 billion funding gap and requires rehabilitation.

SHIP is a Pennsylvania life and health insurance company that wrote LTC policies covering care at home, nursing homes, and assisted-living facilities. Op. 3. SHIP was licensed in 46 states, the District of Columbia, and the U.S. Virgin Islands. *Id*. The greatest concentration of policyholders is clustered in a handful of states. Op. 3–4. For instance, Texas, Florida, Pennsylvania, California, and Illinois have nearly half of the policyholders with active policies. *Id*. at 4. By contrast, the Intervening Regulators' states collectively have less than 5% of SHIP's in-force policies. *Id*. at 3–4.

LTC insurers, like SHIP, collect level premiums under policies. The premium rate is set such that in the early years of the policy, the premium greatly exceeds the expected claims in that year. The bulk of the premium from those years is invested for use in later years when a high volume of claims is expected. *Id*. The policies, by their terms, permit premium rate increases if such increases are actuarially justified and approved by the applicable insurance regulator for all similar policies. Op. 25.

SHIP now faces a $1.2 billion funding gap—the difference between its $1.4 billion in assets and $2.6 billion in liabilities. *Id*. This funding gap was caused by erroneous actuarial assumptions that informed initial premium rates, SHIP's inability to obtain approval for actuarially justified rate increases from state insurance regulators, and poorer than anticipated investment returns. Op. 5.

Erroneous actuarial assumptions. When it underwrote policies decades ago, SHIP made many actuarial assumptions that later proved to be wrong. Op. 13. Projecting these erroneous actuarial assumptions through 2040, "the aggregate effect of the erroneous actuarial assumptions approximately equals the total deficit of $1.2 billion." *Id*.

Discriminatory rate structure. By 2009, SHIP realized its premium rates were inadequate and began seeking premium rate increases from state regulators, as it was permitted to do by the policies. Op. 14. In response, it "received wildly different rate approvals." *Id*. From 2009 to 2019, SHIP failed to get as much as $371 million in cumulative premium due to rejected requests to increase rates. *Id*. State regulators' diverging responses to SHIP's requested rate increases "created a discriminatory rate structure, which has been the focus of criticism in the regulatory community." *Id*. The hodgepodge of regulatory responses has perverse consequences; policyholders "whose state of issue has approved rate increases are effectively subsidizing policyholders whose state of issue has not approved rate

increases." *Id*. This uneven response also created a collective-action problem: states that would be otherwise inclined to approve actuarially justified rate requests hesitate to do so, concerned that other states will not follow suit and enjoy de facto subsidization. *Id*.; *see also* R.1676a–78a.

Underperforming investments. SHIP's problems were compounded by poor investment performance. Market yields on investments were materially lower than they were projected to be when SHIP originally priced the premium on these policies. Op. 13. Hoping to offset this historical underperformance, in 2009, SHIP invested in two programs that led to losses of between $150 million and $300 million. *Id*.

B. The rehabilitator determined that the Plan was preferable to liquidation.

The rehabilitator carefully studied SHIP's fundamental financial problems and determined that the Plan accomplished objectives that could not be achieved in liquidation.

Because SHIP is insolvent, a liquidation would inevitably result in the triggering of the state life and health insurance guaranty associations ("GAs"). Op. 42–48. Once that occurs, the GAs are "triggered" and commence the payment of policy benefits subject to various limitations. Each GA statute (except New Jersey) has limits on what benefits it will pay (which is $300,000 in most states). Op. 35 n.12. GAs have the right to issue replacement policies in their entirety. *See, e.g.*, 40

P.S. § 1991.706(d)(3). They also have the right to seek premium rate increases once triggered and did so in the Penn Treaty liquidation. In the hearings on the Plan, there was extensive testimony about this. Op. 34–35; *see also* R.2354a, 2386a–87a, 2423a.

Once the GAs are triggered, the liquidator is required to deliver to them all of the assets in the estate not necessary for estate administration. 40 P.S. § 221.36. The GAs also receive all ongoing policy premium once triggered. *See, e.g.*, 40 P.S. § 991.1706(e) ("Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association."). The GAs use the premium and estate assets to fulfill, in part, their obligations to policyholders. The GAs supplement those amounts by making assessments on their member insurance companies. Op. 35. Companies conducting insurance business in each state are required to be members of the GAs covering the types of policies that they write. *Id*. In many states, the assessed insurers are permitted to set off the amount of the assessments against premium taxes over a period of years. *Id*. This largely passes the cost of GAs on to taxpayers. Op. 35, 63, 81. In some states, the GA member companies are allowed to increase premium rates on new policies or surcharge existing policies because of GA assessments. *Id*. This passes the cost of assessments back to policyholders of other companies. The rehabilitator was reluctant to "shift[] the burden of the inadequate premium to

taxpayers," concluding that "the better course was to right-size the existing policies to an actuarially justified premium." Op. 14. There was extensive testimony to the effect that GAs had obtained approval of premium rate increases in the Penn Treaty liquidation. The Commonwealth Court, however, found that the rate increases were not—and could not be—implemented quickly and were not uniform across states.

The rehabilitator determined that policyholders could be offered an array of choices for their policies that would be better than what they would receive in a liquidation of SHIP. Op. 42–48. The Commonwealth Court heard extensive testimony on alternatives that had been offered by the GAs to policyholders in the Penn Treaty liquidation. *Id*. The testimony confirmed, and the Court found, that the alternatives were not as advantageous to policyholders as those proposed by the Plan and would take longer to implement. *Id*.

The Plan reflects the rehabilitator's policy decisions to address premium subsidies caused by differing rate actions in different states, provide policyholders diverse choices in accepting premium rate increases or restructuring their policies, and narrow SHIP's funding gap. The Plan implements these goals in three phases. Op. 15–16. Phase One "is the principal phase" and is built around the "If Knew Premium," or the premium that SHIP "would charge had it known when the policy was issued what it knows today." Op. 27. The If Knew Premium is an "accepted methodology for setting premiums for long-term care insurance policies." *Id*. at 7.

Under the Plan, if a policyholder's current premium is below the corresponding "If Knew Premium," the policyholder has four options to restructure the policy. Op. 7.

Option 1. Under this "downgrade" option, the policyholder continues to pay the same premium but adjusts coverage to more appropriately match that premium. Op. 16.

Option 2. Under this middle-ground option, designed to "provide a reasonable package of long-term care coverage at an affordable price," a policyholder may select certain policy endorsements that provide essential benefits for an actuarially justified premium. Op. 7, 16.[3]

Option 3. Under this "non-forfeiture option," the policyholder will receive a "reduced paid-up policy" providing limited benefits but requiring no further premium payments. Op. 7–8. These benefits are "more generous . . . than the typical industry non-forfeiture option or reduced paid-up policy," offering up to 30 months of coverage at no cost to the policyholder. *Id*.; *see also* Op. 18.

Option 4. Option 4 adjusts the premium to match the coverage. Op. 16. Under this option, the policyholder retains the existing coverage but pays an actuarially justified premium. Op. 8.

[3] A variation of this option, referred to as "Option 2A," provides for a longer benefit period and provides for greater inflation protection. *Id*.

Each policyholder will have the opportunity to make an informed choice about which option best fits that policyholder's individual needs and circumstances. Op. 8. Policyholders will receive information "detailing the premiums and benefits associated with each option." *Id*. Consultants who specialize in simplifying medical-benefits information will help craft these materials and design tutorials to guide policyholders through the various options. Op. 19. These materials "will use graphics and be intuitively easy to follow." *Id*. The Plan also provides for a default option pegged to each policyholder's individual coverage situation. Op. 9. In this fashion, policyholders will reorient their coverage in Phase One.

Phase Two and Phase Three build on the groundwork of Phase One. *Id*. In Phase Two, the rehabilitator will evaluate Phase One's results "to determine whether additional policy modifications may be necessary for certain policies that are still underpriced." *Id*. Phase Two "is not absolutely necessary" under the Plan, "because Phase One could close the Funding Gap, or the assumptions deployed in Phase One could play out differently than projected." Op. 30. Further "modifications in Phase Two will largely be based on achieving a self-sustaining premium for every policy," with the aim of eliminating "any Funding Gap not eliminated in Phase One." Op. 9. Finally, in Phase Three, "the Rehabilitator will complete the run-off of SHIP's long-term care insurance business remaining in force." Op. 30.

In short, the Plan, by "increasing premiums or modifying policy coverages," corrects the core condition "that caused SHIP's insolvency: the underpricing of policies." *Id.* In making this correction, the Plan is centered on the fundamental principle of policyholder choice. Op. 9. "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)." Op. 9–10. And the Plan prices policies based on the "characteristics of each policy," not regulatory fortuity like "the policyholder's state of residence or the state where the policy was issued." Op. 10. In commenting on the Plan, "many policyholders were supportive of a rehabilitation and the plans" to rehabilitate SHIP. Op. 20.

The Plan offers several advantages that liquidation could not provide. First, the Plan offers policyholders better choices than they would have in a liquidation. Op. 24, 30. The Plan contains an option for policyholders to retain their current policy level of coverage, which may exceed the applicable GA cap, by paying the If Knew Premium. *Id*. The Plan also offers an enhanced non-forfeiture option that provides reasonable coverage for no additional premium. *Id*. Second, the Plan reduces or eliminates the cross-subsidies provided by some policyholders to others due to the current rate structure. A liquidation would not address this problem but perpetuate it. *Id*. Third, a rehabilitation "can be implemented quickly," but "a

liquidation of SHIP will unnecessarily delay any resolution of SHIP's financial condition." Op. 45, 47.

Even if rehabilitation ultimately proves unsuccessful, attempting it will have helped. *Id*. The Plan will eliminate the "discriminatory subsidies in the premium rate structure" and "the policies will be right-sized," leaving SHIP "in better shape if it eventually has to be liquidated." Op. 25. It will also have given policyholders the chance to make informed choices about the future of their policies. Op. 16. In choosing how to restructure their coverage, policyholders "will be the masters of the fate of SHIP." Op. 25.

SUMMARY OF ARGUMENT

After an extended hearing and careful analysis, the Commonwealth Court correctly approved the rehabilitator's detailed and considered Plan. The Intervening Regulators clearly would have made different policy decisions than the rehabilitator, but they have failed to surmount the high bar to show that the Commonwealth Court's approval of the Plan was an abuse of discretion.

First, the Intervening Regulators' proposed feasibility standard is a product of their own invention. Even if such a standard existed, this Plan—which will materially reduce the $1.2 billion funding gap—would meet it. More importantly, the Plan meets the actual standard for approval, which this Court described in *Mutual Fire II*.

Second, the Intervening Regulators' attempt to require liquidation in this case conflicts with the governing statutes. The rehabilitator determined that the goals of eliminating policyholder cross-subsidization and promoting policyholder choice warranted a rehabilitation plan rather than liquidation. This determination is well within the rehabilitator's discretion.

Third, the Intervening Regulators contend that the Plan is unconstitutional under *Neblett v. Carpenter*, 305 U.S. 297 (1939), because some policyholders supposedly fare worse under the Plan than they would in a liquidation. This is incorrect for several reasons. As a threshold matter, the Plan does not impair the rights of policyholders under their policies, so the constitutional issue does not arise. Even if it did, the Commonwealth Court applied the correct standard, paying careful attention to this Court's constructions of it. Finally, the Intervening Regulators are wrong that valuation based on net present value is required as a matter of law. In comparing outcomes under the Plan and in liquidation, the rehabilitator properly used a valuation standard actually used by policyholders.

Fourth, the Intervening Regulators argue that the Plan cannot be confirmed because it "treats policyholders in different States differently by reducing benefits or increasing premiums more in some states than others." Br. 45. The Plan actually treats all policyholders the same by eliminating the disparities in their premiums from state to state, and this feature of the Plan is well within the rehabilitator's

discretion. The Intervening Regulators lack standing to pursue this issue because they disavowed that they were representing policyholders in their states.

Fifth, the Plan does not unlawfully override other states' regulatory authority, as the Intervening Regulators contend. Nothing in Article V cedes this authority to the states. Article V permits a rehabilitation plan that modifies contracts and allows the Commonwealth Court to review and approve premium rates. Application of the Full Faith and Credit Clause depends on a conflict-of-laws analysis (which the Intervening Regulators all but ignore) that strongly favors application of Pennsylvania law. Finally, the Intervening Regulators inaccurately diminish the Plan's opt-out option, which reserves a rate-approval role for those state regulators who desire it. The Intervening Regulators offer no reason to revisit the Commonwealth Court's ruling in the nature of a directed verdict.

The Plan approved by the Commonwealth Court will eliminate policyholder cross-subsidization, give policyholders better choices than they would have in liquidation and help SHIP materially reduce or eliminate its $1.2 billion funding shortfall. The Commonwealth Court was right to approve it, and this Court should affirm the Commonwealth Court's orders.

ARGUMENT

I. There is no statutory requirement for a rehabilitation plan to be "feasible" as defined by the Intervening Regulators.

The Intervening Regulators contend that the Plan is not "feasible" and therefore should not have been approved. Br. 25–29. The Intervening Regulators use a definition of feasibility not found in Pennsylvania law. They posit that "[f]easibility must be measured against rehabilitation's commonly understood goal of restoring the insolvent company to solvency to benefit policyholders." Br. 28. From this they argue that the Commonwealth Court erred in approving the Plan because Phase One of the Plan is not likely to restore SHIP to solvency. *Id*.

The Commonwealth Court correctly observed that "there is no statutory requirement in Pennsylvania that a rehabilitation plan must be 'feasible' [as defined by the Intervening Regulators] in order to be approved, nor has that standard been adopted in our decisional law." Op. 65. The Intervening Regulators invented this feasibility standard by cobbling together dicta from a handful of cases, none of which supports their position.

The Intervening Regulators and Amici primarily rely on *Sheppard v. Old Heritage Mut. Ins. Co*., 425 A.2d 304 (Pa. 1981), which is almost the exact opposite of the present case. Br. 26–27; Amici Br. 16. There, the insurance department, as receiver, had determined that the company could not be rehabilitated and sought an order of liquidation. Management opposed the request for liquidation and argued

that rehabilitation was feasible and should be pursued. The Court ruled that the burden was on management, not the receiver, to prove that rehabilitation was feasible. *Id*. at 594. In relying on this case, the Intervening Regulators have completely ignored the well-established proposition that the rehabilitation laws vest discretion in the receiver, and that a party (including former management or intervenors) have the burden of overcoming the receiver's exercise of discretion. *Mutual Fire II*, 614 A.2d at 1091 (noting that a plan "must be found to be free from any abuse of the Rehabilitator's discretion."). *Sheppard* does not say anything about what the receiver's burden would have been if the receiver had proposed a rehabilitation plan.[4]

None of the Intervening Regulators' other cases endorse their view of feasibility. For instance, *Mutual Fire II* simply noted, in recounting the background facts, that the rehabilitator herself filed with the court a report on the "feasibility of implementing" the plan. 614 A.2d at 1090. But nothing in this recitation of facts indicates that the feasibility report was designed to satisfy a burden placed on the rehabilitator of proving that the plan was reasonably likely to restore the company

[4] The Intervening Regulators also cite a secondary source in support of this point. Br. 26 (citing 1 *Couch on Insurance* 3d § 5:24 (2021)). That discussion of feasibility, however, cites just two sources: *Sheppard*, which does not support the Intervening Regulators for the reasons discussed, and an Arkansas decision that does not even mention the word "feasible" (*Baldwin-United Corp. v. Garner*, 678 S.W.2d 754, 759 (Ark. 1984)).

to solvency. The Intervening Regulators acknowledge that this discussion was pure dicta, as "feasibility was not an issue on appeal." Br. 27. *Grode* is distinguishable for similar reasons. *See Grode v. Mutual Fire, Marine & Inland Insurance Co.*, 688 A.2d 233, 234 (Pa. Commw. Ct. 1996) (noting simply that the rehabilitator reported to the court on the "feasibility of implementing the plan," but reflecting no discussion of feasibility in connection with the plan's merits). Likewise, *Koken* does not impose any feasibility requirement, and indeed, mentions the word "feasible" just once in the opinion. *Koken v. Fid. Mut. Life Ins. Co*., 907 A.2d 1149, 1155 (Pa. Commw. Ct. 2006).

The Intervening Regulators also attempt to find support for their concept of "feasibility" in the statutory provision for converting rehabilitation to liquidation. Br. 27. But the statute does nothing to support their position. In fact, what the statute provides is that efforts at rehabilitation may continue until "further attempts to rehabilitate an insurer . . . would be futile." 40 P.S. § 221.18. It provides no support for the proposition that every phase of a rehabilitation plan must restore the company to solvency.[5] To the contrary, it suggests that a plan may continue to be modified and adjusted until the rehabilitator is satisfied that rehabilitation has been achieved

[5] The Intervening Regulators cite *Penn Treaty* in arguing that feasibility stems from the futility standard (*see* Br. 27), but that decision does not support their argument. The majority opinion does not address feasibility, and the provisions highlighted by the Intervening Regulators (40 P.S. §§ 221.19, 24) do not involve the futility standard. *See* Br. 27.

or that no further efforts could succeed. In *Koken*, the Court confirmed the rehabilitator's fourth amended plan of rehabilitation. *Koken*, 907 A.2d at 1155; s*ee also Mutual Fire II*, 614 A.2d at 1089–90. Here, the rehabilitator will implement Phase 1 of the Plan with the clear recognition that further phases may be required.

This Court has made clear that "[s]o 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). Restoration to solvency is not the test. All that is required is conservation of assets and equitable administration of them for the benefit of the interested parties. The Plan marshals the assets of the receivership estate and utilizes them to pay policyholders under their policies as modified by the Plan. This fully satisfies the requirement set out in *Mutual Fire II*.

Finally, even if this Court were inclined to create a requirement that a plan must provide for the restoration of the company to solvency, the Plan satisfies this requirement. As the Commonwealth Court correctly concluded, the Plan will materially reduce the funding gap, significantly improve SHIP's financial condition, and, if successful, ultimately restore SHIP to its pre-receivership condition of an insurer winding down its LTC insurance business. Op. 66, 78. The rehabilitator

offered ample evidence that the Plan will serve these ends, but the Intervening Regulators "offered no substantive evidence" in response. Op. 66–67.

II. Established law supports the rehabilitator's choice to pursue the Plan.

The Intervening Regulators and Amici make extended and passionate arguments that the rehabilitator has wrongly chosen rehabilitation over liquidation. Br. 29–37; Amici Br. 13–15. These arguments find no support in Pennsylvania law and run contrary to the facts of this case and the structure of the insurance insolvency system in the United States.

Contrary to the suggestion of the Intervening Regulators and the Amici, triggering the GAs in liquidation will not result in all policyholders receiving the full amount of their policy benefits.[6] It will not even result in all policyholders continuing to pay the same premium for their policies. As discussed (*supra*, § III(B)), the GAs provide limited coverage and have the ability to obtain premium rate increases if actuarially justified. Thus, in liquidation, policyholders would still face diminution of coverage, and likely would receive rate increases.

The question for the rehabilitator was not whether to (a) propose a plan and cause some policyholders loss or (b) liquidate and cause no loss to any policyholder.

[6] *See, e.g.*, Br. 32 ("It is contrary to the statute to restore a company to solvency by simply requiring policyholders to reduce benefits and increase premiums, especially when liquidation offers greater protection through guaranty associations."); Amici Br. 13 ("In liquidation, the policyholders' benefits would not change substantially. They would be able to keep that benefit subject to guaranty association limits.").

Under either the Plan or a liquidation, some policyholders will have some loss. The question presented to the rehabilitator was how should that loss be allocated among policyholders, and what amount of choice should individual policyholders have in that allocation. Under the liquidation statutes, that loss would vary by state depending on each state's GA limit and each GA's decision to issue replacement policies or seek and obtain premium rate increases.

The rehabilitator rejected this patchwork approach to loss allocation. Op. 63–64; *see also* R.1788a, R.2029a–30a. Instead, the rehabilitator proposed a plan that put all policyholders on a level playing field (by benchmarking premium rate increases and benefit modifications to the same actuarially justified premium) and allowed policyholders to elect the option that best fit their individual facts and circumstances (which may have changed significantly since the policies were first issued). *Id*; *see also* R.1703a–04a (testimony of Cantilo noting that there are likely many policyholders who may no longer need or want to pay for their original benefits due to their attained age or current health circumstances). This was not, as suggested by the Intervening Regulators, a punishment for policyholders that had not paid adequate premium in the past. Br. 34. The Plan's premium methodology does not recover for past rate inadequacies. Op. 27–28. It only levels the playing field going forward and maximizes policyholder choice.

In keeping with this approach, the rehabilitator proposed a Plan that gave all policyholders uniform choices for the future of their policies. They could keep their policies intact and pay the actuarially justified premium (if they were not already paying it). Or they could accept other alternatives that reduced premium and/or benefits in a way that was consistent across the nation.

The goals of the rehabilitator—uniformity of rate structure and uniformity of policy restructuring choices—promote fairness among policyholders and will narrow the funding gap. Op. 43. By adjusting the premium and benefits to be uniform across policies nationwide, the Plan should also reduce the ultimate cost to the public if a liquidation becomes necessary in the future. As the Commonwealth Court noted, "[t]he Rehabilitator concluded that shifting the burden to taxpayers and policyholders of other life and health insurers will not serve the 'public good.'" Op. 45 (quoting *Mutual Fire II*, 614 A.2d at 1094). That is exactly the type of determination that falls within a rehabilitator's discretion and is entitled to deference. *Mutual Fire II*, 614 A.2d at 1091.

These goals appear to be anathema to the Intervening Regulators and Amici. But it cannot fairly be said that these goals are irrational, arbitrary, or capricious. They are a rational means by which to allocate unavoidable loss caused by SHIP's insolvency. Moreover, the Intervening Regulators and the Amici are poorly situated to impugn these goals since they are all members of the National Association of

Insurance Commissioners (the "NAIC"). In 2019, the NAIC established a task force "charged with developing a consistent national approach for reviewing long-term care insurance rates that result in actuarially appropriate increases being granted by the states in a timely manner, and *eliminates the cross-state rate subsidization*. Identify options to provide consumers choice regarding modifications to long-term care insurance . . . contract benefits where policies are no longer affordable due to rate increases."[7] These are exactly the goals of the Plan.

The Commonwealth Court found that these goals were appropriate and consistent with Pennsylvania case law that favors rehabilitation over liquidation. Op. 43 ("These goals serve the public good."); *see also Mutual Fire II*, 614 A2d 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); *Penn Treaty*, 63 A.3d at 440 ("[l]iquidation is a remedy of last resort."); *Koken*, 831 A.2d at 1230 (same).

The Intervening Regulators acknowledge longstanding case law "expressing a preference for rehabilitation over liquidation" but try to distinguish these authorities as involving "older cases" that supposedly assume "that rehabilitation

[7] NAIC Proceedings – Spring 2019, Executive (EX) Committee and Plenary, April 9, 2019, Attachment One (emphasis added). *Available at* https://naic.soutronglobal.net/Portal/DownloadImageFile.ashx?fieldValueId=6339 (last visited Jan. 31, 2022).

will protect contractual policy benefits and that liquidation will not." Br. 33. But they provide no authority for ignoring this well-established line of cases. The one case they cite, *In re Rehabilitation of American Investors Assurance Co.*, 521 P.2d 560, 562 (Utah 1974), does not support their position. That case involved shareholders objecting to a rehabilitation plan that transferred assets and liabilities to a newly formed company which would pay policyholders in full. The quotation selected by the Intervening Regulators is taken out of context. It says nothing more than when an insurance company encounters financial difficulties, something must be done. The case actually goes on to say that "[t]he insurance code reflects the public interest involved and provides for rehabilitation if possible." *Id*. (citation omitted). It also notes that "the trial court in its supervisory and reviewing role may not substitute its judgment for that of the Commissioner, but may and should only intervene or restrain when it is made to appear that the Commissioner is manifestly abusing the authority and discretion vested in him and/or embarking upon a capricious, untenable or unlawful course." *Id*. at 563. As the Commonwealth Court noted, 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." Op. 79.

The Plan illustrates the soundness of the law's preference for rehabilitation over liquidation. It offers several important benefits that liquidation does not. Op.

44–48. First, liquidating SHIP would not address the $1.2 billion funding gap; it will simply shift the cost of that shortfall to "the guaranty association system and, ultimately, to the public." Op. 45. The rehabilitator concluded that liquidation would not serve the "public good." *Mutual Fire II*, 614 A.2d at 1094. Second, a liquidation would not address the existing inequitable premium rate structure and cross-policyholder subsidies. Op. 45–46. Instead, it would perpetuate those problems. *Id*. Third, liquidation "would cause a material delay in addressing the policy underpricing which lies at the root of SHIP's insolvency." Op. 46. The experience of the *Penn Treaty* liquidation makes this timing difference clear. Op. 46–47. Fourth, rehabilitation "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." Op. 48. Perhaps the best example of this is that some of the policy restructuring options offered by the Plan could not be offered in a liquidation due to the constraints of the GA laws. Op. 44; *see also* R.2352a. The Intervening Regulators acknowledge as much, conceding that "the Plan may address historic premium structure issues and offer flexibility." Br. 34.

The Intervening Regulators and Amici assert that the existence of the GAs implicates a legislative policy that they must be triggered when a company is insolvent. Br. 30. But this envisions a different system than the one that exists in

the United States. Although each state, including Pennsylvania, has a GA statute that covers life and health insurance (Op. 34), GAs are not triggered upon "insolvency," as the Intervening Regulators imply. Rather, an order of liquidation with a finding of insolvency must be entered by the Court. *See, e.g.*, 40 P.S. §§ 991.1706(c); 991.1702 (defining "Insolvent Insurer"); NAIC Life and Health Insurance Guaranty Association Model Act at §§ 8(b), 5(L) (defining "Insolvent Insurer").[8] As discussed in the previous section, in Pennsylvania, a rehabilitator is not required to commence liquidation until "further attempts to rehabilitate an insurer . . . would be futile." 40 P.S. § 221.18. Article V, like the laws of other states (including the Intervening Regulators'), places that determination within the discretion of the domiciliary regulator. Op. 52–53.

The construction of the GA statutes posited by the Intervening Regulators and Amici simply bypasses the requirement that a liquidation order be entered. The requirement of a liquidation order means that the trigger is dependent on the rehabilitator's conclusion that rehabilitation is either undesirable or futile. In Pennsylvania, the rehabilitator has wide discretion in reaching that judgment, and that judgment is a prerequisite to trigger. Insolvency by itself, does not suffice to trigger the GAs. Thus, the actual provisions of the GA statutes undermine the

[8] *Available at* https://content.naic.org/sites/default/files/MO520.pdf (last visited Jan. 31, 2022).

Intervening Regulators' and Amici's contention that the public policy expressed by the existence of the GAs means that they have to be triggered in this case.[9] They do not. Those statutes were designed to fit hand-in-glove with a receivership system that gives the domiciliary regulator broad discretion over when to rehabilitate and when to liquidate a company.

III. The Plan satisfies all constitutional requirements relevant to evaluating policyholder options in rehabilitation versus liquidation.

The Intervening Regulators contend that the Plan "fails to satisfy the constitutional standard of *Neblett v. Carpenter*, 305 U.S. 297 (1938), because it does not offer all policyholders an option that places them in a position at least as good as they would face in a liquidation." Br. 37. This contention ignores the fundamental facts of this case as well as controlling Pennsylvania precedent construing *Carpenter*. As a threshold matter, the Plan does not impair the rights of policyholders under their policies, so a constitutional issue does not arise. Even if the policies were impaired, under applicable valuation standards, policyholders fare at least as well under the Plan as they would in liquidation. Finally, under the

[9] It should also be noted that if insolvency by itself required triggering of the GAs, there would be no point in having insolvency as one of the grounds for rehabilitation under 40 P.S. § 221.14(1). In every case where GA coverage was available, the associations would be triggered and take over the administration of policies and payment of claims.

precedents of this Court, it is not required that every policyholder receive under the Plan at least what he or she would have received in a liquidation.

A. The Plan does not impair policyholders' rights, so no constitutional issue arises.

"The threshold inquiry" here is "whether the state statute in reality has operated to substantially impair a contractual relationship," such that constitutional contract protections are triggered. *Mutual Fire II*, 614 A.2d at 1094 (citation omitted). No impairment occurs under the Plan because policyholders may keep their coverage intact if they pay approved rate increases. Op. 7–8. Such rate increases are contemplated and permitted by the terms of the policies themselves. Op. 25; R.1948a–49a.

The Intervening Regulators and Amici do not dispute this fact. Instead, they completely ignore that the policies expressly allow for rate increases, and throughout their papers treat the rate increases contemplated by the Plan as an impairment. Br. 40 ("Premium increases alone can reduce the percentage of policyholders with an option providing a net present value in excess of liquidation value below 50%."); Br. 42–43 ("Here, the Plan operates to "substantially impair" the policyholders' rights . . . The Plan, however, requires them to make choices that either reduce their benefits (Options 1-3) or increase their premiums (Option 4) in Phase One."); Br. 44 ("Nor is adjusting premiums to avoid the differences that result from lawful state-based rating [a proper public purpose]."). A plan that raises premium rates under

policies that expressly allow premium rates to be raised does not constitutionally impair those contracts.

Because the policyholders have an option that allows them to retain their full contractual bargain, their contractual rights are not constitutionally impaired. *Mutual Fire II*, 614 A.2d at 1094 n.4 ("The threshold inquiry is to determine whether the state statute in reality has operated to substantially impair a contractual relationship.") (citation omitted).[10] Op. 61–62.

B. Under appropriate valuation standards, policyholders will fare at least as well under the Plan as they would in a liquidation.

In contending that the Plan is unconstitutional, the Intervening Regulators contend that the value of what policyholders receive under the Plan is less than what they would receive in liquidation. They contend that the Constitution requires that this measurement be done on the basis of the net present value of benefits minus the net present value of premiums. Br. 41. However, they cite no authority for this proposition. Instead, they cite a treatise and a Massachusetts decision from 1943 that discuss the computation of a policyholder's claim for damages in a liquidation that did not involve GA coverage. *Id.* The computation of a policyholder's damages for default by the insurer is not relevant to this situation because the policyholders are not getting claims for damages under the Plan nor would they get claims for

[10] The Intervening Regulators address this issue last in this section of their brief. *See* Br. § III(C). Because this is a threshold issue, however, it is addressed first here.

damages under the GA statutes if SHIP were liquidated. Instead, in both situations, they would get replacement coverage. Op. 42, 62–65. In advocating for the use of a measure based on present value of benefits minus present value of premiums, the Intervening Regulators are suggesting that the value of coverage must be measured on a damages model. The Intervening Regulators have provided no support for this proposition. *Carpenter* itself does not support it because the alternatives there were cash under the plan or cash under a liquidation. Op. 64; *Carpenter*, 305 U.S. at 304–05. The proposition is not self-evident.

The rehabilitator advocated the view that the comparison should be based on a valuation method actually used by policyholders in making decisions about their policies. The (undisputed) testimony established that the real-world comparison methodology used by policyholders is the maximum policy value, not the discounted value suggested by the Intervening Regulators. Op. 65. Under this standard, policyholders receive under the Plan at least what they would receive in a liquidation. Op. 62–65.

The Intervening Regulators provided no evidence as to how policyholders view the value of their policies. Edwards, the Intervening Regulators' fact witness, acknowledged that he had no opinion as to whether the metric proposed by the Intervening Regulators actually would be used by policyholders to make elections. Op. 31–33. He simply conducted "mathematical exercises" and did not refute the

expert testimony that policyholders would not actually use the Intervening Regulators' metric to make elections. Op. 44, 64; R.2212a–13a.

To the extent *Carpenter* requires a comparison of value between the Plan and a hypothetical liquidation, the evidence shows that requirement has been satisfied.

C. The Commonwealth Court applied the correct constitutional standard of *Carpenter* and *Mutual Fire II*.

The Commonwealth Court applied *Carpenter* in accordance with this Court's interpretation in *Mutual Fire II*. The Intervening Regulators contend that the Commonwealth Court misconstrued the *Carpenter* standard in two ways. As explained below, they are incorrect on both points.

First, the Intervening Regulators wrongly assert that the *Carpenter* test is satisfied only if the Plan grants every one of the roughly 39,000 policyholders "an option that places them in a position at least as good as they would face in a liquidation." Br. 37. This is not the standard. *Carpenter* is measured on an aggregate, not individual, basis. This Court has stated that "individual interests might have to be sacrificed or compromised in order to preserve the ultimate goal of" rehabilitation. *Mutual Fire II*, 614 A.2d at 1102 (citation omitted); *see also Penn Treaty*, 63 A.3d at 453 (holding that *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"); *accord In re Ambac Assur. Corp.*, 841 N.W.2d 482, 503–04 (Wisc. Ct. App 2014) (agreeing with *Penn Treaty* and rejecting parties'

argument that *Carpenter* means "that a rehabilitation plan is invalid as a matter of law unless policyholders are given the option to opt out and receive at least the liquidation value of their claims"); *cf. Koken*, 803 A.2d at 826 (discussing, in *Carpenter* analysis, "[c]reditors and policyholders" generally).[11]

As discussed in the previous section, the Commonwealth Court found that using appropriate metrics to compare the value of what policyholders receive under the Plan with the value of what they would receive in liquidation, nearly every policyholder fared as well under the Plan. But even using the metric proposed by the Intervening Regulators, 85% of policyholders fare at least as well under the Plan as they would in liquidation. Br. 39–40. Applying the logic of *Mutual Fire II*, the Court concluded that this satisfied the requirements of *Carpenter*. Op. 65.

Second, the Intervening Regulators contend that the Commonwealth Court "sought to dilute" the *Carpenter* standard by invoking this Court's "three-part test in *Mutual Fire II*." Br. 38. The Commonwealth Court, however, correctly followed this Court's decisional law on this issue. Op. 62–63; *see also Mutual Fire II*, 614

[11] In contrast to this case law, the Intervening Regulators rely on a New York decision that does not support their position. Br. 38 (citing *In re Frontier Ins. Co*., 36 Misc. 3d 529, 540 (N.Y. Sup. Ct. 2012)). *Frontier* simply presented a statutory question of whether surety contracts were entitled to GA protection under New York law in the event of liquidation. Because the court concluded that surety claims were entitled to that protection, it held that a rehabilitation plan could not treat surety claimants less favorably than other policies in rehabilitation. Here, no statutory class of policyholders is being excluded or treated less favorably in rehabilitation.

A.2d at 1094 n.4; *Penn Treaty*, 63 A.3d at 453. Under the *Mutual Fire II* test, even if a policyholder is worse off in rehabilitation than in liquidation and that impairment is "substantial," the Court should still confirm the plan so long as the rehabilitator has acted for a legitimate and significant public purpose and the adjustment of contractual rights is reasonable and appropriate to that public purpose. *Mutual Fire II*, 614 A.2d at 1094 n.4. As part of the analysis, "the Court must consider the greater good, including the consequences to the larger class of policyholders and the taxpaying public." *Penn Treaty*, 63 A.3d at 453 (citing *Vickodil v. Commw. of Pa. Ins. Dep't*, 559 A.2d 1010, 1013 (Pa. Commw. Ct. 1989)).

The Plan meets that test. Even if the Plan substantially impaired the policies, it would still serve the legitimate and significant public purpose of promoting fairness and equity among policyholders by eliminating the discriminatory rate structure, appropriately balancing the interests of the policyholders and the broader taxpaying public, offering policyholders meaningful choices with respect to their policies, and narrowing the funding gap. Op. 64. This is enough.

IV. The Plan rectifies (rather than creates) discriminatory treatment based on varied state regulation.

The Intervening Regulators argue that the Plan "treats policyholders in different States differently by reducing benefits or increasing premiums more in some states than others." Br. 45. This is not correct. The Plan treats similarly situated policyholders the same—that treatment is based on the If Knew Premium

methodology. If two identical policies, with identical premium rates, were issued in two different states, they would receive the same treatment under the Plan. Issue state is simply not a variable in that calculation. The Intervening Regulators' argument is just another way of saying that they reject the Plan's goal of eliminating rate cross-subsidization and putting policyholders on equal footing with each other going forward. As discussed in Section III above, this is a legitimate goal of a rehabilitation plan, and the Commonwealth Court found it to be. Op. 68 (eliminating unfair "subsidies between policyholders in different states and between different groups of policyholders" is itself a legitimate goal of rehabilitation. *Id*. (quoting *Penn Treaty*, 63 A.3d at 443, 460).

The Intervening Regulators wrongly rely on Article V's prohibition on creating subclasses within the policyholder class in a liquidation. Br. 45–46 (citing 40 P.S. § 221.44(b)). By that prohibition's plain terms, it applies to a liquidation, not a rehabilitation. Even putting that aside, the Plan does not give "some policyholders greater consideration than others." Br. 46. To the contrary, the Plan "treats similarly situated policyholders the same regardless of the state in which their policy was issued." Op. 69.

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." Op. 68.

Having failed to proffer evidence in support of this point before the Commonwealth Court, the Intervening Regulators have forfeited any argument on the issue now.[12]

Finally, the Commonwealth Court correctly concluded that the Intervening Regulators lack standing to claim that the Plan treats "policyholders in different States differently." Op. 68. The Intervening Regulators "expressly disavowed that they were appearing in a *parens patriae* or other representative capacity for policyholders in their states." *Id*. The Intervening Regulators' attempt to backtrack on that representation is too little, too late.

V. The Plan does not unlawfully override individual states' rate-setting authority.

The Intervening Regulators contend that the Plan "unlawfully overrides" states' regulatory authority to set premium rates for policies that they issue. Br. 48–58. They contend that the Plan inappropriately "supersedes other States' regulatory authority," that the Plan violates the Full Faith and Credit Clause of the U.S.

[12] The Intervening Regulators make a brief argument that "the constitutional standard" also "requires equal treatment of policyholders across states." Br. 47 (capitalization altered). In support, they cite only general provisions of *Carpenter* and *Mutual Fire II*. For the reasons already explained, the Plan satisfies all constitutional requirements (*supra*, § III) and ameliorates (rather than perpetuates) discriminatory treatment of policyholders based on state (*supra*, § IV).

Constitution, and that the Commonwealth Court wrongly granted a directed verdict. *Id*. The Intervening Regulators are wrong on all these points.[13]

A. The rating laws in the Intervening Regulators' states do not supersede the rehabilitation statute.

The Intervening Regulators refer to various state laws that commend regulation of premium rates to insurance departments in various states. They argue that Article V, by its terms, yields to these statutes. It does not.

In the first instance, they argue that Article V invests in the rehabilitator only the powers that management had prior to receivership. Br. 50. In support, the Intervening Regulators primarily rely on Section 221.16(b), which provides in part that the rehabilitator shall have all the powers of the directors, officers, and managers, whose authority shall be suspended, except as redelegated by the rehabilitator. 40 P.S. § 221.16(b). The Intervening Regulators contend that this means the rehabilitator enjoys only the authority that was exercised by management,

[13] The Intervening Regulators contend that they "not aware of any approved rehabilitation plan that has consciously set out to advantage policyholders in some States and disadvantage those in others"—in other words, that has altered varying state-based rates. Br. 45. The Intervening Regulators ignore, however, that there has only been one major receivership involving an LTC insurer. *See Penn Treaty*, 63 A.3d at 461. So this is a small sample size. And in that case, the Court (in denying petitions to convert the rehabilitation to liquidation) ordered the rehabilitator to propose a plan that addressed the inadequate premium rates—which is exactly what this Plan does.

and if management would have had to seek rate increases from the regulators across the country, then so must the rehabilitator. *See* Br. 50.

This argument is foreclosed by other provisions of Article V and decisional law interpreting and applying that statute. Article V grants the rehabilitator with broad authority to "take such action as [s]he deems necessary or expedient to correct the condition" that caused the need for rehabilitation. 40 P.S. § 221.16(b); *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 that given to a statutory liquidator). This includes the ability to prepare a rehabilitation plan that might "impair the contractual rights of some policyholders in order to minimize the potential harm to all of the affected parties." *Penn Treaty*, 63 A.3d at 452 (citing *Mutual Fire II*, 614 A.2d at 1094). Obviously, management of the company outside of rehabilitation does not have the right to impair the contracts of policyholders. Thus, the argument that the rehabilitator is confined to the exercise of only the rights of management fails.

Next, the Intervening Regulators argue that the authority to rehabilitate the company does not authorize the rehabilitator to proceed without other states' "regulatory approvals." Br. 51. Tellingly, the Intervening Regulators offer no statutory or case-law support for this argument other than *Koken*, which does not support their contention. In that case, the plan contemplated sale of the company to

a third party that intended to resume underwriting business outside of rehabilitation proceedings. *Koken* at 826–27. The plan itself provided for the buyer to get necessary approval from various states so it could resume underwriting. The case did not consider whether this was necessary or not. The broad authority of the rehabilitator to address the insolvency of an insurance company, and impair its contracts where necessary, runs contrary to the limitations proposed by the Intervening Regulators.

The Intervening Regulators seek support from provisions of Article V that authorize the rehabilitator to seek stays in courts outside the Commonwealth. Br. 51 (citing 40 P.S. §§ 221.5(b) & 221.17(a)). But those statutes do not provide that courts outside the Commonwealth have jurisdiction over the rehabilitator or the assets of the estate. And they certainly do not address the enforceability of rate regulation in such states against a rehabilitator exercising authority under a plan of rehabilitation.

Similarly, the Intervening Regulators attempt to rely on Article V's proviso that it "shall not be interpreted to limit the powers granted the commissioner by other provisions of the law," contending that provision renders it "absurd" to apply the statute in any way that limits other states' regulatory authority. 40 P.S. § 221.1(a); Br. 52. Carefully read, however, this language is designed to increase the

rehabilitator's powers, not dimmish them (as suggested by the Intervening Regulators).

B. The Plan fully complies with the Full Faith and Credit Clause of the United States Constitution.

The Intervening Regulators contend that the Plan violates the Full Faith and Credit Clause because it "disregard[s]" other states' "statutes governing rates." Br. 53 (citing U.S. Const., art. IV, § 1). The Commonwealth Court correctly rejected this argument. Pennsylvania's rehabilitation statue is entirely consistent with the insolvency statutes of other states, and the rating methodology utilized by the Plan is consistent with the methodology and purpose of the rating statutes of other states. Thus, there is no conflict for purposes of the Full Faith and Credit Clause. Op. 51–58.

Article V empowers the Commonwealth Court to rehabilitate the business of "a domestic insurer or an alien insurer domiciled in this Commonwealth." 40 P.S. § 221.15(a). The insolvent insurer's state of domicile "has an overriding interest in assuring that the rehabilitation, if possible, is effectuated." *Matter of Mut. Ben. Life Ins. Co*., 609 A.2d 768, 777 (N.J. Super. 1992). A 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.

The Plan is also consistent with the laws of Pennsylvania and the Intervening Regulators' states directly addressing interstate rehabilitation of insurers. All four states have adopted model laws designed to provide for uniform handling of an insurer's rehabilitation. Op. 52–53. The three intervening states have adopted, in substantial part, the Uniform Insurers Liquidation Act (the "UILA").[14] *Id*. 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. Commw. Ct. 2019).

Similarly, Pennsylvania adopted the Insurer's Supervision, Rehabilitation and Liquidation Model Act (the "Model Act") approved by the National Association of Insurance Commissioners. Op. 53. 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." 40 P.S.

[14] *See* 24-A Me. Stat. Ann. §4363; *In re Liquidation of Am. Mut. Liberty Ins. Co.*, 747 N.E.2d 1215, 1225 n.13 (Mass. 2001); *Am. Star Ins. Co. v. Grice*, 865 P.2d 507, 509 (Wash. 1994). Notably, the laws of Maine, Massachusetts and Washington also designate the domiciliary insurance commissioner as the receiver of an insurer undergoing liquidation or rehabilitation. *See* 24-A Me. Stat. Ann. § 4364; Mass. Gen. Laws Ann. 175 § 180B; Wash. Rev. Code § 48.99.020.

§ 221.1(c). The Plan furthers the purpose of those model laws by offering "a single, cohesive, [and] uniform handling of SHIP's rehabilitation through a single state." Op. 53.

The Plan is also consistent with the regulatory laws of the intervening states involving rate setting. For instance, the Plan's Phase One is grounded on the If Knew Premium methodology, which assumes a 60% lifetime loss ratio. Op. 57. Similarly, Phase Two's self-sustaining premium will also use a 60% lifetime loss ratio. *Id*. The If Knew Premium methodology is "used by insurance regulators nationwide to set long-term care insurance premium rates." *Id*. And the 60% ratio is the benchmark for a premium rate increase in Pennsylvania and most other states. *Id*. *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%.").

The intervening states also share Pennsylvania's interest in ensuring that premium rates for LTC insurance are not excessive, unfairly discriminatory, or unreasonable in relation to the benefits provided under the policy. Op. 57.[15] The

[15] The laws of Maine, Massachusetts, and Washington each have a variation of the requirement that rates not be "excessive, inadequate or unfairly discriminatory" (24-A Me. Stat. Ann. §2736) and not "unreasonable in relation to the premium charged" (Mass. Gen. Laws Ann. Ch. 175 §108(8)(A); Wash. Rev. Code § 48.18.110). These standards are similar to the Pennsylvania standard for adjusting LTC insurance premium rates. *See* 31 Pa. Code § 89a.117.

Plan will advance this shared interest. It aims to correct SHIP's discriminatory premium rate structure, sets the premium rates to appropriate levels, and employs the If Knew Premium methodology to establish a premium level that is reasonable in relation to benefits. *Id*.

In pressing the constitutional argument, the Intervening Regulators wrongly conflate laws and judgments in the Full Faith and Credit Clause analysis. *See Baker by Thomas v. General Motors Corp*., 522 U.S. 222, 232 (1998). 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 [that] it is competent to legislate." *Id*. (citations 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) (citation omitted). 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 (citation omitted). A court may be guided by the forum state's public policy in determining the law applicable to a controversy, but there is no "public policy exception" to the Full Faith and Credit Clause due a court's judgment. *Id*. at 233 (citation omitted).

Thus, the rate setting methodology proposed by the Plan does not conflict with the laws of the Intervening Regulators' states for purposes of the Full Faith and Credit Clause. Their insolvency laws promote the same interstate recognition of the domiciliary regulator's authority and their rating laws are consistent in operation and purpose to the provisions of the Plan.

C. Any conflict between the Plan's rate-approval mechanisms and state rate making laws should be resolved in favor of the Plan.

If this Court rejects the Commonwealth Court's conclusion that no conflict arises for the purpose of the Full Faith and Credit Clause, it should conclude that the interests of Pennsylvania under Article V should prevail. It is well established that multiple states may have constitutionally legitimate interests in an interstate contract, such that any of those states' laws may constitutionally be applied to the contract. *Allstate Ins. Co. v. Hague*, 449 U.S. 302, 307 (1981) ("[A] set of facts giving rise to a lawsuit, or a particular issue within a lawsuit, may justify, in constitutional terms, application of the law of more than one jurisdiction.") (citations omitted). So long as a court undertakes a conflict-of-law analysis to select the law of one of those interested states, the Full Faith and Credit Clause is satisfied. *See Baker,*, 522 U.S. at 223-24 (traditional conflict-of-laws analysis for determining law applicable to a case is consistent with, not contrary to, the commands of the Full Faith and Credit Clause); *see also Pac. Emp'rs Ins. Co. v. Indus. Accident Comm'n of Calif.*, 306 U.S. 493, 500–02 (1939) ("[T]he 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.").

This is not a situation where Pennsylvania has "no significant contact or significant aggregation of contacts" to the policies that would be modified under the Plan. *Allstate*, 449 U.S. at 308. As the Commonwealth Court found, Pennsylvania has an interest in the insurance policies issued by an insurer domiciled in its state and has an interest in seeing insolvent insurers rehabilitated. Op. 60–61.

Strikingly, the Intervening Regulators offer no meaningful conflict-of-laws analysis at all. *See* Br. 48–58. They simply state that other states' regulations have been displaced and declare that "is not a 'procedural' issue." Br. 53 . But the Commonwealth Court correctly concluded that there was no conflict, and were the supposed conflict to exist, it would be "one of procedure." Op. 58. By failing to advance any meaningful conflict-of-laws argument, the Intervening Regulators have abandoned any argument to rebut the Commonwealth Court's conclusion. In any event, the Intervening Regulators' argument on this point fails for the reasons discussed below.

The first step in the conflict analysis is determining whether the conflict is one of procedure or substantive law. *Wilson v. Transp. Ins. Co*., 889 A.2d 563, 571 (Pa.

Super. Ct. 2005). Substantive law is "the portion of the law which creates the rights and duties of the parties to a judicial proceeding, whereas procedural law is the set of rules which prescribe the steps by which the parties may have their respective rights and duties judicially enforced." *Ario v. Underwriting Members of Lloyd's of London Syndicates*, 996 A.2d 588, 593-94 (Pa. Commw. Ct. 2010) (quoting *Wilson*, 889 A.2d 563 at 571) (internal citation omitted).

i. Procedural Conflict

In this case, the Commonwealth Court concluded that any potential conflict between Pennsylvania receivership law and the laws of the Intervening Regulators' states would be one of procedure. Op. 58. The Intervening Regulators did not put on any evidence that the Plan's standard for the modification of rates differs from that used in their states (or any other) for modifying LTC insurance rates. They contend only that "[i]nsurance rates are a matter of particularly local concern and regulation." Br. 54. That is, the Intervening Regulators take issue with the Court reviewing and approving rates instead of executive officials in other states. As the Commonwealth Court found, that is purely a procedural distinction to which the Court owes the other states' rules no deference. Op. 58–59.

ii. Substantive Conflict—False Conflict

Even if this Court found that a conflict existed and interpreted it to be substantive rather than procedural, Pennsylvania law should apply. To resolve a

substantive conflict-of-law, the court considers the extent of the purported conflict and classifies it as a "true conflict, false conflict or unprovided-for conflict." *McDonald v. Whitewater Challengers, Inc*., 116 A.3d 99, 108 (Pa. Super. Ct. 2015) (citations omitted). This case presents (at most) a "false conflict," which is one where only one jurisdiction's interests would be impaired by applying the other jurisdiction's law. *Lacey v. Cessna Aircraft Co*., 932 F.2d 170, 187 (3d Cir. 1991) (citations omitted).

The interests of Maine, Massachusetts, and Washington would not be impaired by applying Pennsylvania law. Those states' interests are to ensure that LTC insurance premium rates are not excessive, unfairly discriminatory, or unreasonable in relation to the benefits provided under the policy. Op. 57. These interests will not be impaired by the Plan; indeed, those interests will be advanced by the Plan.

The interests of Pennsylvania, however, will be substantially impaired if Pennsylvania law is not applied. Pennsylvania's interest is to use the insolvency and regulatory tools at its disposal to promote the best result for all policyholders and creditors. The stated purpose of Article V is "the protection of the interests of insureds, creditors, and the public generally." 40 P.S. § 221.1(c). Note that the interests to be protected are not just those of the citizens of the Commonwealth, but all insureds and creditors wherever they may be located. This is done through,

among other things, "early detection of any potentially dangerous condition in an insurer, and prompt application of appropriate corrective measures" and "improved methods for rehabilitating insurers, involving the cooperation and management expertise of the insurance industry." *Id*. That is precisely the action being taken under the Plan. *See* R.1136a ("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.").

Substantial historical policy underpricing is at the core of SHIP's insolvency. R.1139a. One of the ways the Plan seeks to address this condition is Option Four, under which policyholders with underpriced policies can retain their current benefits and pay an actuarially justified premium. If the Plan were forced to adhere to a state-by-state premium rate approval process, the Rehabilitator could not realistically offer policyholders an option to keep their policies. The ordinary course rate increase process can years to complete. Op. 60. As the Court concluded, SHIP's financial condition requires action now. Op. 15, 47. Thus, if Pennsylvania receivership law were not applied to the issue of premium rate determinations, it would substantially impair Pennsylvania's interests. Under well-established Pennsylvania conflict-of-law principles, the Court must apply the law of the state whose interests would be harmed if not applied. *Cessna Aircraft Co*., 932 F.2d at 187.

iii. Substantive Conflict—True Conflict

Even if a "true conflict" exists, the interests of Pennsylvania in the successful rehabilitation of its domestic insurance companies outweighs the Intervening Regulators' interest in approving new premium rates. For resolution of true substantive conflicts, Pennsylvania courts apply the analysis prescribed in *Griffith v. United Air Lines, Inc*., 203 A.2d 796 (Pa. 1964). *Ario*, 996 A.2d at 593. Under *Griffith*, "the choice of law determination looks to the law of the jurisdiction with the most significant relationship to the occurrence and the parties, placing importance on analysis of the policies underlying the conflicting laws and the relationship of the particular contacts to those polices." *Id*. (citing *Griffith*, 203 A.2d at 802). This requires a qualitative analysis rather than a quantitative scale of contacts with the respective jurisdictions. *Id*.

The Pennsylvania Supreme Court in *Griffith* adopted "a more flexible rule which permits analysis of the policies and interests underlying the particular issue before the court." *Griffith*, 203 A.2d at 805 (footnote omitted). The Court moved away from a wooden application of a pure "contacts" analysis or a one-size-fits-all approach. It is important to note that the comparison of the interests of the two jurisdictions is not performed in the abstract. Instead,

> Whether the policies of one state rather than another should be furthered in the event of conflict can only be determined within the matrix of specific litigation. What should be sought is an analysis of the extent to which one state rather than another had demonstrated, by reason of

> its policies and their connection and relevance to the matter in dispute, a priority of interest in the application of its rule of law.

McSwain v. McSwain, 215 A.2d 677, 682 (Pa. 1966).

Therefore, the issue is not whether the states represented by the Intervening Regulators have an interest in the LTC insurance rates paid by their residents. Clearly they do, as do all state insurance regulators. The question is whether Pennsylvania's interest is superior in the context of SHIP's rehabilitation. The state-based insurance regulatory system assigns sole responsibility for rehabilitating an insolvent insurer to that insurer's domiciliary regulator. The "matrix of specific litigation" envisioned by the conflict-of-law rule is the rehabilitation proceeding commenced by the Pennsylvania Insurance Commissioner for the purpose of addressing SHIP's insolvency. *McSwain*, 215 A.2d at 683. The rate action proposed to be taken under Article V and the Plan is in furtherance of that superior purpose, and therefore under the conflict-of-law rules, has primacy over the more general interest of other insurance regulators in exercising their individual prerogatives under their domestic rate-making regimes.

D. The Intervening Regulators misconstrue the Plan's opt-out provision and the Commonwealth Court's directed verdict.

Finally, the Intervening Regulators contend that the Plan's opt-out provision "does not cure" the Plan's supposed infringement on other states' regulatory authority. Br. 57. As discussed above, the Plan does not infringe on other states'

regulatory authority, and so the opt-out provision was unnecessary for the confirmation of the Plan.

The Intervening Regulators glancingly challenge the Commonwealth Court's ruling, in the nature of a directed verdict, that the Intervening Regulators "did not present any evidence that their interests would be harmed by the Issue State Rate Approval Option," so "their objection to the Issue State Rate Approval Option cannot serve as a basis for this Court to disapprove the Plan." Op. 69–70.

Starting with the opt-out issue, the Plan's Issue State Rate Approval Option gives "every state . . . the option of opting out of the rate approval section of the Second Amended Plan." Op. 22, 58. If a state opts out, the rehabilitator files an application to increase rates for policies issued in that opt-out state to the If Knew Premium level. *Id*. Under the Plan, the rehabilitator will file the application on a seriatim basis—meaning an individual, "policy by policy" basis—to eliminate subsidies and restore a level playing field. *Id*.; R.2008a, R.2421a. 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. Op. 22, 58. Policyholders in an opt-out state will still have four options: (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. Op. 22.

Despite the flexibility that the opt-out provision offers, the Intervening Regulators dismiss it as a "fig leaf." Br. 25. They contend that the opt-out alternative does not allow regulators to "meaningfully review rates" but ignore that it provides them with the ability to control the mix of benefit reductions and premium rate increase. Br. 57; Op. 58. If a particular state insurance regulator believes that the rehabilitator's proposed rate increase is set too high, the regulator can approve a lower amount, which will then be matched with greater benefit reductions. Op. 58. The Intervening Regulators also object that the opt-out provision does not provide them with enough time to review the rate applications, but as the Commonwealth Court correctly noted, to have a meaningful impact, "the Plan must be implemented quickly because of the advanced age of the policyholders" and SHIP's dire financial condition. Br. 57; Op. 15. In short, the opt-out mechanism allows the Plan to be implemented quickly, while also giving policyholders and out-of-state regulators input into the modification of policies, if desired.

Regardless, the Commonwealth Court correctly granted a directed verdict against the Intervening Regulators on this issue. As the rehabilitator noted, the Intervening Regulators "did not present any evidence that their interests would be harmed by the Issue State Rate Approval Option," so "their objection to the Issue State Rate Approval Option cannot serve as a basis for this Court to disapprove the Plan." Op. 69–70. The Intervening Regulators challenge this ruling by asserting

that the Commonwealth Court did not "consider all the evidence" in the light most favorable to them. Br. 56 (emphasis omitted).

This misstates the record. The rehabilitator offered evidence on the opt-out provision, including testimony from Cantilo. But as the Commonwealth Court correctly concluded in rejecting reconsideration on this point, the Intervening Regulators "did not present any evidence to support their challenge to the opt-out provision of the Plan." Op. 74. Because "no evidence in the record supports" the Intervening Regulators' argument on the opt-out provision, the Commonwealth Court correctly granted a directed verdict, and the Intervening Regulators cannot displace the Plan on this basis.

CONCLUSION

For the foregoing reasons, the Commonwealth Court's order approving the Plan should be affirmed.

Dated: January 31, 2022

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE (Pa. R.A.P. 127)

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

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CERTIFICATE OF COMPLIANCE (Pa. R.A.P. 2135(d))

It is hereby certified that the foregoing Brief complies with the word count limit contained in Pa. R.A.P. 2135(a) because it contains 13,156 words, as computed by the "Word Count" function in Microsoft Word.

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71 MAP 2021

IN THE SUPREME COURT OF PENNSYLVANIA

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	:	71 MAP 2021

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