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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

# BRIEF FOR APPELLEE NATIONAL ORGANIZATION OF LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATIONS

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## COUNTERSTATEMENT OF THE QUESTIONS INVOLVED

The National Organization of Life and Health Insurance Guaranty Associations ("NOLHGA") does not propose counterstatements of questions 1 and 3-7. While NOLHGA likewise does not propose a counterstatement of question 2, it does take issue with the embedded statement that Guaranty Associations "would provide $837 million in additional support" in liquidation. This is discussed in Argument Section I below.

## COUNTERSTATEMENT OF THE CASE

### I. PROCEDURAL HISTORY

NOLHGA adopts Appellants' procedural history and adds the following:

On July 30, 2020, NOLHGA filed an Unopposed Application Requesting Leave To Intervene for a Limited Purpose in the Senior Health Insurance Company of Pennsylvania ("SHIP") receivership proceedings. Dkt. 10. NOLHGA sought to intervene in its associational capacity to advance the collective interests of its affected member life and health insurance guaranty associations ("Guaranty Associations" or "GAs"). *Id.*

On September 15, 2020, the Commonwealth Court granted NOLHGA's request to intervene. Dkt. 38.

NOLHGA, through counsel and the presentation of two witnesses, participated in the Commonwealth Court's hearing on the Second Amended Plan of

Rehabilitation (the "Plan") on May 17-21, 2021. *See, e.g.*, R.2219a-2410a (testimony of Peter Gallanis, President, NOLHGA) and 2411a-2451a (testimony of Matthew Morton, actuary, Long Term Care Group).

NOLHGA actively participated in the Commonwealth Court proceedings on the SHIP Plan and made several filings with the Commonwealth Court. *See, e.g.*, R.2890a-2940a (Proposed Findings of Fact, Conclusions of Law, and Proposed Orders filed on June 14, 2021) and 3081a-3114a (Response to Post-Hearing Filings of All Parties filed on June 28, 2021).

## II. SUPPLEMENT TO STATEMENT OF THE FACTS: GUARANTY ASSOCIATIONS

### A. BACKGROUND

Insurance company solvency and receivership matters are addressed under state insurance statutes and regulations. *See, e.g.*, 40 P.S. §§ 221.1 *et. seq.* (Pennsylvania receivership statute) and 40 P.S. §§ 991.1701 *et. seq.* (Pennsylvania Life and Health Insurance Guaranty Association ("PLHIGA") Act). The Guaranty Association system provides a safety net for policyholders of failed insurers. The legislatures of all fifty states, as well as the District of Columbia and Puerto Rico, have enacted legislation to create Guaranty Associations to protect each jurisdiction's policyholders against a member insurer's failure to perform contractual obligations under life and health insurance policies and annuity contracts due to the member insurer's impairment or insolvency. R.2223a:3-6 and

2223a:25-2224a:2; 40 P.S. § 991.1701; *see also* National Association of Insurance Commissioners ("NAIC") Life and Health Insurance Guaranty Association Model Act[1] ("Model Act") § 2. The Guaranty Associations' governing statutes are based on the NAIC Model Act and are largely consistent from state to state, including Pennsylvania.[2] The statutory rights and obligations of PLHIGA are set forth in 40 P.S. § 991.1701 *et. seq*.

Before the formation of the Guaranty Associations, insurer insolvencies were resolved by reducing policy benefits paid to policyholders to the amount that could be paid by the insolvent insurer's assets. There was no other source of support, so policyholders bore the full burden of an insurer's insolvency. *See* 1971-1 NAIC Proc. 157 at 196 (Dec. 14-15, 1970) (App. A). The advent of the Guaranty Associations changed that paradigm, so that now the Guaranty Associations guarantee a certain level of benefits and continue coverage under their governing statutes, regardless of the assets available from the insolvent insurer. *Id.*; *see generally*, Model Act. Continued coverage means that a life, health, or annuity policy remains in force, the policyholder pays any required

[1] The Model Act is available at https://content.naic.org/sites/default/files/MO520.pdf (last visited Jan. 26, 2022).

[2] Section 1927 of the Statutory Construction Act directs that, "[s]tatutes uniform with those of other states shall be interpreted and construed to effect their general purpose to make uniform the laws of those states which enact them." 1 Pa.C.S. § 1927. Statutes based on the Model Act have been deemed uniform for this purpose by this Court. *Koken v. Reliance Ins. Co.*, 893 A.2d 70, 83 (Pa. 2006).

premiums to the Guaranty Association, and if and when claims are made, the Guaranty Association ensures the claims are paid, subject to the statutory limits. Before Guaranty Associations "there was no means to infuse additional funds where needed to make whole policyholders, insureds, and beneficiaries. The purpose of the model act is to provide protection against losses due to impaired insurers by [prompt] fulfilment of the impaired insurer's contractual obligations." 1971-1 NAIC Proc. 157 (App. A) at 196. Of course, Guaranty Association protection is available only when the Guaranty Associations are statutorily activated (triggered) to provide coverage.

Under the Guaranty Association statutes across the United States, a Guaranty Association is triggered by an order of liquidation with a finding of insolvency. When triggered, the Guaranty Association is then statutorily obligated, subject to the specific statutory limits in its state, to protect policyholders who reside in its state, by either guaranteeing, assuming, or reinsuring the policyholder obligations of the insurer in liquidation itself; by causing the obligations to be guaranteed, assumed, or reinsured by a solvent insurer; or by otherwise providing benefits and continuing coverage in accordance with its governing statute. R.2252a:7-2253a:25; 40. P.S. §§ 991.1702 and 1706(b); *see also* Model Act §§ 5(L) and 8(B). In exchange for providing that protection, any premiums due to be paid by policyholders become payable to the Guaranty Association, and the

Guaranty Association has by statute a priority creditor claim against the insolvent insurer's assets. *See, e.g.*, 40 P.S. § 991.1706(g) & (m) and 1712(c); *see also, e.g.*, Model Act § 8(D), (K) and 14(C).[3]

NOLHGA is a Virginia nonprofit corporation whose voluntary membership consists of the Guaranty Associations of the fifty states and the District of Columbia. R.2224a:5-9. The Guaranty Associations formed NOLHGA to promote, coordinate, and support the plans by which individual Guaranty Associations satisfy their statutory obligations in multi-state life and health insurance company receiverships. R.2224a:5-9; 2225a:2-7; 40 P.S. § 991.1706(n) ("The association may join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association."); *see also* Model Act § 8(M).

NOLHGA is a forum for the individual Guaranty Associations to pursue collaboration and coordination in multi-state insolvencies so that the Guaranty Associations can efficiently carry out their statutory mandates of protecting policyholders. R.2225a:15-2226a:7.[4] Through NOLHGA, member Guaranty

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[3] The GAs are also priority creditors with respect to claims for their administrative expenses. 40 P.S. §221.44(a).

[4] For other relevant background on the Guaranty Association system and NOLHGA, *see generally* Testimony for the Record of the National Organization of Life and Health Insurance Guaranty Associations Before the House Financial Services Subcommittee on Insurance, Housing, and Community Opportunity, "Insurance Oversight and Legislative Proposals," Nov. 16, 2011, at 1-2, *available at* http://financialservices.house.gov/uploadedfiles/111611nolhga.pdf (last visited Jan. 26, 2022).

Associations receive and analyze pertinent facts concerning a potential insolvency, evaluate those facts to develop a plan to satisfy statutory obligations, and adopt coordination plans to serve the needs and obligations of the Guaranty Associations. R.2226a:8-22.

NOLHGA has substantial experience with insurance receiverships, having participated in approximately 100 multi-state receiverships, nine of which involved long-term care ("LTC") insurance. R.2226a:23-25; 2227a:10-16. The Guaranty Associations have protected approximately 2.6 million policyholders and guaranteed more than $25 billion in benefits for policyholders over the course of the Guaranty Association system's existence. R.2227a:1-9.

NOLHGA typically monitors rehabilitation proceedings of life and health insurers and has been monitoring the SHIP receivership proceedings. R.2229a:6-2230a:11. NOLHGA participated in the Commonwealth Court proceedings as an intervenor to comment on the Plan and to provide information about the Guaranty Association system to the Commonwealth Court and the Rehabilitator. R.2217a:23-24 and 2218a:25-2219a:4. NOLHGA neither endorses nor opposes the Plan. R.2222a:13-17. No other party participating in this matter represents the interests of NOLHGA and its member Guaranty Associations. R.2230a:12-16.

## B. GUARANTY ASSOCIATION RIGHTS AND OBLIGATIONS IN LIQUIDATION

Guaranty Associations typically are triggered by the issuance of an order of liquidation with a finding of insolvency.[5] When triggered, the Guaranty Associations provide benefits to resident policyholders consistent with statutory limits. 40 P.S. § 991.1703(a); *see also* Model Act § 3(A). Guaranty Associations provide coverage up to the lesser of the maximum benefit under the policy or the statutory limit for Guaranty Association coverage payments. In most states, the statutory coverage limit is $300,000 for LTC although there are a few states with higher limits. R.2255a:15-22; 2416a:14-16; 40 P.S. § 991.1703(c)(1)(ii)(A)(II)(2); *see also* Model Act § 3(C)(2)(a)(ii)(II).

In liquidation, when LTC policyholders make claims ("go on claim") based on the terms of their policy, the covering Guaranty Association pays the benefits in full for each policyholder who resides in its state until the policyholder either exhausts the maximum benefits under the policy or exceeds the statutory coverage limit. 40 P.S. § 991.1703; *see also* Model Act § 3. (Any benefits paid under the policy by the insurer or the Guaranty Association count toward the policy maximum, but only benefits paid by the Guaranty Association after liquidation

[5] Other circumstances may trigger a Guaranty Association's obligations, but they are less common. For example, a prior version of the Model Act included a trigger when an insurer is under an order of rehabilitation and is not paying claims timely (if certain other elements are satisfied). 1988 Model Act § 8(B) (superseded) (App. B). A few state Guaranty Association statutes still have this provision.

count toward the statutory coverage limit.) Most LTC policyholders are never affected by the statutory coverage limit, either because (1) the maximum benefit under the policy is less than the statutory coverage limit; (2) they never go on claim; or (3) they do not remain on claim long enough to exceed the statutory coverage limit. R.2398a:21-2400a:1; 2417a:24-2418a:15 (testimony by Mr. Morton that "it's really just a fraction of that original bucket [of total policyholders] that would have their policy benefits limited to the GA limit").

Each Guaranty Association's statutory purpose is to protect policyholders against an insurer's failure to fulfill its contractual obligations. 40 P.S. § 991.1701; *see also* Model Act §§ 2(A) and 4 ("This Act shall be construed to effect the purpose under Section 2."). According to a drafting note to the Model Act, the purpose of the Model Act is to protect policyholders against losses "both in terms of paying claims and continuing coverage":

> Unlike the property and liability lines of business, life and annuity contracts in particular are long-term arrangements for security. An insured may have impaired health or be at an advanced age so as to be unable to obtain new and similar coverage from other insurers. The payment of cash values alone does not adequately meet such needs. Thus it is essential that coverage be continued.

Model Act § 2, Drafting Note; *see also* R.2250a:24-2251a:11.

The Guaranty Associations have flexibility to provide policyholder protection as appropriate to a particular insolvency in which Guaranty Association

coverage may be triggered. R.2251a:21-2252a:6. As NOLHGA President Peter Gallanis testified:

> [G]uaranty association statutes and the practice that has evolved contemplate guaranty associations reacting flexibly and creatively and collaboratively to design response plans that are appropriate to a particular insolvency that may trigger guaranty associations.

R.2252a:1-6. For instance, Guaranty Associations may continue coverage under the policy, retain the obligation to pay claims as they come due, and retain the right to receive premiums under the policy. R.2252a:7-19; 2257a:7-11; 40 P.S. §§ 991.1706(b)(1) and (e); *see also* Model Act §§ 8(B)(1) and 8(D). Alternatively, Guaranty Associations may effectuate a transfer of the business to a solvent insurer, generally supported by assets of the estate of the failed company and supported by funding from the Guaranty Associations. R.2252a:22-2253a:10. Less frequently, a Guaranty Association may issue alternative policies as a substitute for policies issued by the failed company. R.2253a:13-25; 40 P.S. § 991.1706(b)(2); *see also* Model Act § 8(B)(2).

In providing continuing coverage, Guaranty Associations may seek rate increases on premiums; indeed, they have done so recently.[6] R.2257a:7-11; 40 P.S. § 991.1706(m)(9); *see also* Model Act § 8(L)(9). Guaranty Associations also

[6] The Appellants note, "The [guaranty association] statutes do not limit guaranty association coverage based upon forensic analysis of premium adequacy." Appellants' Brief at 35. It is true that there is no limitation or exclusion from coverage based on premium adequacy, but the statutes do permit the Guaranty Associations to seek and implement rate increases in liquidation.

may offer benefit modification options to policyholders as an alternative to rate increases; they have done that recently as well. *See* R.2257a:9-2258a:12 and 2426a:13-2427a:7.

Because the Guaranty Association system is dynamic, enterprising, and pragmatic, it has a rich history of protecting policyholders in fiscally responsible ways that take into account competing considerations. In other words, the Guaranty Associations provide protection to policyholders in the way that best suits the circumstances of each insolvency. One such example is the Penn Treaty liquidation (discussed in Section II.C below). Here are a few other examples:

- In the liquidation of Executive Life Insurance Company of New York ("ELNY"), the Guaranty Associations formed a captive insurance company to serve as the vehicle to collectively run off the ELNY annuities covered by the Guaranty Associations. The Guaranty Associations also coordinated with a group of life insurance companies that provided an extra layer of protection to policyholders so that the captive could administer that extra layer of protection. Order of Liquidation and Approval of the ELNY Restructuring Agreement, *In the Matter of the Rehabilitation of Executive*

*Life Ins. Co. of N.Y.,* No. 8023/91 (Nassau Cnty. N.Y. Apr. 19, 2012) (App. C).[7]

- In the liquidation of Golden State Mutual Life Insurance Company, the Guaranty Associations received court approval to have a group life insurance policy terminated and issued replacement individual policies to certificate holders under the group policy (at premium rates approved by the court). Notice of Entry of Order Granting Joint Application for Orders Approving Claim Handling Agreements, Rate Tables and Issuance of Alternative Policies, *Ins. Comm'r of Cal. v. Golden State Mut. Life Ins. Co.*, No. BS123005 (Sup. Ct. Los Angeles Cnty. May 30, 2012) (App. D).
- To address the insolvency of Kentucky Central Life Insurance Company, the Guaranty Associations guaranteed to each covered policyholder that the benefits they would receive under their restructured policies would never be less than the statutory benefits provided under the Guaranty Association statutes. The restructured policies were fully assumed via reinsurance by a solvent insurer. The Guaranty Associations delivered their benefits

[7] Under Pennsylvania Rule of Evidence 201, a court can take judicial notice of facts "from sources whose accuracy cannot reasonably be questioned." Pa.R.E. 201(b)(2). The Supreme Court has taken judicial notice of such matters as published statistics, *Sands Bethworks Gaming, LLC v. Pennsylvania Dep't of Revenue*, 207 A.3d 315, 323 n.7 (Pa. 2019), the laws and judicial decisions of other jurisdictions, *Melmark, Inc. v. Schutt by and through Schutt*, 206 A.3d 1096, 1105 (Pa. 2019), and conduct taking place pursuant to federal statutes, *In re General Statewide Judicial Emergency*, 230 A.3d 1015 (Pa. 2020).

through an agreement with the assuming insurer and provided over $200 million of benefits in a coordinated and seamless way that eliminated any additional administrative burdens on the protected policyholders. *Kentucky Cent. Life Ins. Co. v. Stephens*, 897 S.W.2d 583, 591 (Ky. 1995).

While past examples are illustrative of what Guaranty Associations might do to provide policyholders protection when triggered, the examples are illustrations only. Guaranty Associations are not restricted to the insolvency resolution plans adopted in past insolvencies when addressing policyholder protection in future insolvencies. The governing statutes impose few limitations (such as maximum coverage limits) on Guaranty Associations but do not constrain Guaranty Associations as to the nature or number of options that can be offered to policyholders in liquidation. R.2243a:7-14. Further, each Guaranty Association's board of directors "shall have discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of [the Guaranty Association statute] in an economical and efficient manner." 40 P.S. § 991.1706(p); *see also* Model Act § 8(O).

Guaranty Associations fund their coverage from three sources – the assets of the insolvent insurer, premiums due after liquidation, and assessments of Guaranty Association member insurers. R.2259a:11-2260a:2. These are listed in sequential order, so that if available estate assets and premiums from policyholders are

inadequate to cover claims in liquidation, Guaranty Associations have the authority to assess their member insurers, with any such assessment determined according to a statutory methodology. R.2259a:21-2260a:2; 40 P.S. § 991.1707(a) ("For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary.") and (c)(2); *see also* Model Act §§ 9(A) and 9(C)(3). A Guaranty Association's member insurers are the insurance companies licensed to write covered lines of business in the Guaranty Association's jurisdiction. R.2260a:3-10; *see also* 40 P.S. §§ 991.1702 and 1704(a); Model Act §§ 5(M) and 6(A).

In many states, member insurers may be able to offset some portion of Guaranty Association assessment payments against state premium taxes that the insurance company would otherwise be obligated to pay. R.2260a:22-2261a:3. That tax offset, however, is not direct funding; no Guaranty Association receives direct funds from state general revenues or taxes raised by the state. R.2260a:16-21. In a few states, member insurers may impose a surcharge on health insurance policies to recoup Guaranty Association assessments paid for health insurance insolvencies. R.1701a:19-22; *see, e.g.*, Cal. Ins. Code § 1067.08(i).

## C. THE PENN TREATY LIQUIDATION – A RECENT EXAMPLE

The Pennsylvania liquidation involving Penn Treaty Network America Insurance Company and American Network Insurance Company (collectively referred to as "Penn Treaty") is the largest LTC insurance company insolvency that has triggered Guaranty Association coverage to date. R.2321a:3-6. In that liquidation, the 50 affected Guaranty Associations worked together, through NOLHGA and with outside advisors, to develop an approach to discharge their statutory obligations to Penn Treaty policyholders. As one element, NOLHGA's member Guaranty Associations sought rate increases on the covered LTC insurance policies and alternatively offered policyholders benefit modification options. The Plan offers similar, but not identical, options to SHIP's policyholders. R.2257a:25-2258a:12; 2419a:2-2420a:3; 2426a:13-2527a:7. The Rehabilitator looked to the Guaranty Associations' response to the Penn Treaty liquidation in formulating the rate increase methodology used in the Plan. R.1672a:11-14. The Penn Treaty rate increases applied to about 53,000 policyholders. R.2420a:1-3.

The methodology for calculating premium rate increases used by the Guaranty Associations in the Penn Treaty liquidation is similar to the "If Knew" methodology used in the Plan, but with two significant exceptions. R.2422a:18-2423a:4. First, the Plan calculates rate increases on an individualized basis while the Penn Treaty rate increases were developed on a cohort basis. The Plan

calculates an individual premium rate for each policyholder, meaning that individual policy/policyholder data is used to develop an individual premium rate for each policyholder. R.2008a:12-23. In Penn Treaty, the rate increases were developed using an industry standard cohorts method, meaning that an average rate increase was developed and applied to each group of similarly situated policyholders. R.2421a:13-22; 2423a:5-10. Second, the Penn Treaty premium rates were based on benefits capped at Guaranty Association statutory coverage limits, so policyholders were not charged a premium for benefits that were not covered by the Guaranty Associations in liquidation. The Plan's premium rates are based on full benefits under the existing policies. R.1672a:11-14; 2420a:18-24.

The Guaranty Associations offered policyholders four options in connection with the Penn Treaty rate increases. The options were designed to give policyholders choices and flexibility. R.2428a:14-18. Policyholders could choose to (a) reduce their benefits and maintain the current premium, (b) convert to a reduced paid-up policy, (c) take a cash payment in exchange for terminating the policy, or (d) accept a rate increase and maintain the current benefits. R.2257a:9-2258a:12 and R.2426a:13-2427a:8. Accepting the rate increase was the default option for policyholders who did not make an affirmative election. R.2428a:19-23.

There were a few variations by state; for example, one state regulator did not approve the cash payment option.[8] R.2427a:18-20.

The options offered to Penn Treaty policyholders are not identical to the options offered under the SHIP Plan. Both include options for policyholders to reduce benefits and keep the same premium; however, the methodologies used to determine which benefits are reduced are different. Both provide policyholders an option to accept the rate increase and keep current benefits; but, as explained above, there are differences in the rate increase calculations and, in the Penn Treaty liquidation, benefits were capped at Guaranty Association coverage limits.[9] Both also include a nonforfeiture (reduced paid-up) option, but the Guaranty Associations offered a more typical nonforfeiture benefit, while the Plan offers an enhanced benefit. R.2052a:19-25. In addition, the SHIP Plan offers a Basic and Enhanced Basic Policy, but there were no similar new policy options in the Penn Treaty liquidation. R.2448a:19-2449a:6. The Guaranty Associations offered a cash payment option to Penn Treaty policyholders, while the SHIP Plan does not offer a cash payment option. R.2427a:8-17.

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[8] The Commonwealth Court's Opinion and Order states that "[o]nly one state approved the cash-out option." R.3699a. This appears to be a typographical error because only one state did not approve the cash-out option. R.2427a :18-20.

[9] In addition, in the Penn Treaty liquidation, the Guaranty Associations did not charge policyholders on premium waiver a Differential Premium like that charged under the Plan when such policyholders elect a rate increase. R.2437a:21-2438a:3. However, the rate increase would go into effect for such Penn Treaty policyholders if they went off waiver. R.2451a:2-7.

The Guaranty Associations submitted the proposed Penn Treaty rate increases to state insurance regulators (generally in the state of policy issuance) for approval. R.2424a:16-18. Forty-four out of 48 states issued their approvals within 15 months of the initial filing. R.2425a:16-19. Thirty-four states approved 100% or more of the proposed rate increase; 11 approved between 80% and 100% of the proposed rate increase; and 3 approved less than 60% of the proposed rate increase. R.2425a:2-13. No state denied the Guaranty Associations' rate increase filing in the Penn Treaty liquidation. R.2425a:14-15.

Penn Treaty is one example of how Guaranty Associations have protected policyholders in a specific liquidation with challenging circumstances. Penn Treaty is a recent and the largest example of a LTC insolvency, coincidentally also involving Pennsylvania-domiciled LTC insurers. The parties to this proceeding, including NOLHGA, have therefore reasonably compared and contrasted the SHIP receivership with the Guaranty Associations' experience in Penn Treaty. However, the specifics of Penn Treaty should not be relied on as a prediction of what will happen in another liquidation. R.2357a:25-2358a:4. In a different, nationally significant liquidation, the approach to protecting policyholders might be more (or less) complex than the approach the Guaranty Associations adopted for Penn Treaty. R.2258a:13-25. As the other examples above demonstrate, a plan adopted by the Guaranty Associations in any liquidation is tailored to the issues specific to

that liquidation and an evaluation of the best means by which to meet each Guaranty Association's statutory obligations to its policyholders. *See supra* Section II.B.

### D. GUARANTY ASSOCIATIONS AND SHIP

According to the Plan, SHIP is or was licensed in 46 states (not including Connecticut, New York, Rhode Island, and Vermont) as well as the District of Columbia and the U.S. Virgin Islands. Forty-seven of NOLHGA's member Guaranty Associations therefore have potential obligations to SHIP's policyholders.[10] Although Guaranty Association obligations are not typically triggered by a rehabilitation (and to date no Guaranty Association has been triggered in connection with SHIP's rehabilitation), the Guaranty Associations will be triggered if SHIP is liquidated at some point, and the choices made with respect to SHIP's rehabilitation will affect the Guaranty Associations if and when triggered.

All or virtually all SHIP policyholders are believed to be covered by a Guaranty Association. R.2227a:17-19. The Guaranty Association that covers a policyholder generally is the Guaranty Association in the state in which the policyholder resides at the time of an entry of an order of liquidation with a finding of insolvency. R.2255a:10-14. Under statutes currently in effect, if SHIP were

[10] There is no Guaranty Association in the U.S. Virgin Islands.

placed in liquidation, the covering Guaranty Association would provide each policyholder with coverage up to the maximum benefit under the policy or the statutory limit for Guaranty Association coverage payments (if lower), which, as noted above, is $300,000 in most states and more in a few others. R.2255a:15-22; 2416a:14-16; 40 P.S. § 991.1703(c)(1)(ii)(A)(II)(2); *see also* Model Act § 3(C)(2)(a)(ii)(II).

The Plan gives policyholders certain options to modify their policy premium and/or benefits. R.1136a-1137a. The Rehabilitator intends for the policyholder elections to modify premium and/or benefits permanently, which the Rehabilitator considers necessary to effectuate the purpose of reducing or eliminating the funding gap. R.1951a:14-18. Permanence creates certainty, which is necessary both for policyholders attempting to evaluate their options and for Guaranty Associations if SHIP's rehabilitation ultimately is converted to liquidation. R.1965a:24-1966a:12; 2233a:4-16. The Plan states that it is possible SHIP will be placed in liquidation if the Plan fails to reduce or eliminate the shortfall between SHIP's projected liabilities and its assets and projected premiums. R.1133a.

As the Commonwealth Court observed, no order of the Court will make Guaranty Association coverage unavailable to policyholders. R.2588a:20-2589a:1. In that regard, the Plan will not change the rights or obligations of the Guaranty Associations. The Guaranty Associations will, as their governing statutes require,

provide coverage in the event of SHIP's liquidation. If SHIP were placed in liquidation now, Guaranty Associations would provide coverage for the SHIP policies currently in effect. If SHIP is placed in liquidation after the Plan has been implemented, Guaranty Associations would provide coverage for the policies as modified based on policyholder elections in rehabilitation pursuant to the Plan (since those elections are permanent). In either case, the Guaranty Associations would have the right and ability to seek premium rate increases and offer benefit modification options, as discussed above.

Since the Guaranty Associations cover up to the lesser of the policy maximum or the statutory coverage limit, the Guaranty Association coverage provided to a policyholder in a liquidation of SHIP after the Plan has been implemented could be different than if SHIP were liquidated now because of changes to the policy maximum or other benefit modifications elected by policyholders under the Plan. Of course, the ultimate Guaranty Association coverage obligation also would be impacted by rate increases sought and benefit modification options offered and elected in liquidation.

No party to this proceeding can definitively say how the Guaranty Associations would discharge their statutory obligations in response to a liquidation of SHIP (beyond affirming that the Guaranty Associations will satisfy their statutory obligations if triggered). *See* R.2306a:25-2307a:4. The Guaranty

Associations likely would consider premium rate increases and benefit modifications to address any underpriced policies, as they did in the Penn Treaty liquidation. R.2394a:13-2395a:3. As Mr. Gallanis testified, the Guaranty Associations "also would take into account what they have learned over time and what they are learning from industry receivers and regulators, and primarily the actuarial community, in reaching a conclusion of what such a program would look like." R.2395a:4-9.

In the event of SHIP's liquidation, the Guaranty Associations would together be the largest creditor of SHIP's estate with claims for coverage provided to policyholders in liquidation. *See* 40 P.S. § 221.3 ("'Creditor' is a person having any claim, whether matured or unmatured, liquidated or unliquidated, secured or unsecured, absolute, fixed or contingent.").

## SUMMARY OF ARGUMENT

An accurate record as to the rights and obligations of the Guaranty Association system is critical for this proceeding and the precedent it will create. While this Court is being asked to review the approval of a Plan of Rehabilitation, the rights and obligations of Guaranty Associations in liquidation are important elements of certain of the arguments raised in this case by other parties. In support of Appellants' arguments II and III, in particular, Appellants have offered facts related to Guaranty Association rights and obligations. NOLHGA expects the

Rehabilitator will offer her version of those facts as well. NOLHGA agrees that certain facts related to Guaranty Association rights and obligations must be understood in order to consider and evaluate arguments II and III, and NOLHGA has set forth its Supplement to the Statement of Facts above.

NOLHGA sought to "serve as a resource to [the Commonwealth Court] and to any other interested parties who are interested in getting an accurate understanding of how the guaranty association[s] work" by providing accurate information, based on statutory law and real-life precedent. R.2302a:1-20. NOLHGA likewise wishes to serve as a resource for this Court.

## ARGUMENT

### I. THE PLAN DOES NOT ALTER THE GUARANTY ASSOCIATIONS' STATUTORY COVERAGE OBLIGATIONS TO POLICYHOLDERS IN THE EVENT OF SHIP'S LIQUIDATION, BUT ANY PROJECTION OF GUARANTY ASSOCIATION COVERAGE IS SPECULATIVE AND PREMATURE.

The Appellants repeatedly assert that the Guaranty Associations will provide approximately $837 million in support to policyholders in the event of SHIP's liquidation, and that the Plan will deprive policyholders of that Guaranty Association support. Appellants' Brief at 15-16 ("Guaranty associations would provide approximately $837 million in additional support to benefit policyholders.... The Plan does not trigger the guaranty associations...so these funds will not be available to benefit policyholders under the Plan." (internal

citations omitted)). To the extent the Appellants are suggesting that approval of the Plan would deprive policyholders of Guaranty Association coverage if SHIP goes into liquidation, such a suggestion is inaccurate. If SHIP is placed under an order of liquidation with a finding of insolvency, and the Guaranty Associations are triggered, the affected Guaranty Associations will satisfy their statutory obligations to pay benefits to and continue coverage for policyholders, just as they have done in every other liquidation in the system's history. Policyholders will be eligible for Guaranty Association coverage up to the lesser of their policy's maximum benefits or the statutory coverage limit for their covering Guaranty Association ($300,000 in most states).

While the Plan may result in changes to the benefits and premiums under a policy, which would accordingly change the benefits covered and premiums received by the Guaranty Association, the Plan will not change a policyholder's eligibility for Guaranty Association coverage or the Guaranty Associations' obligation to provide that coverage.[11] As set forth above, the Guaranty Association coverage provided to a policyholder in a liquidation of SHIP after the Plan has been implemented could be different than the coverage that would be provided in

[11] NOLHGA's comments on the impact of the Plan refer only to the impact of Phase One of the Plan. The details of Phase Two are unclear, leaving NOLHGA unable to comment on the impact of Phase Two and raising additional uncertainty about what liquidation might entail.

an immediate liquidation of SHIP, but any such difference would be due to the permanent benefit changes elected by the policyholder during rehabilitation.

With respect to the $837 million figure referenced by the Appellants, NOLHGA notes that the amount was derived by the Appellants based on data provided by the Rehabilitator that included Guaranty Association coverage estimates. NOLHGA and its member Guaranty Associations did not provide and cannot confirm those estimates. At this time, no Guaranty Association has been triggered by SHIP's receivership, and the amount of the Guaranty Associations' coverage obligations cannot be known with certainty until they are triggered.

In addition, the Guaranty Associations' ultimate coverage and funding obligations will depend on several factors, including the estate assets allocated to the Guaranty Associations, the premiums charged by the Guaranty Associations in liquidation, and the results of any benefit modifications offered by the Guaranty Associations. The Rehabilitator's data referenced by the Appellants makes assumptions about estate assets allocated to Guaranty Associations and premium rates to be charged in liquidation, but those assumptions ultimately may not reflect actual experience. The estimates also do not account for potential benefit modification options offered in liquidation.

## II. GUARANTY ASSOCIATIONS HAVE THE AUTHORITY, RESPONSIBILITY, AND FLEXIBILITY TO OFFER MEANINGFUL CHOICES TO POLICYHOLDERS IN LIQUIDATION AND ARE NOT LIMITED TO THE OPTIONS THAT WERE OFFERED TO THE PENN TREATY POLICYHOLDERS.

Other parties to this proceeding have made arguments seemingly based on their conclusions about the rate increase and benefit modification options that could or will be implemented by Guaranty Associations in future liquidations given the approach adopted by the Guaranty Associations in Penn Treaty. The Commonwealth Court itself appears to have assumed that the Guaranty Associations would implement the same approach they implemented in the Penn Treaty liquidation in any future liquidation of an LTC insurer, including a potential liquidation of SHIP. Indeed, the Commonwealth Court's Opinion and Order could be read to imply that Guaranty Associations are limited to offering exactly what they offered in the Penn Treaty liquidation and do not have flexibility to do anything else. *See, e.g.*, R.3707a ("the options available to policyholders under the Second Amended Plan are better than what would be offered by guaranty associations in a liquidation.") and 3710a ("In a liquidation of SHIP, policyholders will not be offered the choices provided under the Second Amended Plan."). NOLHGA's testimony does not support those inferences nor any conclusion about exactly how the Guaranty Associations would address a possible liquidation of SHIP.

NOLHGA disagrees with the implication that policyholders would not have meaningful choices in liquidation. Because Guaranty Associations have flexibility in designing rate increase programs and offering benefit modifications to policyholders in the alternative—and have exercised that flexibility—they can develop meaningful approaches tailored to the circumstances of a particular liquidation. R.2257a:9-2258a:12; 2419a:2-2420a:3; 2426a:13-2427a:7.

As creatures of statute, the Guaranty Associations face certain limitations in their statutory authority. Guaranty Associations are not obligated to cover benefits in excess of the statutory coverage limit and generally would not offer a benefit modification option under which covered benefits would exceed statutory Guaranty Association coverage limits. R.2428a:6-9; 40 P.S. § 991.1703(c)*; see also* Model Act § 3(C).

Based on data provided by the Rehabilitator, as of June 30, 2020, approximately 42% of SHIP's LTC policyholders have policies with maximum policy values that exceed the applicable GA coverage limit.[12] *See* R.1015a (18,076 out of 42,559 policyholders have current present value of benefits greater than the Guaranty Association covered present value of benefits as shown in column W in

[12] While 42% of policyholders fall into this category, the number of policyholders actually expected to have claims that reach the Guaranty Association coverage limit is much lower, because not all policyholders will go on claim and not all policyholders who go on claim will have claims in excess of Guaranty Association limits. See discussion in Section II.B above.

both tabs; data as of 6/30/20). Under the Plan, those policyholders would have the option in rehabilitation to increase the premiums they pay in order to maintain full benefits (including benefits that would be in excess of Guaranty Association limits in liquidation) by choosing Option 4, at least in Phase One.[13] NOLHGA agrees with the Rehabilitator that Guaranty Associations could not offer Option 4 in liquidation as to all policies. NOLHGA disagrees, however, that the Guaranty Associations are thus limited to offering less meaningful options. Subject to the statutory limits on coverage and any approvals required by statute, the Guaranty Associations may offer a wide variety of options to policyholders in liquidation, including options offered and not offered under the Plan. R.2258a:13-25.

Similarly, other parties and the Commonwealth Court appear to have concluded that because the Guaranty Associations did not offer certain benefit options to policyholders in the Penn Treaty liquidation, they are not able to or will not offer such options to any policyholders in a future liquidation. The Guaranty Associations based their policyholder options in Penn Treaty on extensive analysis of Penn Treaty's and its policyholders' position. Not only are the Guaranty Associations not bound in any way to provide the same benefit options that they provided in Penn Treaty, they are obligated and committed to undertaking the same

[13] The record is unclear as to how full benefits could be paid to policyholders electing Option 4 in the event SHIP's Funding Gap is not entirely eliminated.

in-depth analysis of the characteristics of any future liquidation when developing a plan for that liquidation. As Mr. Gallanis testified, the Penn Treaty rate increase program is illustrative, but it does not define or limit what GAs may do or offer in a future liquidation. R.2258a:13-21. Mr. Gallanis stated that, if the Guaranty Associations were triggered by a liquidation of SHIP or another insurer, "at least those options [that were provided to Penn Treaty policyholders] and probably more would be available to the guaranty associations." R.2258a:21-25. It is inaccurate to say that Guaranty Associations cannot or will not offer meaningful choices to policyholders in a future liquidation.

## III. RATE INCREASES AND BENEFIT MODIFICATION OPTIONS TO BE IMPLEMENTED BY GUARANTY ASSOCIATIONS IN A FUTURE LIQUIDATION CANNOT BE DETERMINED OR PREDICTED NOW.

NOLHGA emphasizes that any rate increase/benefit modification program that may be offered in the event of SHIP's liquidation is undetermined at this time. If it appears likely the Guaranty Associations will be triggered by a liquidation of SHIP, the affected Guaranty Associations and NOLHGA will evaluate how the Guaranty Associations will satisfy their statutory obligations, including by offering rate increase and benefit modification options, drawing upon past experience, and analysis of the facts and circumstances available at that time. R.2394a:13-2395a:9.

NOLHGA has noted the risk of making predictions and projections as to rate increases the Guaranty Associations may seek in a liquidation of SHIP. Further,

NOLHGA emphasized that, due to the speculative nature, it would be inappropriate and confusing to share such predictions and projections with policyholders at this time.[14] R.2239a:1-2242a:16. It is unknown whether the Guaranty Associations would seek rate increases in the event of liquidation of SHIP and, if they would, at what levels or upon what basis. Any such decisions depend on what happens in the course of the SHIP rehabilitation proceeding.

The Commonwealth Court seems, however, to have drawn conclusions about what the Guaranty Associations would do in connection with a liquidation of SHIP and to have relied on those conclusions when considering the questions before it. For example, the Commonwealth Court characterizes the testimony of NOLHGA's witness, actuary Matthew Morton as follows:

> 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

[14] NOLHGA expressed concerns about certain mischaracterizations and incomplete statements about Guaranty Association rights and obligations in its written filings and testimony to the Commonwealth Court. In addition to wanting to ensure that the Court was presented with accurate facts, NOLHGA wanted to ensure that policyholders themselves were provided with accurate and full facts so that they could make informed decisions under the Plan. For example, NOLHGA requested that references to Guaranty Association coverage limits and projected rate increases in liquidation be removed from the policyholder election materials (a sample of which was included in the Plan). R.2924a-2925a. The Rehabilitator recently posted the policyholder election materials to the SHIP website. Contrary to NOLHGA's request, the Summary of Current Coverage includes the Guaranty Association coverage limits and expected rate increase that could be pursued in the event of the liquidation of SHIP. Summary of Current Coverage, *available at* https://www.shipltc.com/_files/ugd/f85397_5db8268d3a8c4f179ff5c41a307ebe88.pdf (last visited Jan. 26, 2022).

> 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.

R.3743a.

In fact, however, at no point in his testimony did Mr. Morton discuss what the Guaranty Associations would do in a liquidation of SHIP or in any other liquidation. Instead, on cross-examination, Mr. Morton was explicit that he could not tell the court what the Guaranty Associations would do in liquidation. R.2436a:2-5. Mr. Morton also was clear that he could not tell the court what Guaranty Associations are legally permitted to do in liquidation. R.2436a:11-14. Instead, Mr. Morton testified about what the Guaranty Associations did in response to the Penn Treaty liquidation, as an illustration of what the Guaranty Associations can do and have done. The Commonwealth Court misapprehended Mr. Morton's testimony to the extent it concluded that the Guaranty Associations are only able to do in a future liquidation exactly what they did in the Penn Treaty liquidation.[15]

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[15] Similar misapprehensions about what Guaranty Associations can or cannot do in liquidation continue to be included in public statements. *See, e.g.*, Statement of Pennsylvania Insurance Commissioner Jessica Altman Regarding the Rehabilitation Plan for Senior Health Insurance Company of Pennsylvania, *available at* https://www.shipltc.com/_files/ugd/630dfc_756831f2dd4443f28066f9270a10ffdb.pdf (last visited Jan. 26, 2022) (stating that certain options "would not be available in liquidation") and Defs.' Mem. of Law in Opp'n to Pls.' Prayer for Issuance of a Prelim. Inj., at 44, *Donelon v. Altman, et al.*, 19th Jud. Dist. Ct., Par. of E. Baton Rouge, La. No. 713794 (Jan. 7, 2022) (App. E) (internal citations omitted) ("In a liquidation, the guaranty associations would *still* seek rate

That is not supported by the record at the hearing, by governing statutes, or by the history of Guaranty Association responses to other liquidations.

The statutes governing Guaranty Associations give significant flexibility as to how Guaranty Associations discharge their statutory obligations to policyholders of an insolvent insurer. 40. P.S. §§ 991.1702 and 1706(b); *see also* Model Act §§ 5(L) and 8(B). The Guaranty Associations can exercise flexibility and creativity in addressing a liquidation – and they have done so repeatedly over the course of their history. Whether Guaranty Associations would, for example, seek rate increases, do so on a seriatim or cohort basis, develop a rate increase based on the If Knew or another methodology, offer benefit modification options, or offer a cash payment option will depend on all the facts and circumstances of the insolvency as they are presented at the time one or more Guaranty Associations are triggered.

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increases and limit policyholders to the coverage amounts provided by state law—while also 'having little or no choice for their coverage.'").

## CONCLUSION

For all the reasons set forth above, NOLHGA respectfully requests that the Court consider the record set forth above as it answers the questions before it.

Dated: January 26, 2022

Respectfully submitted,

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## CERTIFICATE OF COMPLIANCE

I hereby certify that this brief contains 7,028 words, as determined by the word-count feature of Microsoft Word 365, the word-processing program used to prepare this document, and excluding the portions of the exempted by Pa.R.A.P. 2135(b).

Dated: January 26, 2022

*/s/ D. Alicia Hickok*
D. Alicia Hickok

## CERTIFICATE OF COMPLIANCE WITH PA.R.A.P. 127

I hereby certify 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.

Dated: January 26, 2022

/s/ *D. Alicia Hickok*
D. Alicia Hickok

## PROOF OF SERVICE

I, D. Alicia Hickok, hereby certify that on January 26, 2022, I caused the foregoing Brief for Appellee National Organization of Life and Health Insurance Guaranty Associations to be served by electronic delivery to the Rehabilitator's counsel and the Special Deputy Rehabilitator at the below addresses:

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Dated: January 26, 2022

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US.136281793.07

# APPENDIX A

STATES WHICH HAVE ENACTED
PROPERTY AND LIABILITY INSOLVENCY FUNDS
as of December 1, 1970

| *Applicable to Substantially All Property and Liability Lines* | *Applicable to Auto and Workmen's Compensation Lines* |
|---|---|
| Alaska | Maryland |
| Arizona | New Jersey |
| California | |
| Delaware | |
| Florida | |
| Georgia | |
| Idaho | |
| Iowa | |
| Kansas | |
| Louisiana | |
| Maine | |
| Massachusetts | |
| Michigan | |
| Mississippi | |
| New Hampshire | |
| New York | |
| Ohio | |
| Pennsylvania | |
| Rhode Island | |
| South Dakota | |
| Vermont | |
| Virginia | |
| West Virginia | |
| Wisconsin | |

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## Uninsured and Partially Uninsured Non-Regulated Plans (B6) Subcommittee (Mtg. 28)

Ref.: 1970 Proc. Vol. IIA p. 602

The meeting of the Uninsured and Partially Uninsured Non-Regulated Plans (B6) Subcommittee met at 10:30 a.m., December 16, 1970, in the Red Lacquer Room of the Palmer House Hotel, Chicago, Illinois. A quorum was present.

There being no new matters submitted to the Subcommittee for consideration, the meeting was adjourned.

Hon. Russell E. Van Hooser by John E. Hurth, Chm., Michigan; Hon. Everette S. Francis, V. Chm., Virginia; Hon. Richards D. Barger, California; Hon. Edwin H. Honda, Hawaii; Hon. James Baylor, Illinois; Hon. Samuel H. Weese, West Virginia; Hon. S. C. DuRose, Wisconsin.

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## To Study Life and Disability Insurance Insolvencies and Prepare Any Necessary Legislation (B7) Subcommittee (Mtg. 2)

Ref.: 1970 Proc. Vol. IIB p. 1071

The (B7) Subcommittee to Study Life and Disability Insurance In-

solvencies and Prepare Any Necessary Legislation met in the Palmer House Hotel, Chicago, Illinois, on December 14-15, 1970.

This Subcommittee was created at the December 1969 meeting in New Orleans. At its June meeting in Cleveland, tentative decisions were made along with direction to the central office staff to prepare an initial draft of model legislation. Such a draft was considered by the Subcommittee at its October 28, 1970 meeting in Chicago at which time industry representatives were afforded an opportunity to be heard. Thereafter, pursuant to the Subcommittee's decisions, the November 1970 draft was submitted to the Subcommittee and to industry representatives prior to this meeting. Here in Chicago, the following persons submitted written statements pertaining to the question of need and desirability of insolvency legislation: Messrs. Robert Montgomery (on behalf of the Life Insurance Association of America, the American Life Convention and the Health Insurance Association of America), Donald Ames (CNA), Ed Jones (New York Life Insurance Company) and Raymond F. Killion (Metropolitan Life Insurance Company). Copies of their statements are attached as Exhibits 2 through 5.

In addition, Messrs. William Nichol (American National Insurance Company), O. L. Frost (Occidental Life Insurance Company), Walter Nelson (State Farm), John Meyerhold (Phoenix Mutual Life Insurance Company) presented oral comments generally supporting the statement of Mr. Montgomery. Subsequently, Mr. Jack Blaine on behalf of the American Life Convention, the Life Insurance Association of America and the Health Insurance Association of America, submitted a written statement suggesting possible modifications in the November 1970 draft. A copy of his statement is attached as Exhibit 6.

Following its series of meetings, study and discussion, the Subcommittee concluded—

(1) No study has demonstrated substantial losses on an aggregate basis to life, annuity and health policyholders attributable to insolvencies. Nevertheless, insolvencies have occurred and losses to the individual victims can be quite severe. These persons purchased their insurance relying on the insurance industry's integrity and good faith in performing contractual obligations. They are entitled to protection.

(2) The enactment of insolvency fund legislation, funded by assessments on insurers doing business in the state, should not be viewed in the context of good companies subsidizing the bad. But rather it provides a mechanism by which each policyholder, through a slightly increased cost, purchases protection for himself against the insolvency of his insurer. This is another form of risk spreading.

(3) Protecting the insurance public against insolvencies involves at least three elements: (a) devices for detecting problems as soon as possible, (b) techniques to prevent insolvencies once difficulties are ascertained, and (c) providing guarantee protection when an insolvency does in fact occur.

Over the period of many years, statutes, regulations and administrative techniques have evolved to prevent insolvencies. Additional work is being done at various levels to further improve preventative measures. It is the recommendation of this Subcommittee that the Financial Condition, Examinations and Reporting (A) Committee (or a subcommittee thereof) be directed to consider possible improvements in the insolvencies preventative mechanism. At the same time, however, it should be recognized that a regulatory system which seeks to provide an absolute guarantee against the occurrence of insolvencies might well be so highly onorous as to be unacceptable to our free enterprise—competitive system. Thus, there is and there will continue to be a need for insolvency fund legislation.

(4) The Subcommittee recommends the adoption of the attached model bill for the reasons expressed above and those expressed in the comments prepared in conjunction with the specific sections of the model bill.

It is recommend that this Subcommittee be continued.

Hon. S. C. DuRose, Chm., Wisconsin; Hon. Russell E. Van Hooser, V. Chm., Michigan; Hon. R. Frank Ussery, Alabama; Hon. A. G. Sykes, Arkansas; Hon. Robert A. Short, Delaware; Hon. Cornelius C. Bateson, Oregon; Hon. Karl V. Herrmann, Washington.

EXHIBIT 2

AMERICAN LIFE CONVENTION

211 East Chicago Avenue, Chicago, Ill. 60611

LIFE INSURANCE ASSOCIATION OF AMERICA

277 Park Avenue, New York, N. Y. 10017

Health Insurance Association of America

332 South Michigan Ave., Chicago, Illinois 60604

December 14, 1970

# TO THE NAIC SUBCOMMITTEE (B7) TO STUDY LIFE AND DISABILITY INSURANCE INSOLVENCIES AND PREPARE ANY NECESSARY LEGISLATION

*Introduction*

This statement is submitted by the American Life Convention, the Health Insurance Association of America and the Life Insurance Association of America, three trade associations of life and health insurance companies, having a combined membership of 485 United States and Canadian companies, which have about 94% of the total life insurance in force, and approximately 90% of the total health insurance written in the United States.

At its 1969 Annual Meeting, the NAIC authorized the appointment of a Subcommittee to Study Life and Disability Insurance Insolvencies and Prepare any Necessary Legislation (B7). The Subcommittee, at its first meeting, on March 24, 1970, informed the three industry associations that it did not wish to receive submissions, nor hear arguments, relating to evidence of need for legislation on the subject of insolvencies that might involve life and health insurance companies, but that an opportunity would be provided at the 1970 NAIC Regular Meeting for both submissions and arguments. Accordingly, this is the first time that the associations have been allowed to address themselves to the subject of need and appropriateness. In the meantime, however, they have commented on and made suggestions regarding successive drafts of model legislation being considered by the Subcommittee, on each occasion reserving the right to be heard on the far more significant matters of need and appropriateness. Further comments and suggestions on the latest draft prepared for the Subcommittee by NAIC staff will be made in a statement to follow this one. They are not to be taken as any concession by the associations that guaranty legislation is either necessary or appropriate.

*Action by the Subcommittee Would be Premature and Misdirected*

The industry associations and their members of course are concerned about any policyholder who might be injured by reason of the insolvency of an insurer. Nevertheless, for the reasons given in this statement, the associations vigorously oppose the promulgation of model legislation by this Subcommittee. Such action would be superficial in that it is not based on a thorough consideration of the problem to be solved. In has not involved a full evaluation of various approaches that would tend to prevent insolvencies and thereby eliminate the problem altogether. Instead, it looks to a quick solution by means of a particular type of law which would accomplish little, if anything, toward a lasting solution that would contribute to the sound operation of life and health insurance companies and, at the same time, avoid inequitable and unfair treatment of policyholders.

It would seem much more logical to consider the problem under consideration by the Subcommittee in terms of the need for *solvency* legislation rather than insolvency legislation.

The primary purpose of state insurance regulation is to protect all policyholders. Continued solvency of companies is the true standard for state regulation to measure up to in fulfilling its purpose. To the extent that this standard is not met, and that any policyholder of one company is compelled to assume the risk of loss to a policyholder of another company by reason of a preventable insolvency, the primary purpose of state legislation is not fulfilled.

*General Need for Legislation Questioned*

Although the name of this Subcommittee and its charge express two distinct assignments, one involving the study of life and disability insurance insolvencies and the other involving the preparation of any legislation found to be necessary, we do not see any evidence that the Subcommittee has studied the history of such insolvencies nor made any attempt to determine the various reasons why they occurred. We are aware of no studies which would demonstrate or substantiate the need for or the desirability of the form of legislation which the Subcommittee is now considering.

One of the few generally known studies relating to life insurance company solvency is reported in Volume II of the 1969 Proceedings of the NAIC, on pages 564-593. Interestingly enough, it was made by the Texas State Board of Insurance on behalf of the NAIC in connection with the preparation of an insolvency guaranty measure, eventually adopted in 1969, applicable to property and casualty insurance companies.

When the NAIC made the study a part of its proceedings, the adopting resolution (Volume II, 1969 NAIC Proceedings, on pages 550-552) recited the conclusions that losses suffered by policyholders as a result of insurance company insolvencies had been substantially overstated by those who advocated federal legislation; and the state regulation is competent and adequate to deal effectively with the prevention of insolvencies, as evidenced by the fact that property and casualty insolvencies had been reduced considerably during the years 1966 through 1968 as compared to the preceding period of 1960 through 1965 (from 6.0 cents per $100 of premium to 4.9 cents per $100 of premium).

As it relates to life insurance, the study reached the following significant conclusions: (1) insolvencies of life insurance companies have been relatively insignificant in the history of the life insurance industry, (2) comparison of losses to policyholders of life insurance companies for the 30 year period 1939 through 1968 was $.00074 per $1,000 of reserves, as compared with the current federal deposit insurance corporation net rate of $.31 per $1,000 of deposits, and (3) even for the depression years 1930 through 1939, the average annual loss to policyholders was less than 75 cents per $1,000 of policyholders' funds. The summary portion of the study goes on to say that ". . . It is obvious that the states' performance in supervising the solvency of legal reserve life insurance companies has been excellent and outstanding . . . The losses to life insurance policyholders have been minimal in comparison with net charges of the FDIC to protect bank depositors."

Thus, the only authoritative generally published NAIC study on this subject indicates, that there is no need for special guaranty fund legislation with respect to life insurance companies, recognizes that present laws and regulations have proved to be generally sufficient to prevent life insurance company insolvencies, and clearly implies that perceptive adjustments of present regulatory techniques probably would suffice to eliminate the problem.

It should be added that, although the study does not provide information in sufficient detail to determine the various regulatory processes that might have played major parts in maintaining such a good record over the last 30 years, it is generally acknowledged that experience under various state rehabilitation and conservation laws has been adequate in handling occasional life and health company financial distress so as to prevent actual losses to policyholders. The beneficial application of these laws, often with the voluntary cooperation of the insurance industry, has cured potential insolvencies in the best traditions of state regulation—by preserving solvency without resort to inequitable treatment.

*Insolvency Guaranty Legislation is Unfair to Policyholders*

Several considerations should serve as the context for any evaluation of the need for the model legislation being considered by the Subcommittee.

*Purpose of State Regulation to Protect Policyholders Against Insolvency*

Since the basic purpose of all state regulation of life and health insurance is to protect a policyholder's interest in, and expectations from, his contracts, one of the calamities against which he is to be guarded is the insolvency of the company with which he holds his contract. Many, perhaps most, of the state regulatory provisions under which insurance companies now operate are designed to maintain the solvency of companies, and to make certain that companies will be able to meet their obligations to policyholders. Two obvious references will illustrate this principle: (a) provisions establishing minimum capital and surplus requirements and (b) provisions for periodic examination of companies. Many other regulatory provisions are related in various degrees to continued company solvency.

Specific legislation designed to clear up the debris of an insolvency from which

policyholders should have been protected emphasizes burial rather than therapy. Moreover, the claim, which has not been substantiated or publicly asserted, that such legislation is urgently needed in effect suggests that present state regulatory provisions may be inadequate to prevent insolvencies, and tends to bring into question the sufficiency of their implementation.

As far as the industry associations know, the Subcommittee has not examined, from the standpoint of application to potential insolvencies, the adequacy of present patterns of state laws for this purpose, nor the significance and vitality of specific regulatory provisions which have a particularly important bearing on prior protection against insolvencies.

*All Policyholders Should be Equally Protected*

One fundamental characteristic of state regulation of life and health insurance is, or should be, the affording of equal protection to all policyholders. Policyholders of one company should not be protected at the expense of policyholders of other companies. Otherwise, the concept of policyholder protection by present regulation becomes illusory. Insolvency guaranty laws which provide for assessments against solvent companies in order to "protect" the policyholders of an insolvent company not only are contrary to the basic purpose of insurance regulation, they are unjust and may be injurious to the very policyholders who look to state regulation for protection. They would, under the color of "protecting" policyholders, shift to policyholders the risks of possible lapses in regulation. Under such laws, the policyholder of a sound company who already pays, in addition to all of his other taxes, substantial insurance taxes levied for the purpose of protecting him, would be required to assume the additional burden of paying for the breakdown of a company subject to comprehensive and detailed regulation ostensibly administered for his benefit.

*Precipitous Action Unjustified*

The increasing complexity of governmental regulation frequently encourages a rush to find quick, apparently simple, solutions to problems that are not responsive to such solutions. Often, the facile "solution," although it looks attractive, misses the point. Moreover, it may obscure a continuing need for the right solution. What is infinitely worse, it sometimes loses sight of the people for whose benefit the solution should be sought.

We respectfully suggest that the approach being considered by the Subcommittee seems to follow this pattern. There is nothing to indicate, as far as we can see, that other, fairer and more appropriate, solutions to the problems felt to exist with regard to life and health company solvency have been considered and evaluated by the Subcommittee. The only credential of the type of model legislation contemplated by the Subcommittee seems to be the recent promulgation of a model law on property and casualty company solvency—a model law for which the most persuasive and urgent reason appears to be the imminence of federal legislation.

*Positive Dangers in Insolvency Guaranty Legislation*

Not only do insolvency guaranty laws fail to meet the real purpose of insurance regulation, they create at least two positive dangers which could result in generating insolvencies that might not otherwise occur.

They would, especially without prior or simultaneous advancement of other specific recommendations involving the strengthening of preventive legislation, in effect subsidize inefficiency, ineptness and carelessness, and perhaps even unscrupulous and uninhibited practices.

Furthermore, from the other side, guaranty laws of the kind being considered by the Subcommittee may have a narcotic effect on the insurance regulator's zeal to protect policyholders by the prevention of insolvency. Prompt, constructive and decisive action by the regulator is essential when conditions appear to be leading a company toward insolvency. Often, there is a tendency to delay the hard decisions necessary to prevent the increasing financial distress of a company, because of pressures brought to bear on the regulator. Guaranty laws might serve to increase the pressures and perhaps even justify further delay.

*Role of Federal Legislation*

One of the most important reasons for the promulgation by the NAIC of the model insolvency guaranty bill for property and casualty insurance was the consideration by Congress of a proposal to establish a Federal Insurance Guaranty Corporation for the purpose of guaranteeing the payment of claims against insolvent property and casualty insurance companies.

Our three industry associations, although concurring in opposition to federal

legislation on this subject, submit that the urgency underlying the action on property and casualty insurance does not exist with respect to life and health insurance. There are no present indications of congressional action relating to the subject of life and disability insurance company insolvencies.

*Conclusions and Recommendations*

It is submitted that the Subcommittee has not fully addressed itself to one of its primary assignments, since it has not, as far as we know, made any adequate study of life and health insurance company insolvencies. Nor has the Subcommittee adduced any evidence of general need for legislation on its assigned subject, particularly evidence showing the model legislation would be appropriate.

Furthermore, there is nothing to indicate that the Subcommittee has endeavored to explore other approaches to the problem of possible insolvencies of life and health insurance companies.

The Subcommittee has not, in our opinion, produced any evidence that would tend to rebut either the findings of the NAIC's own study that problems of insolvency are declining, or the implication of the study that strengthening of present state regulatory procedures might suffice to prevent insolvencies altogether.

Therefore, the three industry associations urge that the Subcommittee:

1. Complete its assignment "to study life and disability insurance insolvencies," in order to provide a basis for the evaluation of need for any legislation on this subject;

2. Explore the possibilities of other approaches to the insolvency problem, if it is established that a significant problem in fact exists, particularly approaches based on preserving and protecting the solvency of companies rather than on accepting the inevitability of insolvencies. Two examples, mentioned earlier, of present regulatory devices designed to prevent insolvencies that should be given special attention are laws and regulations establishing minimum capital and surplus requirements and laws and regulations applicable to the periodic examination of companies. On the latter, we particularly urge that the NAIC undertake a program that would involve a re-evaluation of the convention examination system, to include, among other things, consideration of the following:

(a) use of independent audits, where available and acceptable to the commissioner, (b) utilization of "spot" or interim convention examinations more selectively for the purpose of early discovery and correction of problems and the prevention of insolvencies, and (c) authorization to permit the extension of periods between required convention examinations as to companies and classifications of companies when, in the judgment of the insurance commissioner, such an extension is appropriate; and

3. Defer any action with regard to model legislation until credible evidence indicating a need for legislation generally, and the desirability of the specific model legislation under consideration by the Subcommittee, is adduced.

Our three associations and their members continue to offer cooperation and assistance to the Subcommittee in whatever efforts are made to follow these recommendations.

Respectfully submitted by

AMERICAN LIFE CONVENTION
211 East Chicago Avenue
Chicago, Illinois 60611

HEALTH INSURANCE ASSOCIATION OF AMERICA
332 South Michigan Avenue
Chicago, Illinois 60604

LIFE INSURANCE ASSOCIATION OF AMERICA
277 Park Avenue
New York, New York 10017

December 14, 1970

EXHIBIT 3

STATEMENT OF CNA/INSURANCE TO B7 SUBCOMMITTEE TO STUDY LIFE AND DISABILITY INSURANCE INSOLVENCIES AND PREPARE ANY NECESSARY LEGISLATION

My name is Donald C. Ames, Counsel for CNA/insurance. CNA is a Chicago based group of insurance companies of which Continental Assurance Company is the major life insurer.

We generally support the two statements made today by ALC, LIAA and HIAA.

On the question of a fire and casualty insolvency fund law CNA has taken the position that under many circumstances recourse should be afforded to policyholders of, and claimants against, insolvent insurers. However, because the managements of well-managed companies have no means of controlling the managements of sick, dying or dead companies, the well-managed and responsible companies (which means their stockholders and policyholders) should not have to bear the burden of losses due to insolvencies. Yet it is squarely on these people that the proposed draft bill would place that burden.

Our position on any proposed model life and health insolvency fund law concerning the question of who bears the financial burden of bailing out defunct insurers is no different from our position on the property and casualty bill. In the life and health area, we have a further concern that adequate attention has not yet been given to the degree of need for the insolvency fund approach. Nor has much attention been given to the need for reforms in insurance law and practice which would contribute to the minimization of insurer insolvencies. One of these potential areas of improvement is the examination system and the need to use it in the most efficient manner as an insolvency-avoidance device. We would also suggest that solidity programs, such as the exemplary one being developed by the Illinois Department of Insurance, be given consideration by regulatory officials in other states.

We do not believe that policyholders of well-managed and responsible life and health insurance companies will be happy to find out that although they have made a careful choice as to the insurer from which they buy they will nevertheless wind up having fewer dollars in their pockets (because of increased premiums or reduced dividends) as a result of a law which says that policyholders of questionable companies must be made whole by policyholders of responsible ones. If a decision is made to make policyholders of defunct insurers whole because society through its elected representatives believes that this is the right thing to do, then society as a whole should make available the necessary funds on as wide a base as possible (general revenues) for the fulfillment of that social need. The breadth of the potential spread of assessments in the life and health area is, of course, even more limited than in the fire and casualty area because of the inability to load the already fixed premiums of the many existing policyholders of life insurers.

We thank the Subcommittee for the opportunity to make these brief comments and respectfully ask for its consideration of them.

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EXHIBIT 4

December 14, 1970

STATEMENT OF NEW YORK LIFE INSURANCE COMPANY REGARDING THE PROPOSED NAIC MODEL LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT SUBMITTED TO THE NAIC SUBCOMMITTEE TO STUDY LIFE AND DISABILITY INSURANCE COMPANY INSOLVENCIES AND PREPARE ANY NECESSARY LEGISLATION

Mr. Chairman and Members of the Subcommittee to Study Life and Disability Insurance Insolvencies:

We appreciate the opportunity to appear before you and discuss the need for the proposed Model Life and Health Insurance Guaranty Association Act. Since the first draft appeared, we have been studying its implications and considering the need and desirability of legislation of this type, and would like to share our views with you.

The proposed Model Act rests on the underlying ~~concept~~ that the ~~cost burden~~ of

improper management of life and health insurance companies should by statute be placed upon properly managed companies and their policyholders. We believe that this underlying concept is unsound and that enactment of insolvency fund legislation by any state is not in the best interests of policyowners, insureds and beneficiaries, or the life and health insurance industry. Accordingly, we urge you to adopt the proposed Model Act, for reasons which I shall explain.

*First Priority to Strengthening State Regulation*

1. To seek compulsory insolvency fund legislation is to place priority on correcting mistakes after they occur rather than on preventing them from occurring. It is like locking the barn door after the horse has been stolen. We believe that highest priority should rather be given by state insurance commissioners and their staffs to the strengthening of state regulation.

Procedures should be established and maintained under which developing problems will be observed promptly, in time to permit the taking of corrective steps so that losses to policyholders, their insureds and beneficiaries will not occur. Timely interim reports should be required and timely audits and examinations should be made by qualified experts. Safeguard standards and guidelines should be re-examined and improved where necessary. We understand that the Insurance Commissioners are presently conducting studies to this end, and we applaud such work. If sound and effective State regulation is achieved, logic compels acceptance of the conclusion that insolvency fund legislation is neither necessary nor desirable for the protection of policyholders, beneficiaries and the industry.

*Encouragement of Unsound Companies and Practices*

2. The type of insolvency law under consideration would tend to encourage improvident management and the creation of marginally financed companies, which would, in the long run, hurt the industry. With insolvency laws in effect throughout the States, promoters could well organize a disproportionately large number of companies in those states where capital and surplus and other legal and regulatory requirements are less stringent.

Potential policyholders would no longer need to be concerned with the financial condition and stability of the company from which they are considering the purchase of life and health insurance. The public will be lulled into overlooking the need for dealing with sound companies, since an unsound company may be as "safe" as a sound company under compulsory insolvency legislation. As we see it, insolvency fund legislation constitutes a subsidy for inefficient, careless and improper life insurance practices. None of these results seem desirable to us from the viewpoint of our policyholders, the public and the entire life industry.

*Natural Forces Operating to Protect Policyholders*

3. In our consideration of this matter, we have recognized that some policyholders in insolvent companies may suffer a loss of part, or even all, of their cash values or insurance coverage, which they would not have suffered if insolvency fund legislation were in effect. We also appreciate that there is a natural tendency to want legislation to protect policyholders from potential loss. However, we believe that natural business forces will tend to keep policyholder losses to a minimum. Experience has shown that in the ordinary course of business one or more sound companies normally will be prepared to buy or take over blocks of business of an impaired company, for a variety of reasons. They may want to expand their business volume more quickly and easily. They may want to gain quick entry into a particular state, or may be able to utilize tax carryover losses of the impaired company. These factors minimize the need for imposing statutory sanction on all life companies in order to achieve protection for policyholders of impaired companies.

We recognize in such cases that purchasing or assuming companies may be able to drive a harder bargain with an impaired company and that its stockholders may not fare as well, if an insolvency statute is not in effect. However, it is certainly not the responsibility of sound insurance companies and their policyholders to spend their money for the protection of stockholders of an impaired or insolvent company. Yet, that is where an insolvency fund statute inevitably leads us. We submit that such a result is unfair to our policyholders.

*Unsound Underwriting and Inadequate Premium Rates*

4. The uniqueness of the life insurance product is particularly important to the proper assessment of insolvency fund legislation. The face amount of life insurance coverage is usually many times the amount received from the policyholders. Improperly managed companies, with unsound underwriting, can book large amounts of face amount coverage for stockholders and others. With insolvency fund legislation in

effect, unsound underwriting, which in some instances could be intentional and collusive, is thus automatically reinsured by sound companies. We think that a statute which leads to such a result does not deserve the support of the insurance industry's regulatory authorities. Some contend that this problem can be controlled by having the statute impose low limits on the coverage to be reinsured by sound companies under insolvency fund legislation; but, this does not eliminate the inherent unsoundness of the underlying concept.

The undesirable aspects of unsound underwriting become even more significant when coupled with inadequate permium rates. Both of these factors obviously tend to promote the sale of larger volumes of life insurance. This is an objective that original promoters may well seek to achieve, in order to boost the market value of stocks owned by them. As we all know, it may take a long time for losses to emerge from unsound business. In the meantime, original promoters may sell out with large profits and leave the guaranty association and sound companies liable for the amounts required to protect policyowners against the losses which will eventually emerge.

We would also point out that voluntary actions taken by sound companies to "rescue" an impaired company after impairment develops are entirely different from advance legislative guarantees. The voluntary procedure cannot be used in sales talks, and would not be a factor in encouraging unsound management.

*Risk of Stockholder Suits*

5. Another inherent problem stems from the usual requirement in insolvency fund legislation that solvent companies take an active part in decisions affecting operating matters of the impaired company. This type of statutory requirement exposes sound and well managed companies to the risk of damage suits by dissident stockholders, who will have the advantage of hindsight, regarding important decisions made in good faith by sound and well managed companies. To expose companies acting in good faith to such risks is not sound policy.

*Drain on Time of Personnel of Sound Companies*

6. The time consumed by personnel of sound companies in attempting to deal with the rehabilitation of an impaired or insolvent company can be substantial—out of all proportion to any conceivable benefit derived by solvent companies. The time that would be spent by life company personnel in dealing with these matters would certainly be better spent in pursuing legitimate objectives of their own companies.

*Indeterminate Drain on Assets of Sound Companies*

7. Direct financial drain on sound companies will result. We have no way of determining how large this financial drain will be. In this connection the unique nature of the life insurance business is also important. The large amounts of life coverage that often exist, and the long-term commitments under annuity contracts, present long-term risks of a consequential nature. We are seriously concerned about having this potential drain imposed on us by statute, and believe we must make our views known to you.

*Investment Risks*

8. Managements of life insurance companies have particular responsibilities to their own policyholders in connection with investments. Insurance companies and their managements are often compared to trustees of other people's monies. We doubt that legislators would ever seek to saddle the trustee of a well-managed trust fund with the investment mistakes of a different trustee, Yet, that is what insolvency fund legislation is sanctioning, in concept.

This analogy seems particularly pertinent in the light of the increasing powers of life company managements to invest greater percentages of their general assets in common stocks not meeting any particular specifications. As the discretionary powers of management and the percentage of assets invested in leeway stocks increase, the risk of loss to well-managed companies under insolvency fund legislation on account of poor investment decisions of poorly run companies increases commensurately.

You will appreciate that companies domiciled in states with more stringent investment standards will think this risk to be particularly onerous, since the proposed insolvency fund legislation would make them potentially liable for the investment mistakes of companies domiciled in states with less restrictive investment standards.

In a similar vein, many holding companies with life insurance company subsidiaries may wish to obtain the highest possible amount of dividends from their subsidiary life companies for a variety of reasons. Insolvency fund legislation would tend to encourage them in this endeavor. This is undesirable and unsound from the

viewpoint of policyholders of the subsidiary life company, and from the viewpoint of the entire life industry.

Pertinent also, is the new, but increasing, tendency of life companies to engage in businesses that may be unrelated to the life, health and annuity business. No one can foresee its dimensions at this time. However, it is another reason for not adopting the concept of insolvency fund legislation in the life insurance industry.

*Federal Insolvency Laws*

9. In our deliberations, we have not been unmindful of the argument that adoption of model insolvency fund legislation by the National Association of Insurance Commissioners is desirable in order to forestall enactment of federal insolvency fund legislation. This presumes that federal insolvency fund legislation is otherwise inevitable. We do not think this presumption is correct. The need for federal insolvency fund legislation in the life insurance industry has not yet been debated, any more than the need for state insolvency fund legislation has been debated before the National Association of Insurance Commissioners until this very day.

We are concerned that adoption by the National Association of Insurance Commissioners of a model insolvency fund bill may backfire, and speed Congressional enactment of a bill. Our reason for this concern stems from the logical conclusion that, if state Insurance Commissioners think this legislation is necessary, there must be a serious problem in existence. Whether we like it or not, and whether right or wrong, the conclusion will be drawn that the Insurance Commissioners are concerned about the effectiveness of their own regulation in forestalling impairments and insolvencies. Otherwise, there would be no compelling reason for Commissioners to make sure that the assets of well-managed companies will be available to bail-out poorly-managed, and inferentially poorly-regulated, companies. This line of reasoning, which we do not espouse but which exists, casts doubt upon the validity of the concept that state regulation is best for the life industry. New York Life would prefer to avoid any question regarding the validity of that concept, by not having state insolvency fund legislation proposed or enacted.

The argument is sometimes made at this point that a significant number of insolvencies may develop, and that federal inquiry into the matter will be forestalled if state insolvency fund legislation is on the books. We think the soundness of this contention is questionable. If a larger number of insolvencies develop, many questions may be raised by well-managed companies before paying over any significant amounts of money to or on behalf of poorly-managed companies. Litigation to contest the validity of insolvency fund legislation may ensue. In any event, policyholders and their beneficiaries will be restless. The conclusion will be drawn, and perhaps justly at this point, that state regulation has not worked effectively, and federal inquiry into the matter is likely to occur despite the existence of state insolvency fund legislation.

*Summary*

In summary, we think that there is no substitute for sound and effective regulation at the state level, in order to prevent losses to policyholders, their insureds and beneficiaries.

Insolvency fund laws will tend to encourage improvident management and creation of marginally financed companies. This will have an adverse effect on the entire industry.

We do not believe it is sound for policyholders of sound and well-managed companies to be saddled with the burden of impaired and improperly managed companies.

In most cases of potential insolvency, particularly if they are detected promptly, mergers and acquisitions by sound companies will protect the policyholders of impaired companies.

We recognize that stockholders of some companies may not fare as well without insolvency fund legislation as they would with it, but certainly assets of well-managed companies should not be legislatively drained off for the benefit of stockholders of poorly-managed companies.

Particular consideration should be given to the risk implications for sound companies of potential underwriting abuses and the fixing of inadequate premium rates of poorly-managed companies, and to the greater investment latitude in the types of businesses in which life insurance companies may engage.

The drain upon the time of personnel of sound companies in dealing with impairments under insolvency fund legislation, the unlimited potential drain upon the financial resources of well-managed companies and the risk of stockholder suits are factors that deserve the closest attention and assessment.

Implications with respect to federal insolvency fund legislation also need close scrutiny and assessment.

For all of these reasons, we urge the Insurance Commissioners of our states to direct their attention away from compulsory insolvency fund legislation. We urge them to give highest priority specifically to the task of strengthening legal and regulatory requirements in all states regarding required reserves, minimum capital and surplus, investment safeguards, expense limitations, and generally to increasing the effectiveness of state supervision and control, all to the end that impairments and insolvencies will not develop in the life industry and that policyholders, insureds and their beneficiaries will be truly protected under adequate and enlightened state regulation by the dedicated body of Insurance Commissioners and their staffs.

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## EXHIBIT 5

## STATEMENT FOR PRESENTATION TO THE NAIC

December 14, 1970

Mr. Chairman and Members of the Subcommittee:

I am Raymond F. Killion, Senior Vice-President of Metropolitan Life Insurance Company. I wish briefly to emphasize our concurrence with the spokesmen for the American Life Convention, the Health Insurance Association of America, the Life Insurance Association of America and the New York Life Insurance Company.

Metropolitan's central concern with the proposed Model Life and Health Insurance Guaranty Association Act is that it establishes open-ended liability for an unknown cost arising from circumstances over which neither our management nor our policyholders have any power to prevent.

The industry has not been provided with evidence as to the need for this legislation, but assuming that the need exists, it is our contention that at least two steps—neither of which have been taken—should precede the enactment of the proposed bill:

1. There should be carefully conceived research as to the dimensions of potential liability for the insurance industry before an effort is made, as your proposed bill seeks to do, to distribute that liability for mismanagement of a few companies among the well-managed majority of companies.

2. The NAIC should sponsor the enactment of legislation which will strengthen state regulation, make it more difficult for marginal promoters to enter the field of insurance, and thus provide a much-needed foundation for the prevention of insolvencies.

I do not propose to quarrel with the language of the bill now before you although it is my understanding that there remain a number of serious drafting deficiencies therein. It is my purpose today to urge that until the necessary research has been accomplished, and until significant steps have been taken to prevent or at least deter the incidence of future insolvencies, management of Metropolitan feels that it has a fiduciary obligation to its policyholders to prevent the impairment of their contractual rights by subjecting such rights to the consequences of mismanagement of other companies as well as the inadequacy of state supervision thereof. In short, gentlemen, there is a fundamental and apparent unfairness in asking our policyholders to bear the fiscal impact of insolvencies of companies over which we have no control whatsoever.

Finally, there are other ways in which the proposed legislation is unfair:

1. It would require the properly managed companies to bear the fiscal consequences of an impaired insurer without any prior obligation on the part of either an upstream or downstream holding company, in the same corporate complex as the impaired insurer, to reduce its dividends by an amount necessary to stand back of the contracts made by the impaired company.

2. There is nothing in the bill to prevent its application to an insurer which has been technically insolvent for 10 or 20 years but which is not declared to be in such status until after the enactment of the bill in that particular jurisdiction.

3. This "free reinsurance" bill would provide the means for agents of marginal companies to tell prospective insureds: "If our high risk investments are productive, you will benefit; if not, you are protected against loss." Properly managed com-

panies would thus be placed in an intolerable competitive position at their own expense!

For these reasons, and those contained in the trade association statements, Metropolitan urges NAIC not to adopt the proposed model bill until these deficiencies have been corrected.

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EXHIBIT 6

AMERICAN LIFE CONVENTION

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LIFE INSURANCE ASSOCIATION OF AMERICA

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Health Insurance Association of America

322 South Michigan Ave., Chicago, Illinois 60604

December 14, 1970

*TO THE NAIC SUBCOMMITTEE (B7) TO STUDY LIFE AND DISABILITY INSURANCE INSOLVENCIES AND PREPARE ANY NECESSARY LEGISLATION*

Re: *Provisions to Be Included in any Life and Health Insurance Guaranty Association Model Bill*

In an accompanying statement to this Subcommittee today our associations have pointed out the absence of any demonstrated need for model legislation for life and health insurance guaranty measures. In discussing the specific provisions of the proposed draft of such a model bill we wish to emphasize that we do so without in any way diminishing, or detracting from, that position. As in our previous statements to your Subcommittee and in conferences with NAIC Central Office staff, we want to ensure that, if this Subcommittee decides to recommend a Model Bill, any such proposal would incorporate provisions which would best serve the interests of all policyholders and the industry.

In the statement submitted by our three organizations at the June 16, 1970, meeting of your predecessor Subcommittee, we set forth a list of principles which we recommended be included in any model legislation which might be drafted on this subject. Since that Meeting our committees assigned this subject for study have reviewed those principles and, without endorsing the need or desirability of such legislation, further refined those principles. The following are, therefore, principles which we regard as essential ingredients of any such legislation, and we submit that a Model guaranty bill for life and health insurance should:

1. Provide for the continuation of life insurance and health insurance coverages, rather than providing only for termination of policies and payment of liquidated claims.

2. Provide for similar treatment of health insurance regardless of whether policies are written by life insurance or casualty insurance companies.

3. Provide for application to all policies of domestic companies, wherever the policyholders may be located, and to policies of foreign or alien companies issued to residents located in the enacting state.

4. Provide for post-impairment assessment rather than pre-impairment assessment, and that assessments be based on (a) types of insurance coverages (life—annuity—health) written by the impaired company on the basis of net premiums received during the preceding calendar year for each type of coverage written; (b) in the case of an impaired domestic company, on portions of net premiums received during the preceding calendar year by the assessed company in the states in which it and the impaired company are both authorized to do business and are receiving premiums and (c) in the case of an impaired foreign or alien insurer, on portions of net premiums received in the enacting state during the preceding calendar year by the assessed company; and moreover, limits the aggregate amounts of all assessments against a company to a definite pencentage of net premiums, not to exceed 2%, collected per year in the state in which the insolvency occurs.

5. Contain provisions designed to prevent duplication of benefits to an insured or beneficiary should more than one guaranty association law be applicable to the particular contact and to prevent the duplication of assessments against companies with respect to the same insurance contract.

6. Provide for the issuance of certificates of assessments which, to the extent feasible, are permitted as assets in some form.

7. Permit assessments to be offset against premium taxes or income taxes.

8. Provide for the use of temporary liens and moratoriums with regard to policies of an impaired company, subject to approval of the Insurance Commissioner.

9. Include provisions designed to prevent insolvencies, and to allow their early detection by creating warning systems and other protective requirements and devices.

10. Provide that the administration of the guaranty law be vested in an association made up of industry representatives.

11. Contain provisions establishing a reasonable per life dollar limitation beyond which the guaranty association is not responsible.

12. Provide standards of responsibility on the part of a holding company system for its life or health insurance company subsidiaries to which the legislation becomes applicable.

13. Provide only for application to companies which become insolvent after the effective date of the legislation.

We are pleased that, in many respects, the draft of a proposed model bill prepared by the NAIC Central Office staff at your direction, contains in substance many of the above principles. We do find, however, that there are some significant substantive provisions that we now urge this Subcommittee to adopt to incorporate each of those principles.

Attached to this statement is a copy of the Revised Second Draft of the proposed Model Bill prepared by the NAIC Central Office staff, with changes designated therein which we propose be made. Many of those suggested changes are technical in nature and are offered primarily for purposes of clarification or consistency, and although they are nevertheless of inportance we will not comment on them in this statement. Those proposed changes which are of a substantive nature are discussed herein and references will be made to the appropriate sections and subsections of the text before you.

### I. *Three Accounts — (a) Life Insurance, (b) Health Insurance and (c) Annuities*

Your Subcommittee does not take issue with the principle of treating life insurance and health insurance separately and for many of the same reasons underlying that decision we feel that life insurance and annuities should be separated into their respective accounts. Just as it would be inequitable to charge a company doing only a health insurance business with responsibility for a life insurance company impairment, a company doing a substantial annuity business should not be assessed on its annuity considerations for a life insurance or health insurance company impairment. Annuities are normally treated separately from life insurance, both in annual statement accounting and in regulatory measures, and no specific difficulties would be encountered in treating such business separately for purposes of this proposed Model legislation. We believe that the figures prepared for the Subcommittee showing the volume of annuity considerations in each state and the respective proportion of such business written by the larger insurance companies (each of which has over $1 billion in assets), supports the proposition that separating annuities from life insurance would not cause a serious problem in the administration of such a law.

We submit that the provisions for three accounts—life insurance, health insurance and annuities—should be substituted for the language relating to accounts in Section 5 (1) and Section 6 (1) and changes made in the comments appropriately.

### II. *Administration of the Guaranty Law Should Be Vested in the Association Made Up of Industry Representatives*

We believe that the basic purpose of this proposed model legislation is to establish a mechanism to provide for continuation of life and health insurance coverage through guaranties, assumptions of obligations and reinsurance, of the payment of contractual obligations. We have also felt that the reason for creating the association of licensed life and health insurers was to facilitate the carrying out of those pur-

poses, and coincidentally thereto there would, where necessary, be assessments against such member companies to raise funds to do so.

As presently drafted, however, Subsections (1) through (4) of Section 8 would relegate the association to the status of a mere conduit for furnishing the necessary financial resources for the use of the impaired company, the liquidator, rehabilitator or conservator, by directing the association to "provide monies, pledges, notes, guaranties or other means."

*We wish to make it perfectly clear that if these funds are to be taken from solvent, well-managed companies to make up the deficiencies and inadequacies of incompetent or dishonest management, then industry must have a paramount voice in how those funds are to be used.*

The language which we propose is set forth as new subsections (1) and (2) in Section 8, and would replace subsections (1) through (4).

Philosophically this new language differs from the proposed language in that it places the responsibility for guaranteeing, assuming or reinsuring, or causing to be guaranteed, assumed or reinsured, the covered policies, and for making payment of contractual obligations, *in the Association itself.* Whatever funds that are needed for accomplishing this function would obviously still be raised by assessments on member insurers, but the use of those funds would be at the direction and control of the Association itself, *subject to the requirements of the law and the insurance commissioner's overall approval.* It seems very basic to us that the Association, whose members will be providing the funds or standing behind any guaranties, assumptions or reinsurance, is not only entitled to see that those funds are used properly and economically, but has a vested interest in doing so. As pointed out earlier in our accompanying statement, if solvent, well-managed companies were to be forced to pay for the ineptness and improprieties of insolvent companies, then to not have a voice in how those resources are to be used is reprehensible.

The Association might, for example, have good reason to object to simply putting up money to rehabilitate a company if those funds simply would only be dissipated by the same management or for the same reasons that caused its impairment. The use of monies and guaranties alone is not always sufficient, and in many instances changes in management or other practices may be called for. The interest of the Association in minimizing the need for further assessments would act as an incentive to find solutions to the basic underlying problems of an impaired company. The technical expertise available from solvent, well-managed companies would be called upon for that purpose.

In addition to this very significant substantive issue, the proposed new language eliminates the provision relating to powers of the association in connection with a foreign or alien insurer prior to an order of liquidation. We urge deletion of that subsection since we cannot envision a state guaranty association voluntarily interjecting itself into the affairs of a non-domestic company prior to a formal adjudication of insolvency, and model legislation should not propose language which is essentially impractical or may involve legal complications if it were to be used. Without attempting to cover all the potential, and real, problems that may be encountered if a guaranty association in one state attempted to become involved in the affairs of a company domiciled in another state prior to a formal adjudication of insolvency, we would simply point out that there does not appear to be any justification for including such a provision in this proposed model legislation and in the absence of some logical reason for doing so we urge its deletion.

To accomplish the above purposes, we respectfully urge that you adopt our proposed language in Subsections (1) and (2) of Section 8, and that you delete the words "to provide funds or assistance" in Subsection (8) of that Section, as indicated, and insert in lieu thereof the words "under this Act."

Also, in Subsection (8) of Section 8, we would recommend that the sentence beginning at the bottom of page 7 and ending on page 8, be amended, as shown, to strike everything after the word "Association" at the top of page 8. For one thing, we think that stricken matter is redundant since it merely restates the responsibilities of the Association under the Act. In addition, since those responsibilities are included in the Act, questions are raised as to what else may be included, and what is meant by "determination of the covered policies and contractual obligations."

In addition, it would be necessary to delete Subsection (1) (d) of Section 11, since the first sentence of that Subsection would give the liquidator, rehabilitator or conservator the responsibilities and duties which we feel should be placed in the guaranty

association. The balance of that Subsection would then be covered in our revised Subsection (3) of Section 14, and covered under point number IV of this statement.

III. *Limitation on Liability of the Association*

Consistent with the primary purpose of this proposed model legislation to protect the large majority of policyholders and beneficiaries, we propose an amendment to Subsection (10), renumbered Subsection (8) in our suggested revision, of Section 8, to place a limit on single death claims of $300,000. Although a life company which becomes impaired may have fairly small retention limits, there is concern by industry representatives that reinsurance coverage may have terminated and that the Association could be stuck with an extraordinarily large claim before new reinsurance protection could be acquired. Since solvent companies would be the ones standing behind these obligations, it seems inequitable to have no limits on their potential liability. The figure of $300,000, which is consistent with that used in the NAIC Model Bill for property-casualty insurance, is in itself a large amount of coverage on any one life, in a single company, and should be adequate to cover a substantially high percentage of the insured public.

*We feel it is essential, therefore, that there be a limit on the Association's potential liability, and strongly urge the adoption of this language.*

IV. *Certificates of Contribution*

In the first draft of a model bill prepared by the Central Office staff of the NAIC provision was made for the issuance of certificates of contribution, in the amount of assessments paid by member insurers, which could be carried by member insurers as admitted assets to the extent of their value. At your meeting in Chicago on October 28, 1970, it was decided to delete that provision, presumably because of concern that such items ought not be carried as admitted assets because of their questionable or indefinite value. We strongly urge that such a provision be contained in this proposed model bill, and the language of our suggested Subsection (7) or Section 9 would accomplish this purpose.

You will notice that this language provides that the certificates may be carried as an asset, but in "such form and for such amount and period of time as the Commissioner may approve." Thus, for example, the Commissioner may decide that the certificates issued pursuant to an assessment for a specific impaired insurer can be carried only as a non-admitted asset, for 50% of their face amount. After a few years he may, on the basis of the rehabilitated company's performance, decide that they do have real value and that in all likelihood they will be retired by payment from the companies to carry them as admitted assets, perhaps even at a higher value.

The major point we wish to make is that you should not foreclose the use of this important item in your proposal. These certificates could very well have value, and to that extent the effect of assessments on member insurers could be somewhat reduced by reflecting the value of the certificates in the company's financial statements. There is a significant precedent for their use in the New York Law, Sec. 224.6(c), and they have been utilized in connection with the rehabilitation of impaired companies under that law.

Your Subcommittee should bear in mind that this proposed measure takes a different approach than the NAIC Model Bill for property-casualty insurance, in that it does much more than merely provide for payment of claims. This proposed model bill takes into account the fact that the insurance coverage will be continued, and that business may very well become profitable in later years. We therefore propose substituting language in Subsection (7) to make provision for certificates of contributions, and that present Subsection (7) be deleted for reasons which will be covered later under point VIII.

V. *Claims of the Association Against Assets of the Impaired Company*

The change which we suggest in Subsection (3) of Section 14 also affects Section 11(1)(d). In the latter section the NAIC Central Office staff draft recognizes the importance of utilizing a portion of the assets of the impaired insurer to provide the continuance of coverage which this Act mandates. The staff's draft and our suggestion is in 100% agreement on this concept. Our language, however, differs somewhat from the staff's draft because of the differences in our thinking as to the role which the association is to play in this scheme. As pointed out earlier in our discussion under point II, in our view, the association should be much more than a mere conduit of funds. We should be the moving party for the arrangements to continue coverage and these actions should go forward outside of the rehabilitation or liquida-

tion proceedings, except to the extent necessary to achieve the desired results with legal certainty. Under our approach then, the only way in which the association can obtain a right to receive its share of the assets of the impaired insurer is for the Act to make the Association a creditor of the impaired insurer to that extent. Our language accomplishes this. There is no dispute as to the share of assets to which we should be entitled and our language is identical with the staff's draft in this area.

We have, because of other language in Section 11(1)(d) deleted that provision and taken the pertinent language from that Section and put it in Section 14(3). However, we have made a change in the staff draft with respect to Section 14(3). That draft effectively accords priority to the Association over all general creditors as to the assets in question. We do not believe this language is necessary in light of the balance of our suggested provision, although it can be argued that insurers operating under any guaranty legislation, casualty, life or health, ought to have priority over suppliers, etc. However, we do not want, nor expect, any priority over another guaranty association, such as a casualty guaranty association working on an impaired casualty company that also wrote health insurance. Our language puts us on a parity with such an association in getting our share of that insurer's assets; our share being that proportion of the assets which are attributable to the reserves the company should have held for the health insurance business. No comparable problem exists, of course, with respect to a life insurance company.

### VI. *Use of Guaranty Law in Solicitation of Business*

In Section 14, you will notice that we have proposed a new Subsection (5) to prohibit any person (agent or company) from using the existence of the guaranty law as a reason for buying insurance from that company. The NAIC Model Bill for property-casualty insurance, in the "General Comments," suggests that a state may wish to include a provision either specifically permitting or prohibiting advertisements which include a reference to the guaranty law. Wisconsin incorporated a provision in its enactment of guaranty legislation making it an unfair trade practice to do so. We think this approach—of prohibiting the use of such guaranty legislation is not only appropriate but essential to avoid the unscrupulous from taking advantage of the guaranty law and the well-managed companies which would be called upon to pay for the mistakes of poor management. Such activity could be used by the unethical as a means of putting a lot of business on the books of the company without real concern for the adequacy of underwriting or management, in the expectation of selling the business at a quick profit. One need not stretch the imagination too far to visualize the agent of a company which is in trouble telling his prospects that they need have no concern since the guaranty law, and the assets of all other companies in the State, are there to protect him if his company's rates or underwriting are inadequate. Agents of solvent, well-managed companies could very well be placed at a competitive disadvantage as a result of such unfair practices.

For these reasons we regard this provision as essential to your proposed model bill.

### VII. *Recovery of Dividends Paid to Holding Company Systems When Unreasonable or Unlawful*

Another new provision which we urge be adopted is Subsection (6) of Section 14, set forth in the revised draft attached to this statement.

This provision is patterned after a section of Wisconsin Ch. 398, L. 1969, and provides a means of recapturing dividends paid to holding companies, if such dividends were unlawful or unreasonable at the time they were paid. It is designed to recapture excessive dividend payments to affiliates that exercise control over the impaired insurer. The NAIC Model Holding Company Regulatory Act in large measure prevents improper distribution of dividends by an insurer to its holding company, since extraordinary dividends are subject to the prior approval of the Commissioner, and ordinary dividends are required to be reported to the Commissioner. If, however, dividends are paid under circumstances that the insurer should have reasonably known that such payment could reasonably be expected to affect its ability to perform its contractual obligations to its policyholders, the holding company and affiliates should be required to repay such dividends subject to certain reasonable limitations.

### VIII. *Tax Offsets for Assessments Against Member Insurers*

We would now direct your attention to our proposed new Section 17, providing for tax write-offs of certificates of contribution. We have, as you will notice, proposed

deletion of Subsection (7) of Section 9, since that provision has no real meaning to life insurance and certain forms of health insurance. Life and health insurers are not now prohibited from adjusting dividends, or premium rates on future policies, to take into account increased taxes and expenses. In addition, the practical value of that provision becomes somewhat meaningless in terms of existing business.

Our proposed new Section 17 is taken from a bill introduced in the State of Washington this year. The NAIC Model Bill for property and casualty insurance provides, in Sec. 16, that rates "shall include amounts sufficient to recoup a sum equal to the amounts paid to the Association . . . ." Similarly, Sec. 646.21(9), Wis. Stats., provides that rates shall not be deemed excessive because they contain an amount reasonably calculated to recoup assessments. It is obvious that life insurance premiums, and premiums for certain forms of health insurance, cannot be changed on existing policyholders.

The comment relative to Subsection (7) of Section 9 appearing in the staff draft, which presumably is the rationale behind the proposed subsection, shows either a complete disregard of the arguments we have presented to this Subcommittee before or a complete misunderstanding of the absolute necessity for providing insurers an effective method for recoupment of assessments. Proposed Subsection (7), according to the comment, would allow companies to build into their rate and dividend structures an amount reasonably necessary to meet its assessment obligations under the Act. This would indicate that (1) insurance departments have some positive control over the rate structures of life and health insurance companies and (2) a presumption that insurers, to say nothing of insurance departments, can actually put a price tag on what a future assessment might be. It is submitted that neither presumption is valid in either a theoretical or practical sense.

Even if an insurance department was put in a position to acquiesce in a fund of some type being set aside for potential assessments, it is beyond the capability of any insurer or insurance department to say what such an amount might be. This is due to the simple fact that they do not know (1) if an assessment will ever be necessary or (2) whether any amount which might be set aside would be sufficient for what might be needed.

To carry the draft proposal to its logical conclusion, this Subsection would in effect require pre-funding, a concept which was not only disregarded as undesirable in the property and liability area, but was disregarded by this Subcommittee in establishing a post-assessment concept in this very bill.

To propose that premium rates and dividend scales can or should be adjusted so as to provide an avenue for recoupment, even if it could be done, creates an unfair discrimination against the policyholders of companies who will be expected to pay the costs of an assessment. To place this burden on these policyholders alone is unconscionable and completely ignores any participation by the state in a situation for which the state must, in all good faith, be considered at least partially responsible.

The only suitable and practicable method of recoupment available to companies writing life and health insurance lies in offsets against premium or other taxes on such companies. The method suggested in Section 17 is not only equitable to the companies involved but also reduces the impact on state revenue by the partial offset over a period of years. To the extent the ultimate value of the certificates exceeds the tax credit received, the state would be the ultimate beneficiary. Such equitable treatment of assessment for tax purposes would have additional positive effects: (1) the state government would have an additional incentive for providing adequate funds for insurance department personnel and administration, and (2) participation in the economic loss would be shared, to some degree, by the general public rather than solely by insureds, thus minimizing what might otherwise be a penalty on thrift and savings.

*Summary*

We have attempted in this statement to cover those points of substantial concern to our associations if model legislation on this subject is to be proposed. Many of the other changes set forth on the attached draft are also of significance and we also urge their adoption.

In urging these principles we would emphasize that they are, in our view, essential

to any such measure which may be introduced in a state legislature. We would be glad to answer any questions you may have regarding these points.

Respectfully submitted by,

AMERICAN LIFE CONVENTION
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Chicago, Illinois 60611

HEALTH INSURANCE ASSOCIATION OF AMERICA
332 South Michigan Avenue
Chicago, Illinois 60604

LIFE INSURANCE ASSOCIATION OF AMERICA
277 Park Avenue
New York, New York 10017

Enclosure.

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## EXHIBIT 7

NAIC Model Life and Health Insurance

Guaranty Association Act

As prepared by The NAIC Central Office Staff at the

direction of the NAIC (B7) Subcommittee

With

changes suggested by the

American Life Convention,

Health Insurance Association of America,

and

Life Insurance Association of America

to the

NAIC Subcommittee (B7) To Study Life and

Disability Insurance Insolvencies and Prepare

Any Necessary Legislation

December 14, 1970

(NOTE: Matter to be added is shown by underlining; matter

to be deleted shown by bracketing [1. ]

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## NAIC MODEL LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

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## NAIC MODEL LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Section 1. Title.

This Act shall be known and may be cited as the (state) Life and Health Insurance Guaranty Association Act.

COMMENT: This model act is to be distinguished from the NAIC model guaranty association act for property and liability insurance. Although several philosophical and technical differences exist between this bill and the property and liability model act, to the extent possible and appropriate, provisions and the format of the latter are utilized in this model act.

Section 2. Purpose.

The purpose of this Act is to protect policyowners, insureds, beneficiaries, annuitants, payees, and assignees of life insurance policies, health insurance policies, annuity contracts, and supplemental contracts, subject to certain limitations, against failure in the performance of contractual obligations due to the impairment of the insurer issuing such policies or contracts. To provide this protection, (1) an association of insurers is created to enable the guaranty of payment of benefits and of continuation of coverages, (2) members of the Association are subject to assessment to provide funds to carry out the purpose of this Act, and (3) the Association is authorized to assist the Commissioner, in the prescribed manner, in the detection and prevention of insurer impairments.

COMMENT: The basic purpose of this model act is to protect policy-

owners, insureds, beneficiaries, annuitants, payees, and assignees against losses (both in terms of paying claims and continuing coverage) which might otherwise occur due to an impairment of an insurer. Unlike the property and liability situations, life and annuity contracts in particular are long term arrangements for security. An insured may be in impaired health or at an advanced age so as to be unable to obtain new and equivalent coverage from other insurer. The payment of cash values alone does not adequately meet such needs. Thus it is essential that coverage be continued. In like manner, an insured may be unable to obtain new health insurance or, at least, he may lose protection for prior illness.

Section 3. Scope.

(1) This Act shall apply to direct life insurance policies, health insurance policies, annuity contracts, and contracts supplemental to life and health insurance policies and annuity contracts issued by persons authorized to transact insurance in this state at any time.

(2) This Act shall not apply to:

(a) Any such policies or contracts, or any part of such policies or contracts, under which the risk is borne by the policyholder;

(b) Any such policy or contract or part thereof assumed by the impaired insurer under a contract of reinsurance, other than reinsurance for which assumption certificates have been issued;

(c) Any such policy or contract issued by (.....).

COMMENT: This model act does not apply to reinsurance. Furthermore, it applies only to direct insurance "issued by persons authorized to transact insurance in this state at any time. Coverage issued by insurers which have not submitted to the application of a state's regulatory safeguards is excluded from protection by this act. However, states may wish to consider modifying the scope provision to cover certificate holders under group policies validly issued in other states by unauthorized insurers.

The model bill covers life, health, and annuities and contracts supplemental thereto. The term health insurance is intended to include "accident and health" insurance, "sickness and accident" insurance, "disability" insurance, etc. The individual state may want to adjust this language to fit its particular terminology.

Subsection 2(a) is directed toward variable policies and contracts. That portion of the contract where the risk is borne by the policyholder is excluded. However the obligations of the insurer (e.g. mortality and expense guarantees) are covered. Furthermore, Sec. 8(8) [Sec. 8(10)] provides that the Association's liability shall not exceed the contractual obligations of the impaired insurer.

Subsection 2(b) exempts the reinsurance business of the impaired insurer other than reinsurance for which assumption certificates are used.

Subsection 2(c) provides a ready means by which an individual state can exempt from the act those policies and contracts issued by insurers or similar organizations deemed appropriate for exemption by such state. Some of those which have been suggested for the exemption are assessment mutuals, fraternals, nonprofit hospital and medical service plans, burial societies, and cooperative hospital associations.

Some additional limitations on the scope are found elsewhere in the act. For example, the Association assumes no liability concerning policies of non-residents issued by a foreign or alien insurer or for policies of residents issued by a foreign or alien insurer if such insurer is domiciled in a state having a comparable act (See Section 8). These limitations are not found in the scope section since it provides exclusion from the entire act, not just portions thereof.

Section 4. Construction.

This Act shall be liberally construed to effect the purpose under s. 2 which shall constitute an aid and guide to interpretation.

Section 5. Definitions.

As used in this Act:

(1) "Account" means either of the three [two] accounts created under s. 6.

(2) "Association" means the (state) Life and Health Insurance Guaranty Association created under s. 6.

(3) "Commissioner" means the Commissioner (Director or Superintendent) [of] of Insurance of this state.

(4) "Contractual obligation" means any obligation under covered policies.

(5) "Covered policy" means any policy or contract within the scope of this Act under s. 3.

(6) "Impaired insurer" means (a) an insurer which after the effective date of this Act, becomes insolvent and is placed under a final order of liquidation, rehabilitation, or conservation by a court of competent jurisdiction, or (b) an insurer determined [deemed] by the Commissioner after the effective date of this Act to be unable or potentially unable to fulfill its contractual obligations.

(7) "Member insurer" means any person authorized to transact in this state any kind of insurance to which this Act applies under s. 3.

(8) "Premiums" means direct gross insurance premiums and annuity considerations written on covered policies, less return premiums and considerations thereon and dividends paid or credited to policyholders on such direct business. "Premiums" do not include premiums and considerations on contracts between insurers and reinsurers. As used in s. 9 "premiums" are those for the calendar year preceding the determination of impairment.

(9) "Person" means any individual, corporation, partnership, association or voluntary organization.

(10) "Resident" means any person who resides in this state at the time the impairment is determined and to whom contractual obligations are owed.

> COMMENT: This act covers "impaired insurers" which are defined in subsection (6) to include (a) an insolvent insurer under an order of liquidation, rehabilitation, or conservation or (b) an insurer determined [deemed] by the Commissioner to be unable or potentially unable to fulfill its contractual obligations. As will be treated in Section 8 on the powers and duties of the Association, this model bill enables the Association to become involved prior to an actual court order. The finding by the Commissioner that an insurer is impaired, even though not subject to a court proceeding, serves as a triggering mechanism enabling the Association to function. For further discussion see the comment on Section 8.
>
> Subsection (10) defines resident for the purpose of determining on whose behalf the Association may become liable under Section 8 if a foreign or alien insurer becomes impaired.
>
> Each state will wish to examine its own statutes to determine whether these definitions are applicable and to determine whether some should be deleted and others added.

Section 6. Creation of the Association.

(1) There is created a non-profit legal entity to be known as the (state) Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the Association as a condition of their authority to transact insurance in this state. The Association shall perform its functions under the plan of operation established and approved under s. 10 and shall exercise its powers through a board of directors established under s. 7. For purposes of administration and assessment, the Association shall maintain three [two] accounts:

(a) The health insurance account; [and]

(b) The life insurance [and annuity] account[.]; and

(c) The annuity account.

(2) The Association shall come under the immediate supervision of the Commis-

sioner and shall be subject to the applicable provisions of the insurance laws of this state.

COMMENTS: Each state will wish to examine its own statutes to determine whether a corporate structure would be a more appropriate form for the Association.

Subsection (2) creates three [two] accounts, for both administration and assessment purposes, the health insurance account [and], the life insurance account, and the annuity account. These three [two] categories of coverage would seem to be significantly different, so that persons protected by virtue of one account should not be required to pay for the protection afforded persons protected by the other accounts.

Section 7. Board of Directors.

(1) The board of directors of the Association shall consist of not less than five nor more than nine members serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the Commissioner. Vacancies on the board shall be filled for the remaining period of the term in the manner described in the plan of operation. To select the initial board of directors, and initially organize the Association, the Commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer shall be entitled to one vote in person or by proxy. If the board of directors is not selected within 60 days after notice of the organizational meeting, the Commissioner may appoint the initial members.

(2) In approving selections or in appointing members to the board, the Commissioner shall consider, among other things, whether all members insurers are fairly represented.

(3) Members of the board may be reimbursed from the assets of the Association for expenses incurred by them as members of the board of directors but members of the board shall not otherwise be compensated by the Association for their services.

COMMENTS: Subsection (1) provides that the number and the term of the members of the Board of Directors shall be determined in the plan of operation. To avoid problems in initially selecting the board, this section includes a provision for a start-up meeting which will be called by the Commissioner. To determine voting rights at the organizational meeting each member insurer would have one vote. Thereafter the plan of operation will establish the voting procedures, by-laws, etc. governing the conduct of the Association.

Section 8. Powers and Duties of the Association.

In addition to the powers and duties enumerated in other sections of this act,

[(1) If a domestic insurer is an impaired insurer, the Association may, prior to an order of liquidation or rehabilitation, and subject to any conditions imposed by the Association other than those which impair the contractual obligations of the impaired insurer, and approved by the impaired insurer and the Commissioner,

(a) Guarantee or reinsure, or cause to be guaranteed, assumed, or reinsured, all the covered policies of the impaired insurer;

(b) Provide such monies, pledges, notes, guarantees, or other means as are proper to effectuate par. (a), and assure payment of the contractural obligations of the impaired insurer pending action under par. (a);

(c) Loan money to the impaired insurer;]

[(2) If a foreign or alien insurer is an impaired insurer, the Association may, prior to an order of liquidation, rehabilitation, or conservation, with respect to the covered policies of residents and subject to any conditions imposed by the Association other than those which impair the contractual obligations of the impaired insurer, and approved by the impaired insurer and the Commissioner;

(a) Guarantee or reinsure, or cause to be guaranteed, assumed, or reinsured, the impaired insurer's covered policies of residents;

(b) Provides such monies, pledges, notes, guarantees or other means as are proper to effectuate par. (a), and assure payment of the impaired insurer's contractual obligations to residents pending action under par. (a);

(c) Loan money to the impaired insurer.]

[(3) If a domestic insurer is an impaired insurer under an order of liquidation or rehabilitations, the Association shall, upon request of the Commissioner as liquidator or rehabilitator, provide such monies, pledges, notes, guarantees, or other means as are reasonably necessary to guarantee, reinsure, or cause to be guaranteed, assumed or reinsured the covered policies of the impaired insurer, and to assure payment of contractual obligations of the impaired insurer.]

[(4) If a foreign or alien insurer is an impaired insurer under an order of liquidation, rehabilitation, or conservation, the Association shall, upon request of the Commissioner, as conservator, provide such monies, pledges, notes, guarantees, or other means as are reasonably necessary to guarantee or reinsure, or cause to be guaranteed, assumed or reinsured, the covered policies of residents, and to assure payment of the impaired insurer's contractual obligations to residents.]

(1) If a domestic insurer is an impaired insurer, the Association,

(a) may, prior to an order of liquidation or rehabilitation, and subject to any conditions imposed by the Association other than those which impair the contractual obligations of the impaired insurer and approved by the impaired insurer and the Commissioner, or

(b) shall, after entry of an order of liquidation or rehabilitation, subject to any conditions imposed by the Association and approved by the Commissioner,

guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the covered policies of the impaired insurer, and shall make or cause to be made prompt payment of the contractual obligations of the impaired insurer.

(2) If a foreign or alien insurer is an impaired insurer under an order of liquidation, rehabilitation, or conservation, the Association shall, subject to any conditions imposed by the Association and approved by the Commissioner, guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the covered policies of residents, and shall make or cause to be made prompt payment of the impaired insurer's contractual obligations to residents.

(3)[(5)] (a) In carrying out its duties under subs. (1)(b) and (2) [(3) and (4)], the Association may request that there be imposed policy liens, contract liens, moratoriums on payments, or other similar means and such liens, moratoriums, or similar means may be imposed if the Commissioner

(i) Finds that the amounts which can be assessed under this Act are less than the amounts needed to assure full and prompt performance of the impaired insurer's contractual obligations, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of policy or contract liens, moratoriums, or similar means to be in the public interest, and

(ii) Approves the specific policy liens, contract liens, moratoriums, or similar means to be used.

(b) Before being obligated under subs. (1)(b) [(3)] and (2) [(4)] the Association may request that there be imposed temporary moratoriums or liens on payments of cash values and policy loans and such temporary moratoriums and liens may be imposed if they are approved by the Commissioner.

(4)[(6)] The Association shall have no liability under this section for any covered policy of a foreign or alien insurer whose domiciliary jurisdiction or state of entry provides by statute or regulation, for residents of this state protection substantially similar to that provided by this Act for residents of other states.

(5)[(7)] The Association may render assistance and advice to the Commissioner, upon his request, concerning rehabilitation, payment of claims, continuations of coverage, or the performance of other contractual obligations of any impaired insurer.

(6)[(8)] The Association shall have standing to appear before any court in this state with jurisdiction over an impaired insurer concerning which the Association is or may become obligated under this Act [to provide funds or assistance]. Such standing shall extend to all matters germane to the powers and duties of the

Association.[, including, but not limited to, proposals for reinsuring or guaranteeing the covered policies of the impaired insurer and the determination of the covered policies and contractual obligations.]

(7)[(9)](a) Any person receiving benefits under this Act shall be deemed to have assigned his rights under the covered policy to the Association to the extent of the benefits received because of this Act whether the benefits are payments of contractual obligations or continuation of coverage. The Association may require an assignment to it of such rights by any payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any rights or benefits conferred by this Act upon such person. The Association shall be subrogated to these rights against the assets of any impaired insurer. [for any amounts expended by the Association.]

(b) The subrogation rights of the Association under this subsection shall have the same priority against the assets of the impaired insurer as that possessed by the person entitled to receive benefits under this Act. [who benefited from the expenditures of the Association.]

(8) [(10)] The contractual obligations of the impaired insurer for which the Association becomes or may become liable shall be as great as but no greater than the contractual obligations of the impaired insurer would have been in the absence of an impairment unless such obligations are reduced as permitted by subsection (3), but the Association shall have no liability with respect to any portion of a covered policy or policies to the extent that the death benefit coverage on any one life exceeds an aggregate of $300,000. [(5).]

(9)[(11)] The Association may,

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this Act.

(b) Sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments under s. 9.

(c) Borrow money to effect the purposes of this Act. Any notes or other evidence of indebtedness of the Association not in default shall be legal investments for domestic insurers and may be carried as admitted assets.

(d) Employ or retain such persons as are necessary to handle the financial transactions of the Association, and to perform such other functions as become necessary or proper under this Act.

(e) Negotiate and contract with any liquidator, rehabilitator, conservator, or ancillary receiver to carry out the powers and duties of the Association.

(f) Take such legal action as may be necessary to avoid payment of improper claims.

(g) Exercise, for the purposes of this Act and to the extent approved by the Commissioner, the powers of a domestic life or health insurer, but in no case may the Association issue insurance policies or annuity contracts other than those issued to perform the constructual obligations [pursuant to covered policies] of the impaired insurer.

COMMENTS: Subsections (1) — (3)[(5)] constitute the heart of this model Act. These subsections detail the duties of the Association by distinguishing (a) between those insurers whose "impaired" status is attributable to a finding by the Commissioner prior to an order of liquidation, rehabilitation or conservation and those whose "impaired" status is attributable to such orders and (b) between impaired domestic insurers and impaired foreign or alien insurers.

Prior to an order of liquidation, rehabilitation or conservation, the Association has no liability. However upon a finding by the Commissioner that the insurer is impaired, the Association is authorized to guarantee, assume, or reinsure or cause to be guaranteed, assumed, or reinsured the covered policies of the impaired insurer and to assess member insurers the amounts necessary to effectuate this activity. The Association could [would presumably] do so in those situations where early assistance would prevent a more costly impairment later (e.g. liquidation). The

Association, as a condition of its assistance, may negotiate any requirements or safeguards it deems necessary so long as they are approved by the Commissioner and are accepted by the impaired insurer and do not impair the contractual obligations to the policyowners, insureds, and beneficiaries. In the absence of any court order, before any negotiations become final, the impaired insurer's acceptance of the terms of the Association is necessary. Through this approach, a mechanism is provided for early action by the Association before the situation further deteriorates. The policyholders, insureds, and beneficiaries are protected, claims are paid and coverage is continued, for example, through rehabilitating the impaired insurers or reinsuring the policies elsewhere. Furthermore, the statutory language is highly flexible as to what techniques the Association may employ so as to be able to meet a variety of situations.

If the insurer acquires its "impaired" status as a result of a final order of liquidation, rehabilitation or conservation, the Association shall (rather than may), [upon request of the liquidator, rehabilitator, or conservator provide such monies, pledges, notes, guarantees, or other means as are reasonably necessary to] guarantee, assume, reinsure, or cause to be guaranteed, assumed, or reinsured, the covered policies of the impaired insurer and to assure payment of contractual obligations. [The liquidator, rehabilitator, or conservator has a wide latitude in how this might be done.]

It should be noted that the duties of the Association whether before or after an impairment, vary with the kind of insurer. If it is a domestic insurer then all the covered policies must be continued and the contractual obligations met. However, if the impaired insurer is a foreign or alien insurer, contractual obligations of [or] covered policies which apply to residents of the state must be paid or continued, if they are not covered by a similar law in such insurer's domiciliary jurisdiction.

Subsection (3) [(5)] relates to the imposition of policy and contract liens, moratoriums, etc. These are devices which have been used in the past in connection with continuation of the impaired insurer's coverage. Since, by definition, the assets of the impaired insurer were not adequate to support its contractual obligations, liens were used to reduce those obligations to a level where the assets would be adequate. However, in the past there was no means to infuse additional funds where needed to make whole policyowners, insureds, and beneficiaries. The purpose of the model act is to provide protection against losses due to impaired insurers by [prompt] fulfillment of the impaired insurer's contractual obligations. [To the extent that liens and moratoriums are sanctioned, the model act retreats from this principle. Of course, in] In situations prior to a court order there may be some question whether a lien or moratorium could be legally imposed so as to impair the contractual obligations of the insurer even in the absence of the specific provisions of this Act.

On the other hand, it can be argued that if liens and moratoriums cannot be used, there will be a run on the assets of the impaired company. In the past this seems to have been true. However, unlike the past, the performance of the insurer's contractual obligations would be guaranteed.

The [Also, the] standard nonforfeiture laws provide that an insurer in its policies shall reserve the right to defer the payment of cash values for a period of six months after demand therefor with surrender of the policy. Similarly, it is common to require an insurer to reserve for a period of six months the right to defer the granting of any policy loan (other than to pay premiums). [For these various reasons, the model act does not encourage the use of liens and moratoriums in ordinary situations.]

In [On the other hand, in] periods of severe liquidity problems and economic stress, perhaps of even catastrophic proportions, such devices may become essential. While the model bill concentrates on the protection of those to whom the impaired insurer has a contractual obligation, the impact of assessments on the policyholders of assessed companies is also an important consideration (e.g. significant sales of depressed value assets in a tight money market). Consequently subsection (3) [(5)] (a) authorizes the Association to cause to be imposed liens and moratoriums (or other similar means):

(i) if the Commissioner finds that the amounts assessable are less than what is needed, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the use of such tools in the public interest and

(ii) the Commissioner approves the use of the specific lien, moratorium, etc. This provides a highly flexible mechanism while at the same time it avoids impairing the contractual obligations of the impaired insurer as a routine matter under ordinary economic and financial conditions.

Furthermore, to provide added flexibility in a temporary situation (e.g., run on assets), subsection (3)(b) [5(b)] provides for temporary moratoriums or liens on payment of cash values and policy loans, but not on the payment of other benefits, with [if at] the commissioner's approval [discretion].

Subsection (4)[(6)] avoids duplication of coverage by providing that the Association shall have no liability for any covered policy of a foreign or alien insurer domiciled in a state having a similar bill. If every state adopts the model act, each state association would protect only covered policies of domestic insurers.

Subsection (6)[(8)], to enable the Association to protect its interests and the best interests of the policyholders [public] in the handling of an impairment, provides that the Association shall have standing to appear in a court with jurisdiction over an impaired insurer and such standing will extend to any matters concerning the duties of the Association. This would enable the Association, for example, to present to the court a reinsurance or rehabilitation proposal which it believes to be superior to or less costly than others which may be under consideration [the one submitted by the liquidator.] It also provides the Association a means to assure the proper application of the assets of the impaired insurer to continue coverage. [vis-a-vis the claims of general creditors. See section 11(1)(d).]

Section 9. Assessments.

(1) For the purpose of providing the funds necessary to carry out the powers and duties of the Association, the board of directors shall assess the member insurers, separately for each account, at such times and for such amounts as the board finds necessary. The board shall collect the assessment after 30 days written notice to the member insurers before payment is due.

(2) There shall be three classes of assessments, as follows:

(a) Class A assessments shall be made for the purpose of meeting administrative costs and other general expenses not related to a particular impaired insurer.

(b) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the Association under s. 8 with regard to an impaired domestic insurer.

(c) Class C assessments shall be made to the extent necessary to carry out the powers and duties of the Association under s. 8 with regard to an impaired foreign or alien insurer.

(3) (a) The amount of any Class A assessment for each account shall be determined by the board. The amount of any Class B or C assessment shall be divided among the accounts in the proportion that the premiums received by the impaired insurer on the policies covered by each account bears to the premiums received by such insurer on all covered policies.

(b) Class A and Class C assessments against member insurers for each account shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies covered by each account bears to such premiums received on business in this state by all assessed member insurers.

(c) Class B assessments for each account shall be made separately for each state in which the impaired domestic insurer was authorized to transact insurance at any time, in the proportion that the premiums received on business in such state by the impaired insurer on policies covered by such account bears to such premiums received in all such states by the impaired insurer. The assessments against member insurers shall be in the proportion that the premiums received

on business in each such state by each assessed member insurer on policies covered by each account bears to such premiums received on business in each such state by all assessed member insurers [in such state].

(d) Assessments for funds to meet the requirements of the Association with respect to an impaired insurer shall not be made until necessary to implement the purposes of this Act. Classification of assessments under sub. (2) and computation of assessments under this subsection shall be made with a reaonable degree of accuracy, recognizing that exact determinations may not always be possible.

(4) The Association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. The total of all assessments upon a member insurer for each account shall not in any one calendar year exceed 2% of such insurer's premiums in this state on the policies covered by the account.

(5) In the event an assessment against a member insurer is abated or deferred, in whole or in part, because of the limitations set forth in sub. (4), the amount by which such assessment is abated or deferred may [shall] be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. If the maximum assessment, together with the other assets of the Association in either account, does not provide in any one year in either account an amount sufficient to carry out the responsibilities of the Association, the necessary additional funds shall be assessed as soon thereafter as permitted by this Act.

(6) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each member insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the Association with regard to that account, including assets accruing from net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the Association and for future losses if refunds are impractical.

[(7) It shall be proper for any member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance within the scope of this act, to consider the amount reasonably necessary to meet its assessment obligations under this Act.]

(7) The Association shall issue to each insurer paying an assessment under this Act a certificate of contribution, in a form prescribed by the Commissioner, for the amount so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount and period of time as the Commissioner may approve.

COMMENT: Subsection (2) outlines different assessment methods for assessments needed to cover foreign or alien insurers and for assessments needed to cover domestic insurers. When a foreign or alien insurer is impaired the member insurers will be assessed on the basis of the premiums they write in the state. This corresponds to the Association's liability which is limited to covered policies or residents when the policies are issued by a foreign or alien insurer. When a domestic insurer is impaired, the total amount to be assessed will be allocated to each state in which the impaired insurer was authorized at any time to transact insurance in the proportion that the impaired insurer's premium income in each state bears to its total premium income. The amount allocated to each such state will then be assessed to member insurers in the proportion that the member's premium income from such state bears to all premium income of member insurers from that state. In any case, assessments would be made separately for each account and the amount assessed from each account will be in the proportion that the total premiums of the impaired insurer bear to the premiums of the impaired insurer from the kind of insurance in the account.

For example, if a total assessment of $100,000 is needed for the health insurance account and the domestic impaired insurer received 50% of its premium income from state X, then 50% of $100,000 or $50,000 will be allocated to state X. Member insurers receiving premium income from state X will then be assessed in proportion to their share of that state's market, as reflected in premium income. For example, if member insurers

receive $30 million in premium from state X and a certain member receives $3 million of that amount, then 3/30 of the $50,000 assessment will come from this company, that is, the company will be assessed $5,000. (3/30 = 1/10 and 1/10 of $50,000 is $5,000.)

This assessment system should be relatively simple to administer. More importantly, it provides a base broad enough to meet fairly large demands on the Association. Equally important, since it reflects the market share of each member in the state considered, it is an equitable method of apportioning the burden of the assessments.

The maximum assessment per year may be varied from state to state depending on the size of the base and the concentration of the business. The 2% maximum should produce an adequate amount while at the same time not impose an undue strain in any given year on the assessed companies and their policyholders.

In order to prevent further financial difficulties caused by an assessment, sub. (4) permits abatement of assessments when such financial difficulties might result.

Subsection (4) and (5) provide some limitation on the amounts which can be assessed in any given year. If these limits are reached, to fulfill its responsibilities the Association is empowered to borrow [bestow] funds which later can be repaid out of future assessments.

[Subsection (7) provides that a member insurer may consider in its premium rates and dividend scale an amount reasonably necessary to meet its assessment obligations. This makes it clear that the cost can be ultimately passed on to the policyowners — i.e., to persons who enjoy the protection provided by the Act. The insurers serve merely as conduits. Through an appropriate expense loading in the premium all future policyowners would contribute their fair share. Recoupment against current participating policyowners can be achieved through the dividend route. There seems to be no feasible method to reach current nonparticipating policyowners. However, with the passage of a few years the number of such policyowners will rapidly decrease. In short, any insurer which does not make provision for recoupment of assessments should look only to itself to blame. This act puts every insurer on notice to plan for the assessment contingency.]

Subsection (7) provides that the Association shall issue to assessed insurers certificates of contribution in the amount levied which certificates may be carried by an insurer in its annual statement as an asset in such form, amount and period as may be approved by the Commissioner. The assessments could, in particular cases, have a substantial impact on the surplus of assessed insurers. By permitting the companies to carry these certificates as an asset, to the extent of their estimated value, the impact on member insurers will be lessened.

Section 10. Plan of Operation.

(1) (a) The Association shall submit to the Commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the Association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the Commissioner.

(b) If the Association fails to submit a suitable plan of operation within 180 days following the effective date of this Act or if at any time thereafter the Association fails to submit suitable amendments to the plan, the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this Act. Such rules shall continue in force until modified by the Commissioner or superseded by a plan submitted by the Association and approved by the Commissioner.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation shall, in addition to requirements enumerated elsewhere in this Act:

(a) Establish procedures for handling the assets of the Association.

(b) Establish the amount and method of reimbursing members of the board of directors under s. 7.

(c) Establish regular places and times for meetings of the board of directors.

(d) Establish procedures for records to be kept of all financial transactions of the Association, its agents, and the board of directors.

(e) Establish the procedures whereby selections for the board of directors will be made and submitted to the Commissioner.

(f) Establish any additional procedures for assessments under s. 9.

(g) Contain additional provisions necessary or proper for the execution of the powers and duties of the Association.

(4) The plan of operation may provide that any or all powers and duties of the Association, except those under ss. 8 (11) (c) and 9, are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this Association, or its equivalent, in two or more states. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the Association and shall be paid for its performance of any function of the Association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the Commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this Act.

Section 11. Duties and Powers of the Commissioner.

In addition to the duties and powers enumerated elsewhere in this Act,

(1) The Commissioner shall

(a) Notify the board of directors of the existence of an impaired insurer not later than 3 days after a determination of impairment is made or he receives notice of impairment.

(b) Upon request of the board of directors, provide the Association with a statement of the premiums in the appropriate states for each member insurer.

(c) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders, if any. The failure of the insurer to promptly comply with such demand shall not excuse the Association from the performance of its powers and duties under this Act.

[(d) As liquidator, rehabilitator, or conservator, cause the impaired insurer's contractual obligations to be paid and its covered policies to be continued and, to the extent the assets of the impaired insurer are insufficient, shall request the aid of the Association under s. 8. All assets of the impaired insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired insurer as required by this Act. As used in this paragraph, "assets attributable to covered policies" is that proportion of the assets which the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired insurer.]

[(e)] (d) In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator. If a foreign or alien member insurer is subject to a liquidation proceeding in its domiciliary jurisdiction or state of entry, the Commissioner shall be appointed conservator.]

(2) The Commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the Commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture shall not exceed 5% of the unpaid assessment per month, but no forfeiture shall be less than $100 per month.

(3) Any action of the board of directors or the Association may be appealed to the Commissioner by any member insurer if such appeal is taken within 30 days of the action being appealed. Any final action or order of the Commissioner shall be subject to judicial review in a court of competent jurisdiction.

(4) The liquidator, rehabilitator, or conservator of any impaired insurer may notify all interested persons of the effect of this Act.

COMMENT: Subsection (1)(c) requires that the Commissioner give notice of an impairment to the impaired insurer, and hence to its stockholders, and serve a demand that the impairment be made good. If the company and stockholders fail to raise the necessary funds, this will be a factor bearing upon the stockholder's ownership rights under Section 14(4).

[Subsection (1)(d) imposes on the liquidator, rehabilitator, or conservator the duty to provide continuation of coverage and payment of claims. In doing so, he may call upon the Association to assess member insurers to provide funds which, in addition to the available assets of the insurer, will be sufficient to carry out this duty. However, to minimize assessments against member insurers (and hence their policyowners) the assets of the impaired insurer must be applied to the performance of this duty. Only the residue of such assets, if any, shall be available to the general creditor.]

Subsection (1)[(e)](d) provides that the Commissioner shall be appointed liquidator or rehabilitator of a domestic insurer and conservator of a foreign or alien insurer being liquidated or rehabilitated. This subsection is not needed in those states having the Uniform Insurers Liquidation Act. Requiring the Insurance Commissioner to be the receiver is necessary to obtain the benefits of a "reciprocal" state under the Uniform Act.

Proceedings for the liquidation, rehabilitation, or conservation of insurers present several difficulties which the Uniform Insurers Liquidation Act seeks to solve. Briefly, the difficulties have two sources. First, in some states the liquidator, rehabilitator, or ancillary receiver may be a person unfamiliar with insurance regulation. Inefficient administration of the proceedings may result.

Second, the laws of more than one state may be applied to the proceedings, particularly regarding ownership of assets and preferences for payment. The result is confusion and inequity in the collection and distribution of the assets. The Uniform Insurers Liquidation Act meets the first source of problems by designating the Insurance Commissioner as the receiver of a domestic insurer or the ancillary receiver of a foreign insurer. To solve the problem of multiple laws and marshalling of assets, the Uniform Act gives the receiver title to the assets. The ancillary receiver is then required to forward all assets to the receiver. The Uniform Act also details the laws under which preferences in the distribution of assets will be determined.

In drafting this model guaranty bill, particular effort was made to avoid (to the extent possible) disrupting existing state liquidation and rehabilitation laws. However, each individual state may want to consider adopting (1) the Uniform Insurers Liquidation Act, if it has not already done so (27 states have the Act — the Act has been recommended by the NAIC (1936 *Proc. of NAIC* 33)) or (2) the Rehabilitation and Liquidation Act found in Chapter 645 of the Wisconsin Statutes which has been recommended by the NAIC (I *Proc of NAIC* 241 (1969)).

Section 12. Prevention of Impairments.

To aid in the detection and prevention of insurer impairments,

(1) The board of directors shall, upon majority vote, notify the Commissioner of any information indicating any member insurer may be unable or potentially unable to fulfill its contractual obligations.

(2) The board of directors may, upon majority vote, request that the Commissioner order an examination of any member insurer which the board in good faith believes may be unable or potentially unable to fulfill its contractual obligations. The Commissioner may conduct such examination. The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by such persons as the Commissioner designates. The cost of such examination shall be paid by the Association and the examination report shall be treated as are other examination reports. In no event shall such examination report be released to the board of directors of the Association prior to its release to the public, but this shall not excuse the Commissioner from his obligation to comply with subsection (3). The

Commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the Commissioner but it shall not be open to public inspection prior to the release of the examination report to the public and shall be released at that time only if the examination discloses that the examined insurer is unable or potentially unable to meet its contractual obligations.

(3) The Commissioner shall report to the board of directors when he has reasonable cause to believe that any member insurer examined at the request of the board of directors may be unable or potentially unable to fulfill its contractual obligations.

(4) The board of directors may, upon majority vote, make reports and recommendations to the Commissioner upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer. Such reports and recommendations shall not be considered public documents.

(5) The board of directors may, upon majority vote, make recommendations to the Commissioner for the detection and prevention of insurer impairments.

(6) The board of directors shall, at the conclusion of any insurer impairment in which the Association carried out its duties under this Act or exercised any of its powers under this Act, prepare a report on the history and causes of such impairment, based on the information available to the Association, and submit such report to the Commissioner.

> COMMENT: These are basically the same prevention functions found in the NAIC property and liability model guaranty bill. However, subsection (2) provides that the Commissioner may conduct the examination requested by the board of directors instead of requiring that he do so as is found in the NAIC property and liability model guaranty bill.

Section 13. Appointment of Association Nominee.

The Association may recommend a natural person to serve as a special deputy to act for the Commissioner and under his supervision in the liquidation, rehabilitation, or conservation, of any member insurer.

> COMMENT: In order to harness the expertise of member insurers in the conduct of liquidation, rehabilitation, or conservation of impaired insurers, this section provides that the Association may recommend someone to serve as a special deputy, under supervision of the Commissioner, in the handling of a liquidation, rehabilitation, or conservation if the Commissioner tenders such appointment. The Commissioner must be the actual receiver to preserve a state's "reciprocal" status under the Uniform Insurers Liquidation Act.

Section 14. Miscellaneous Provisions.

(1) Nothing in this Act shall be construed to reduce the liability for unpaid assessments of the insureds of an impaired insurer operating under a plan with assessment liability.

(2) Records shall be kept of all negotiations and meetings in which the Association or its representatives are involved to discuss the activities of the Association in carrying out its powers and duties under s. 8. Records of such negotiations or meetings shall be made public only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired insurer, upon the termination of the impairment of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the Association to render a report of its activities under s. 15.

[(3) General creditors of the impaired insurer shall have no claim against those assets of the impaired insurer which are necessary for the liquidator, rehabilitator, or conservator to carry out his duties under s. 11 (1)(d).]

(3) For the purpose of carrying out its obligations under this Act, the Association shall be deemed to be a creditor of the impaired insurer to the extent of assets attributable to covered policies reduced by any amounts to which the Association is entitled as subrogee pursuant to s. 8(7). All assets of the impaired insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired insurer as required by this Act. Assets attributable to covered policies, as used in this subsection, is that proportion of the assets which the reserves that should have been established for such policies bear to the

reserves that should have been established for all policies of insurance written by the impaired insurer.

(4) (a) Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the Association, the shareholders and policyowners of the impaired insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of such impaired insurer. In such a determination, consideration shall be the welfare of the policyholders of the continuing or successor insurer.

(b) No distribution to stockholders, if any, of an impaired insurer shall be made until and unless the total amount of assessments levied by the Association with respect to such insurer have been fully recovered by the Association.

(5) No person shall make use in any manner of the protection afforded by this Act as a r eason for buying insurance from him.

(6) (a) If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under such order shall have a right to recover on behalf of the insurer from any affiliate that controlled it the amount of distributions, other than stock dividends paid by the insurer on its capital stock, at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of paragraphs (b) to (d).

(b) No such dividend shall be recoverable if the insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(c) Any person who was an affiliate that controlled the insurer at the time the distributions were paid shall be liable up to the amount of distributions he received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions he would have received if they had been paid immediately. If two persons are liable with respect to the same distributions they shall be jointly and severally liable.

(d) The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets to pay the contractual obligations of the impaired insurer.

(e) If any person liable under paragraph (c) is insolvent, all its affiliates that controlled it at the time the dividend was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

COMMENT: Subsection (1) is intended to preserve the assessment liability of the insureds of assessment mutuals.

Subsection (2) requires that records be kept of negotiations and actions by the Association. The Association should be held publicly accountable for its actions. On the other hand, effective handling of the rehabilitation or liquidation effort requires minimum publicity. Thus such records will be made public only after the liquidation, rehabilitation or conservation proceeding is terminated, the impairment is terminated or there is a prior order by a court of competent jurisdiction.

[Subsection (3), together with s. 11 (1)(d) will assure that the assets of the impaired insurer are used to carry out the contractual obligations of the impaired insurer.]

Since this Act imposes the obligation upon the Association to continue coverage for policyholders of impaired insurers, the assets of the impaired insurer ought to be used, to the extent available, for the purpose of continuing such coverage. Subsection (3) is designed to accomplish this purpose.

Subsection (4), in conjunction with Section 11(1)(c), is intended to prevent the shareholders of an impaired insurer from sitting back and

doing nothing and then reaping the benefit of funds put up by the Association. These stockholders should not obtain a more advantageous position than they would have occupied in the absence of this act. The court is empowered to modify and distribute the ownership rights of an impaired insurer in order to do equity as between the interested parties.

The purpose of subsection (5) is to prohibit the use of the Act by any insurer or agent in competing for business.

Subsection (6) is designed to recapture excessive dividend payments to affiliates that exercised control over the impaired insurer. The NAIC Model Holding Company Regulatory Act in large measure prevents improper distribution of dividends by an insurer to its holding company since extraordinary dividends are subject to the prior approval of the Commissioner, and ordinary dividends are required to be reported to the Commissioner. If, however, dividends are paid under circumstances that the insurer should have reasonably known that such payment could reasonably be expected to affect its ability to perform its contractual obligations to its policyholders, the holding company and affiliates should be required to repay such dividends subject to certain reasonable limitations.

Section 15. Examination of the Association; Annual Report.

The Association shall be subject to examination and regulation by the Commissioner. The board of directors shall submit to the Commissioner, not later than May 1 of each year, a financial report for the preceding calendar year in a form approved by the Commissioner and a report of its activities during the preceding calendar year.

Section 16. Tax Exemptions.

The Association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.

Section 17. Tax Write-offs of Certificates of Contribution.

(1) Unless a longer period has been allowed by the Commissioner, a member insurer shall at its option have the right to show a certificate of contribution as an asset in the form approved by the Commissioner pursuant to Section 9(7), at percentages of the original face amount approved by the Commissioner, for calendar years as follows:

100% for the calendar year of issuance
80% for the first calendar year after the year of issuance;
60% for the second calendar year after the year of issuance;
40% for the third calendar year after the year of issuance;
20% for the fourth calendar year after the year of issuance.

(2) The insurer may offset the amount written off by it in a calendar year under subsection (1) above, against its premium (or income)* tax liability to this state accrued with respect to business transacted in such year.

(3) Any sums acquired by refund, pursuant to Section 9(6), from the Association which have theretofore been written off by contributing insurers and offset against premium (or income) taxes as provided in subsection (2) above, and is not then needed for purposes of this Act, shall be paid by the Association to the Commissioner and by him deposited with the state treasurer for credit to the general fund of this State.

COMMENT: Subsection (1) sets up an amortization schedule, subject to modification by the Commissioner, for writing down certificates of contribution which the Association is authorized to issue to assessed

*Insert in states where domestic insurer is subject to income instead of premium taxation.

insurers pursuant to Section 9(7). Subsection (2) provides that the amount of the write down may be offset against the premium or other tax as the case may be.

The NAIC model insolvency guaranty bill for property and casualty insurance provides, in §16, that rates "shall include amounts sufficient to recoup a sum equal to the amounts paid to the Association. . . " It is obvious that life insurance premiums, and premiums for certain forms of health insurance, cannot be changed on existing policyholders. Thus, recoupment is virtually unattainable through existing policy premium rates and building such assessments into rates for future policyholders is not only impractical but unfair to all policyholders. The only suitable and practicable method of recoupment available to companies writing life and health insurance lies in offsets against premium or other taxes on such companies. The method suggested in this section is not only equitable to the companies involved but also reduces the impact on state revenue by the partial offset over a period of years. To the extent the ultimate value of the certificates exceeds the tax credit received, the state would be the ultimate beneficiary. Such equitable treatment of assessment for tax purposes would have additional positive effects: (1) the state government would have an additional incentive for providing adequate funds for insurance department personnel and administration, and (2) participation in the economic loss would be shared, to some degree, by the general public rather than solely by insureds, thus minimizing what might otherwise be a penalty on thrift and savings. It may be advisable in some jurisdictions to provide a cross-reference to the premium or other tax statutes to avoid questions of conflicting statutory provisions.

Section 18. [17]. Immunity.

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents or employes, the Association or its agents or employes, members of the board of directors, or the Commissioner or his representatives, for any action taken by them in the performance of their powers and duties under this Act.

COMMENT: Each state may wish to review its own statutes to determine whether its Tort Claims Act, if it has one, could be used as an alternative to this section insofar as it applies to the Commissioner or his representative.

Section 19 [18]. Stay of Proceedings; Reopening Default Judgments.

All proceedings in which the impaired insurer is a party in any court in this state shall be stayed 60 days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the Association on any matters germane to its powers or duties. As to a judgment under any decision, order, verdict, or finding based on the default the Association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such suit on the merits.

GENERAL COMMENT: As a means of preventing further deterioration of an insurer's financial condition, each state might consider enacting a rehabilitation and liquidation act based on present Wisconsin law which has been recommended by the NAIC as model legislation (I *Proc. of NAIC* 241 1969) or in lieu thereof that each state consider enacting the summary proceeding provisions of that law or of similar laws in other states. Such provisions would enable a commissioner to take effective action at the earliest possible moment and thus avoid complications and further losses to policyowners and beneficiaries.

It should again be noted that each state will wish to compare the language of this model act with its statutes. Where necessary, the language used herein should be altered to conform to existing statutory language.

[Each state might consider enacting, as part of this act or in a separate act, a provision which makes it an unfair trade practice for any insurer to advertise the protection afforded by this act in an attempt to sell its policies or contracts.]

# APPENDIX B

4. Consider Continuation of Task Force

Chairman Gillies noted that obviously since there are outstanding issues to be considered with respect to HMO solvency and guaranty funds, he recommended that the task force be continued. Upon motion duly made and seconded, the task force recommended to the Executive Committee that it be continued for another year.

Having no further business, the Guaranty Fund (EX4) Task Force adjourned at 4:55 p.m.

Peter W. Gillies, Conn., Chairman; David N. Levinson, Del., Vice Chair; Roxani Gillespie, Calif.; Bill Gunter, Fla.; John E. Washburn, Ill.; William D. Hager, Iowa; Sherman A. Bernard, La.; Herman W. Coleman, Mich.; George Dale, Miss.; William H. McCartney, Neb.; James P. Corcoran, N.Y.; Earl R. Pomeroy, N.D.; Theodore "Ted" Kulongoski, Ore.; Constance B. Foster, Pa.; Elaine A. McReynolds, Tenn.; Doyce R. Lee, Texas; Harold C. Yancey, Utah; Steven T. Foster, Va.; Robert D. Hasse, Wis.

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ATTACHMENT ONE

LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MODEL ACT

*[Editor's Note: The model as published here includes all amendments as adopted by the Guaranty Fund (EX4) Task Force and the Financial Condition (EX4) Subcommittee.]*

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Section 1. Title

This Act shall be known and may be cited as the [state] Life and Health Insurance Guaranty Association Act.

Comment: This model act is to be distinguished from the NAIC model guaranty association act for property and liability insurance. Although several philosophical and technical differences exist between this bill and the property and liability model act, to the extent possible and appropriate, provisions and the format of the latter are utilized in this model act.

Section 2. Purpose

A. The purpose of this Act is to protect, subject to certain limitations, the persons specified in Section 3A against failure in the performance of contractual obligations, under life and health insurance policies and annuity contracts specified in Section 3B, because of the impairment or insolvency of the member insurer that issued the policies or contracts.

B. To provide this protection, an association of insurers is created to pay benefits and to continue coverages as limited herein, and members of the Association are subject to assessment to provide funds to carry out the purpose of this Act.

Comment: The basic purpose of this model act is to protect policyowners, insureds, beneficiaries, annuitants, payees and assignees against losses (both in terms of paying claims and continuing coverage) which might otherwise occur due to an impairment or insolvency of an insurer. Unlike the property and liability situations, life and annuity contracts in particular are long-term arrangements for security. An insured may have impaired health or be at an advanced age so as to be unable to obtain new and similar coverage from other insurers. The payment of cash values alone does not adequately meet such needs. Thus it is essential that coverage be continued. In like manner, an insured may be unable to obtain new health insurance or, at least, he may lose protection for prior illness.

Section 3. Coverage and Limitations

A. This Act shall provide coverage for the policies and contracts specified in Subsection B:

(1) to persons who, regardless of where they reside (except for non-resident certificate holders under group policies or contracts), are the beneficiaries, assignees or payees of the persons covered under Paragraph (2), and

(2) to persons who are owners of or certificate holders under such policies or contracts; or, in the case of unallocated annuity contracts, to the persons who are the contract holders, and who

(a) are residents, or

(b) are not residents, but only under all of the following conditions:

(i) the insurers which issued such policies or contracts are domiciled in this state;

(ii) such insurers never held a license or certificate of authority in the states in which such persons reside;

(iii) such states have associations similar to the association created by this Act; and

(iv) such persons are not eligible for coverage by such associations.

B. (1) This Act shall provide coverage to the persons specified in Subsection A for direct, non-group life, health, annuity and supplemental policies or contracts, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this Act. Annuity contracts and certificates under group annuity contracts include but are not limited to guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement agreements, lottery contracts and any immediate or deferred annuity contracts.

(2) This Act shall not provide coverage for

(a) any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract holder;

(b) any policy or contract of reinsurance, unless assumption certificates have been issued;

(c) any portion of a policy or contract to the extent that the rate of interest on which it is based

(i) averaged over the period of four years prior to the date on which the Association becomes obligated with respect to such policy or contract, exceeds a rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for that same four year period or for such lesser period if the policy or contract was issued less than four years before the Association became obligated; and

(ii) on and after the date on which the Association becomes obligated with respect to such policy or contract, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available;

(d) any plan or program of an employer, association or similar entity to provide life, health or annuity benefits to its employees or members to the extent that such plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association or similar entity under

(i) a Multiple Employer Welfare Arrangement as defined in Section 514 of the Employee Retirement Income Security Act of 1974, as amended;

(ii) a minimum premium group insurance plan;

(iii) a stop-loss group insurance plan; or

(iv) an administrative services only contract;

(e) any portion of a policy or contract to the extent that it provides dividends or experience rating credits, or provides that any fees or allowances be paid to any person, including the policy or contract holder, in connection with the service to or administration of such policy or contract; and

(f) any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this state.

(g) any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation; and

(h) any portion of any unallocated annuity contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery.

C. The benefits for which the Association may become liable shall in no event exceed the lesser of:

(1) the contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer, or

(2) (a) with respect to any one life, regardless of the number of policies or contracts:

(i) $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

(ii) $100,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values;

(iii) $100,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(b) with respect to each individual participating in a governmental retirement plan established under Section 401(k), 403(b) or 457 of the U.S. Internal Revenue Code covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, $100,000 in present value annuity benefits, including net cash surrender and net cash withdrawal values;

provided, however, that in no event shall the Association be liable to expend more the $300,000 in the aggregrate with respect to any one individual under Subsections 2(a) and 2(b) above:

(c) with respect to any one contract holder covered by any unallocated annuity contract not included in 2(b) above, $5,000,000 in benefits, irrespective of the number of such contracts held by that contract holder.

Comment: This section and Section 8 are key sections of the Act. Section 3 identifies who and what are covered and not covered by the Act. Section 8 specifies the responsibilities of the Association toward covered persons with covered policies.

Protection of this Act is primarily extended to resident persons but certain non-residents under specific circumstances will be protected by this Act if the insolvent insurer was domiciled in this state.

This model does not apply to reinsurance unless assumption certificates were issued to the direct insureds. Furthermore, it applies only to direct individual or group certificate insurance issued by insurers licensed to transact insurance in this state at any time. Coverage issued by insurers or other entities which have not submitted to the application of a state's regulatory safeguards applying to insurers is excluded from protection by this Act. (See more particularly the definition of member insurer in Section 5.)

The model bill covers life, health and annuity policies and contracts and contracts supplemental thereto. The term health insurance is intended to include "accident and health" insurance, "sickness and accident" insurance, "disability" insurance, etc. The individual state may want to adjust this language to fit its particular terminology. Certificate holders under group contracts are explicitly covered, but group contract holders are not covered; this avoids the possibility of double coverage and indirect coverage of non-resident certificate holders through a resident group contract holder. However, contract holders of unallocated annuity contracts are covered, but no coverage is provided to individuals under unallocated annuity contracts because there is no contractual guaranty by the insurer to specifically identified individuals under such contracts.

Subsection B(2) identifies certain types of contracts or portions of contracts which are specifically not covered by this Act. If a portion of a contract is not covered, the remainder of the contract is covered unless excluded otherwise. Subsection B(2) also provides a ready means by which an individual state can exempt from the Act those policies and contracts issued by insurers or similar organizations deemed appropriate for exemption by such state.

Subsection B(2)(h) excludes coverage for any unallocated annuity contract not used to fund a benefit plan for natural persons or governmental lottery and is intended to exclude from coverage those products commonly referred to as "financial guaranty" products.

Section 4. Construction

This Act shall be liberally construed to effect the purpose under Section 2 which shall constitute an aid and guide to interpretation.

Section 5. Definitions

As used in this Act:

A. "Account" means any of the two accounts created under Section 6.

B. "Association" means the [state] Life and Health Insurance Guaranty Association created under Section 6.

C. "Commissioner" means the Commissioner [Director or Superintendent] of Insurance of this state.

D. "Contractual obligation" means any obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under Section 3.

E. "Covered policy" means any policy or contract within the scope of this Act under Section 3.

F. "Impaired insurer" means a member insurer which, after the effective date of this Act, is not an insolvent insurer, and (1) is deemed by the Commissioner to be potentially unable to fulfill its contractual obligations or (2) is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

G. "Insolvent insurer" means a member insurer which after the effective date of this Act, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

H. "Member insurer" means any insurer licensed or which holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under Section 3, and includes any insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

(1) A non-profit hospital or medical service organization;

(2) A health maintenance organization;

(3) A fraternal benefit society;

(4) A mandatory state pooling plan;

(5) A mutual assessment company or any entity that operates on an assessment basis;

(6) An insurance exchange; or

(7) Any entity similar to any of the above.

I. "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

J. "Person" means any individual, corporation, partnership, association or voluntary organization.

K. "Premiums" means amounts received on covered policies or contracts less premiums, considerations and deposits returned thereon, and less dividends and experience credits thereon. "Premiums" does not include any amounts received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under Section 3B except that assessible premium shall not be reduced on account of Sections 3B(2)(c) relating to interest limitations and 3C(2) relating to limitations with respect to any one individual, any one participant and any one contractholder; provided that "premiums" shall not include any premiums in excess of five million dollars on any unallocated annuity contract not issued under a governmental retirement plan established under Section 401(k), 403(b) or 457 of the United States Internal Revenue Code.

L. "Resident" means any person who resides in this state at the time a member insurer is determined to be an impaired or insolvent insurer and to whom a contractual obligation is owed. A person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business.

M. "Supplemental contract" means any agreement entered into for the distribution of policy or contract proceeds.

N. "Unallocated annuity contract" means any annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under such contract or certificate.

Comment: This act covers "insolvent insurers" which are defined to include an insolvent insurer under an order of liquidation issued by a court of competent jurisdiction. An "impaired insurer" is an insurer deemed by the Commissioner to be unable or potentially unable to fulfill its contractual obligations. As will be treated in Section 8 on the powers and duties of the Association, this model bill enables the Association to become involved prior to an actual court order. The finding by the Commissioner that an insurer is impaired, even though not subject to a court proceeding, serves as a triggering mechanism enabling the Association to function. For further discussion see the Comment on Section 8.

Each state will wish to examine its own statutes to determine whether these definitions are applicable and to determine whether some should be deleted and others added. The NAIC is currently studying the definitions of premiums to determined the appropriate treatment for return premiums and cash surrenders and withdrawals because of various accounting methods presently utilized by insurers.

Section 6. Creation of the Association

A. There is created a nonprofit legal entity to be known as the [state] Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the Association as a condition of their authority to transact insurance in this state. The Association shall perform its functions under the plan of operation established and approved under Section 10 and shall exercise its powers through a board of directors established under Section 7. For purposes of administration and assessment the Association shall maintain two accounts:

(1) The life insurance and annuity account which includes the following subaccounts:

(a) Life Insurance Account;

(b) Annuity Account;

(c) Unallocated Annuity Account which shall include contracts qualified under Section 403(b) of the United States Internal Revenue Code.

(2) The health insurance account.

B. The Association shall come under the immediate supervision of the Commissioner and shall be subject to the applicable provisions of the insurance laws of this state. Meetings or records of the Association may be opened to the public upon majority vote of the board of directors of the Association.

Comment: Each state will wish to examine its own statutes to determine whether a corporate structure would be a more appropriate form for the Association.

Section 7. Board of Directors

A. The board of directors of the Association shall consist of not less than five nor more than nine member insurers serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the Commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the Commissioner. To select the initial board of directors, and initially organize the Association, the Commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer shall be entitled to one vote in person or by proxy. If the board of directors is not selected within sixty days after notice of the organizational meeting, the Commissioner may appoint the initial members.

B. In approving selections or in appointing members to the board, the Commissioner shall consider, among other things, whether all member insurers are fairly represented.

C. Members of the board may be reimbursed from the assets of the Association for expenses incurred by them as members of the board of directors but members of the board shall not otherwise be compensated by the Association for their services.

Comment: Subsection A provides that the number and term of the members of the board of directors shall be determined in the plan of operation. To avoid problems in initially selecting the board, this section includes a provision for a start-up meeting which will be called by the Commissioner. To determine voting rights at the organizational meeting each member would have one vote. Thereafter the plan of operation will establish the voting procedures, by-laws, etc. governing the conduct of the Association.

Consistent with the comment in Section 6, states which are amending an existing statute should provide for a continuation of the board.

Section 8. Powers and Duties of the Association

A. If a member insurer is an impaired domestic insurer, the Association may, in its discretion, and subject to any conditions imposed by the Association that do not impair the contractual obligations of the impaired insurer, that are approved by the Commissioner, and that are, except in cases of court-ordered conservation or rehabilitation, also approved by the impaired insurer:

conditions imposed by the Association that do not impair the contractual obligations of the impaired insurer, that are approved by the Commissioner, and that are, except in cases of court-ordered conservation or rehabilitation, also approved by the impaired insurer:

(1) guarantee, assume or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer;

(2) provide such monies, pledges, notes, guarantees or other means as are proper to effectuate Paragraph (1) and assure payment of the contractual obligations of the impaired insurer pending action under Paragraph (1); or

(3) loan money to the impaired insurer.

B. (1) If a member insurer is an impaired insurer, whether domestic, foreign or alien, and the insurer is not paying claims timely, then subject to the preconditions specified in Paragraph (2), the Association shall, in its discretion, either:

(a) take any of the actions specified in Subsection A, subject to the conditions therein; or

(b) provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for health claims, periodic annuity benefit payments, death benefits, supplemental benefits, and cash withdrawals for policy or contract owners who petition therefor under claims of emergency or hardship in accordance with standards proposed by the Association and approved by the Commissioner.

(2) The Association shall be subject to the requirements of Paragraph (1) only if:

(a) the laws of its state of domicile provide that until all payments of or on account of the impaired insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the impaired insurer shall have been approved by the guaranty associations:

(i) the delinquency proceeding shall not be dismissed;

(ii) neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management;

(iii) it shall not be permitted to solicit or accept new business or have any suspended or revoked license restored; and

(b) (i) the impaired insurer is a domestic insurer, it has been placed under an order of rehabilitation by a court of competent jurisdiction in this state; or;

(ii) the impaired insurer is a foreign or alien insurer,

(I) it has been prohibited from soliciting or accepting new business in this state;

(II) its certificate of authority has been suspended or revoked in this state; and

(III) a petition for rehabilitation or liquidation has been filed in a court of competent jurisdiction in its state of domicile by the Commissioner of the state.

C. If a member insurer is an insolvent insurer, the Association shall, in its discretion, either:

(1) (a) guaranty, assume or reinsure, or cause to be guaranteed, assumed or reinsured, the policies or contracts of the insolvent insurer; or

(b) assure payment of the contractual obligations of the insolvent insurer; and

(c) provide such monies, pledges, guarantees, or other means as are reasonably necessary to discharge such duties; or

(2) with respect only to life and health insurance policies, provide benefits and coverages in accordance with Subsection D.

D. When proceeding under Subsections B(1)(b) or C(2), the Association shall, with respect to only life and health insurance policies:

(1) assure payment of benefits for premiums identical to the premiums and benefits (except for terms of conversion and renewability) that would have been payable under the policies of the insolvent insurer, for claims incurred:

(a) with respect to group policies, not later than the earlier of the next renewal date under such policies or contracts or forty-five days, but in no event less than thirty days, after the date on which the Association

becomes obligated with respect to such policies;

(b) with respect to individual policies, not later than the earlier of the next renewal date (if any) under such policies or one year, but in no event less than thirty days, from the date on which the Association becomes obligated with respect to such policies;

(2) make diligent efforts to provide all known insureds or group policyholders with respect to group policies thirty days notice of the termination of the benefits provided; and

(3) with respect to individual policies, make available to each known insured, or owner if other than the insured, and with respect to an individual formerly insured under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of Paragraph (4), if the insureds had a right under law or the terminated policy to convert coverage to individual coverage or to continue an individual policy in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or had a right only to make changes in premium by class.

(4) (a) In providing the substitute coverage required under Paragraph (3), the Association may offer either to reissue the terminated coverage or to issue an alternative policy.

(b) Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy.

(c) The Association may reinsure any alternative or reissued policy.

(5) (a) Alternative policies adopted by the Association shall be subject to the approval of the Commissioner. The Association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

(b) Alternative policies shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The Association shall set the premium in accordance with a table of rates which it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten.

(c) Any alternative policy issued by the Association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the Association.

(6) If the Association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the Association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the Commissioner or by a court of competent jurisdiction.

(7) The Association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date such coverage or policy is replaced by another similar policy by the policyholder, the insured, or the Association.

E. When proceeding under Subsections B(1)(b) or C with respect to any policy or contract carrying guaranteed minimum interest rates, the Association shall assure the payment or crediting of a rate of interest consistent with Section 3B(2)(c).

F. Nonpayment of premiums within thirty-one days after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the Association's obligations under such policy or coverage under this Act with respect to such policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this Act.

G. 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, and the Association shall be liable for unearned premiums due to policy or contract owners arising after the entry of such order.

H. The protection provided by this Act shall not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

I. In carrying out its duties under this Section B and C, the Association may, subject to approval by the court:

(1) impose permanent policy or contract liens in connection with any guarantee, assumption or reinsurance agreement, if the Association finds that the amounts which can be assessed under this Act are less than the amounts needed to assure full and prompt performance of the Association's duties under this Act, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest;

J. If the Association fails to act within a reasonable period of time as provided in Subsections B(1)(b), C and D of this section, the Commissioner shall have the powers and duties of the Association under this Act with respect to impaired or insolvent insurers.

K. The Association may render assistance and advice to the Commissioner, upon his request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

L. The Association shall have standing to appear before any court in this state with jurisdiction over an impaired or insolvent insurer concerning which the Association is or may become obligated under this Act. Such standing shall extend to all matters germane to the powers and duties of the Association, including, but not limited to, proposals for reinsuring, modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The Association shall also have the right to appear or intervene before a court in another state with jurisdiction over an impaired or insolvent insurer for which the Association is or may become obligated or with jurisdiction over a third party against whom the Association may have rights through subrogation of the insurer's policyholders.

M. (1) Any person receiving benefits under this Act shall be deemed to have assigned the rights under, and any causes of action relating to, the covered policy or contract to the Association to the extent of the benefits received because of this Act, whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative coverages. The Association may require an assignment to it of such rights and cause of action by any payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any right or benefits conferred by this Act upon such person.

(2) The subrogation rights of the Association under this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this Act.

(3) In addition to Paragraphs (1) and (2) above, the Association shall have all common law rights of subrogation and any other equitable or legal remedy which would have been available to the impaired or insolvent insurer or holder of a policy or contract with respect to such policy or contracts.

N. The Association may:

(1) enter into such contracts as are necessary or proper to carry out the provisions and purposes of this Act;

(2) sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under Section 9 and to settle claims or potential claims against it;

(3) borrow money to effect the purposes of this Act; any notes or other evidence of indebtedness of the Association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

(4) employ or retain such persons as are necessary to handle the financial transactions of the Association, and to perform such other functions as become necessary or proper under this Act;

(5) take such legal action as may be necessary to avoid payment of improper claims;

(6) exercise, for the purposes of this Act and to the extent approved by the Commissioner, the powers of a domestic life or health insurer, but in no case may the Association issue insurance policies or annuity contracts other than those issued to perform its obligations under this Act.

O. The Association may join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the Association.

Comment: Along with Section 3, this section is a key to the specific responsibilities of the Association toward covered persons. That responsibility varies by type of policy or contract involved.

The Association is primarily intended to act after the entry of an order of liquidation with the finding of insolvency against a member insurer. However, the Association may act (Section 8A) in the case of an impaired domestic member insurer to guarantee, assume or reinsure any or all policies or otherwise provide money to the member insurer. Note that action under this subsection is not limited to resident policyholders but to all policies or contracts issued by the insurer.

The Association must act under Section 8B even without an order of liquidation if several conditions exist, the most important being a statutory provision for the repayment of the Association prior to the return of the company to shareholder or private control. The Association's role here is the payment of benefits and "hardship" cash withdrawals to covered persons.

It is imperative that each state incorporate these preconditions into its delinquency statutes in order to allow Section 8B to be used. Because there is such variety in delinquency statutes, each state should develop specific language which embodies these concepts and fits in its present framework.

It is imperative that each state incorporate these preconditions into its delinquency statutes in order to allow Section 8B to be used. Because there is such variety in delinquency statutes, each state should develop specific language which embodies these concepts and fits in its present framework.

Section 8C details the main role of the Association in the instance of an order of liquidation against an insolvent member insurer. The responsibilities of the Association vary depending on the kind of coverage and type of policy—group or individual. The Association may offer alternative policies or change the premiums or benefits of existing contracts. "New contracts" shall be offered without new underwriting and with coverage for most existing conditions. In order to facilitate the sale of blocks of business for which the Association is responsible, the cooperation of the domestic receiver will be necessary. Each state should review its receivership statutes to make sure that such sales by the Association are permitted and that the receiver will act to accomplish this.

Subsection H relates to the imposition of policy and contract liens, moratoriums, etc. These are devices which have been used in the past in connection with continuation of the insolvent insurer's coverage. Since, by definition, the assets of the insolvent insurer were not adequate to support its contractual obligations, liens were used to reduce those obligations to a level where the assets would be adequate. However, in the past there was no means to infuse additional funds where needed to make whole policyowners, insureds, and beneficiaries. The purpose of the model act is to provide timely payment and protect against losses due to an insolvency, by providing prompt fulfillment of insurance benefits to the extent of the Association's obligations under this Act. To the extent that liens and moratoriums are sanctioned, the model act retreats from this principle.

On the one hand, it can be argued that if liens and moratoriums cannot be used, there will be a run on the assets of the impaired company. In the past this seems to have been true. However, unlike the past, the performance of the insurer's contractual obligations would be guaranteed.

Also, the standard nonforfeiture laws provide that an insurer in its policies shall reserve the right to defer the payment of cash values for a period of six months after demand therefor with surrender of the policy. Similarly, it is common to require an insurer to reserve for a period of six months the right to defer the granting of any policy loan (other than to pay premiums). For those various reasons, the model act does not encourage the use of liens and moratoriums in ordinary situations.

On the other hand, in periods of severe liquidity problems and economic stress, perhaps of even catastrophic proportions, such devices may become essential. While the model bill concentrates on the protection of those to whom the impaired insurer has a contractual obligation, the impact of assessments on the policyholders of assessed companies is also an important consideration (e.g., significant sales of depressed value assets in a tight money market). Consequently Subsection D(1) authorizes the Association to cause to be imposed liens and moratoriums (or other similar means):

> (i) if the Court finds that the amounts assessable are less than what is needed, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the use of such tools in the public interest and
>
> (ii) the Court approves the use of the specific lien, moratorium, etc.

This provides a highly flexible mechanism while at the same time it avoids impairing the contractual obligations of the impaired insurer as a routine matter under ordinary economic and financial conditions. The provision also recognizes that while contractual rights of policyowners may not constitutionally be impaired, when the insolvent insurer's obligation under the contract is assumed by another insurer the policyowner has two options. The policyowner may accept the new contract with such liens or moratoriums as permitted by the court, or accept such pro rata payment as is available from the estate of the insolvent insurer.

Furthermore, to provide added flexibility in a temporary situation (e.g., run on assets), Subsection H(2) provides for temporary moratoriums or liens on payment of cash values and policy loans, but not on the payment of other benefits, with the Court's approval.

Subsection K, to enable the Association to protect its interest and the best interests of the policyholders in the handling of an impairment or insolvency, provides that the Association shall have standing to appear in courts with jurisdiction over an insolvent insurer and such standing will extend to any matters concerning the duties of the Association.

Subsection O explicitly recognizes that prompt and efficient discharge of the Association's obligations will be greatly facilitated, especially in multistate insolvencies by acting in concert through the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) to develop and, where appropriate, carry out coordinated plans.

Section 9. Assessments

> A. For the purpose of providing the funds necessary to carry out the powers and duties of the Association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty days after prior written notice to the member insurers and shall accrue interest at [insert amount] percent per annum on and after the due date.
>
> B. There shall be two assessments, as follows:

(2) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the Association under Section 8 with regard to an impaired or an insolvent insurer.

C. (1) The amount of any Class A assessment shall be determined by the board and may be made on a pro rata or non-pro rata basis. If pro rata, the board may provide that it be credited against future Class B assessments. A non-pro rata assessment shall not exceed $150 per member insurer in any one calendar year. The amount of any Class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

(2) Class B assessments against member insurers for each account and subaccount shall be in the proportion that the premiums received on business in this state by each assessed member insurer or policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the insurer became impaired or insolvent, as the case may be, bears to such premiums received on business in this state for such calendar years by all assessed member insurers.

(3) Assessments for funds to meet the requirements of the Association with respect to an impaired or insolvent insurer shall not be made until necessary to implement the purposes of this Act. Classification of assessments under Subsection B and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

D. The Association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

E. (1) The total of all assessments upon a member insurer for the life and annuity account and for each subaccount thereunder shall not in any one calendar year exceed two percent and for the health account shall not in any one calendar year exceed two percent of such insurer's average premiums received in this state on the policies and contracts covered by the account during the three calendar years preceding the year in which the insurer became an impaired or insolvent insurer. If the maximum assessment, together with the other assets of the Association in any account, does not provide in any one year in either account an amount sufficient to carry out the responsibilities of the Association, the necessary additional funds shall be assessed as soon thereafter as permitted by this Act.

(2) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(3) If a one percent assessment for any subaccount of the life and annuity account in any one year does not provide an amount sufficient to carry out the responsibilities of the Association, then pursuant to Subsection C(2), the board shall access all subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in Subsection E(1) above.

F. The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the Association with regard to that account, including assets accruing from assignment, subrogation, net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the Association and for future losses.

G. It shall be proper for any member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance within the scope of this Act, to consider the amount reasonably necessary to meet its assessment obligations under this Act.

H. The Association shall issue to each insurer paying an assessment under this Act, other than Class A assessment, a certificate of contribution, in a form prescribed by the Commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the Commissioner may approve.

Comment: When an insurer is impaired or insolvent the member insurers will be assessed on the basis of the premiums they write in the state. This corresponds to the Association's liability which, in most cases, is limited to covered policies of residents. This assessment system provides a base broad enough to meet fairly large demands on the Association. Equally important, since it reflects the market share of each member in the state considered, it is an equitable method of apportioning the burden of the assessments.

The maximum assessment per year may be varied from state to state depending on the size of the base and the concentration of the business. The two percent maximum assessment per year should produce an adequate amount while at the same time not impose an undue strain in any given year on the assessed companies and their policyholders.

In order to prevent further financial difficulties caused by an assessment, Subsection D permits abatement of assessments when such financial difficulties might result. Subsections D and E provide some limitation on the amounts which can be assessed in any given year. If these limits are reached, to fulfill its responsibilities the Association is empowered to borrow funds which later can be repaid out of future assessments.

Subsection G provides that a member insurer may consider in its premium rates and dividend scale an amount reasonably necessary to meet its assessment obligations. This makes it clear that the cost can be ultimately passed on to the policyowners—i.e., to persons who enjoy the protection provided by the Act. Subsection H provides that the Association shall issue to assessed insurers certificates of contribution in the amount levied. The certificates may be carried by an insurer in its annual statement as an asset in such form, amount and period as may be approved by the Commissioner. By permitting the companies to carry these certificates as an asset, to the extent of their estimated value, the impact on member insurers will be lessened.

Section 10. Plan of Operation

A. (1) The Association shall submit to the Commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the Association. The plan of operation and any amendments thereto shall become effective upon the Commissioner's written approval or unless he has not disapproved it within thirty days.

(2) If the Association fails to submit a suitable plan of operation within 120 days following the effective date of this Act or if at any time thereafter the Association fails to submit suitable amendments to the plan, the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this Act. Such rules shall continue in force until modified by the Commissioner or superseded by a plan submitted by the Association and approved by the Commissioner.

B. All member insurers shall comply with the plan of operation.

C. The plan of operation shall, in addition to requirements enumerated elsewhere in this Act:

(1) establish procedures for handling the assets of the Association;

(2) establish the amount and method of reimbursing members of the board of directors under Section 7;

(3) establish regular places and times for meetings including telephone conference calls of the board of directors;

(4) establish procedures for records to be kept of all financial transactions of the Association, its agents, and the board of directors;

(5) establish the procedures whereby selections for the board of directors will be made and submitted to the Commissioner;

(6) establish any additional procedures for assessments under Section 9;

(7) contain additional provisions necessary or proper for the execution of the powers and duties of the Association.

D. The plan of operation may provide that any or all powers and duties of the Association, except those under Section 8M(3) and Section 9, are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this Association, or its equivalent, in two or more states. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the Association and shall be paid for its performance of any function of the Association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the Commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this Act.

Section 11. Duties and Powers of the Commissioner

In addition to the duties and powers enumerated elsewhere in this Act,

A. The Commissioner shall:

(1) upon request of the board of directors, provide the Association with a statement of the premiums in this and any other appropriate states for each member insurer;

(2) when an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time; notice to the impaired insurer shall constitute notice to its shareholders, if any; the failure of the insurer to promptly comply with such demand shall not excuse the Association from the performance of its powers and duties under this Act;

(3) in any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator.

B. The Commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the Commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture shall not exceed five percent of the unpaid assessment per month, but no forfeiture shall be less than $100 per month.

C. Any action of the board of directors or the Association may be appealed to the Commissioner by any member insurer if such appeal is taken within sixty days of the final action being appealed. If a member company is appealing an assessment, the amount assessed shall be paid to the Association and available to meet Association obligations during the pendancy of an appeal. If the appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member company. Any final action or order of the Commissioner shall be subject to judicial review in a court of competent jurisdiction.

D. The liquidator, rehabilitator, or conservator of any impaired insurer may notify all interested persons of the effect of this Act.

Comment: Subsection A(2) requires that the Commissioner give notice of an impairment to the impaired insurer, and hence to its stockholders, and serve a demand that the impairment be made good. If the company and stockholders fail to raise the necessary funds, this will be a factor bearing upon the stockholder's ownership rights under Section 14D.

Subsection A(3) provides that the Commissioner shall be appointed liquidator or rehabilitator of a domestic insurer and conservator of a foreign or alien insurer being liquidated or rehabilitated. This subsection is not needed in those states having the Uniform Insurers Liquidation Act. Requiring the Insurance Commissioner to be the receiver is necessary to obtain the benefits of a "reciprocal" state under the Uniform Act.

Proceedings for the liquidation, rehabilitation or conservation of insurers present several difficulties which the Uniform Insurers Liquidation Act seeks to solve. Briefly, the difficulties have two sources. First, in some states the liquidator, rehabilitator or ancillary receiver may be a person unfamiliar with insurance regulation. Inefficient administration of the proceedings may result.

Second, the laws of more than one state may be applied to the proceedings, particularly regarding ownership of assets and preferences for payment. The result is confusion and inequity in the collection and distribution of the assets. The Uniform Insurers Liquidation Act meets the first source of problems by designating the Insurance Commissioner as the receiver of a domestic insurer or the ancillary receiver of a foreign insurer. To solve the problem of multiple laws and marshalling of assets, the Uniform Act gives the receiver title to the assets. The ancillary receiver is then required to forward all assets to the receiver. The Uniform Act also details the laws under which preferences in the distribution of assets will be determined.

In drafting this model guaranty bill, particular effort was made to avoid (to the extent possible) disrupting existing state liquidation and rehabilitation laws. However, each individual state may want to consider adopting the Uniform Insurers Liquidation Act, if it has not already done so.

Section 12. Prevention of Insolvencies

To aid in the detection and prevention of insurer insolvencies or impairments,

A. It shall be the duty of the Commissioner

(1) To notify the commissioners of all the other states, territories of the United States and the District of Columbia when he takes any of the following actions against a member insurer:

(a) revocation of license;

(b) suspension of license; or

(c) makes any formal order that such company restricts its premium writing, obtains additional contributions to surplus, withdraws from the state, reinsures all or any part of its business, or increases capital, surplus, or any other account for the security of policyholders or creditors.

Such notice shall be mailed to all commissioners within thirty (30) days following the action taken or the date on which such action occurs.

(2) To report to the board of directors when he has taken any of the actions set forth in Paragraph (1) or has received a report from any other commissioner indicating that any such action has been taken in another state. Such report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner.

(3) To report to the board of directors when he has reasonable cause to believe from any examination, whether

completed or in process, of any member company that such company may be an impaired or insolvent insurer.

(4) To furnish to the board of directors the NAIC Insurance Regulatory Information System (IRIS) ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners, and the board may use the information contained therein in carrying out its duties and responsibilities under this Section. Such report and the information contained therein shall be kept confidential by the board of directors until such time as made public by the Commissioner or other lawful authority.

B. The Commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting his duties and responsibilities regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this state.

C. The board of directors may, upon majority vote, make reports and recommendations to the Commissioner upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state. Such reports and recommendations shall not be considered public documents.

D. It shall be the duty of the board of directors, upon majority vote, to notify the Commissioner of any information indicating any member insurer may be an impaired or insolvent insurer.

E. The board of directors may, upon majority vote, request that the Commissioner order an examination of any member insurer which the board in good faith believes may be an impaired or insolvent insurer. Within thirty days of the receipt of such request, the Commissioner shall begin such examination. The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by such persons as the Commissioner designates. The cost of such examination shall be paid by the Association and the examination report shall be treated as are other examination reports. In no event shall such examination report be released to the board of directors prior to its release to the public, but this shall not preclude the Commissioner from complying with Subsection A.

The Commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the Commissioner but it shall not be open to public inspection prior to the release of the examination report to the public.

F. The board of directors may, upon majority vote, make recommendations to the Commissioner for the detection and prevention of insurer insolvencies.

G. The board of directors shall, at the conclusion of any insurer insolvency in which the Association was obligated to pay covered claims, prepare a report to the Commissioner containing such information as it may have in its possession bearing on the history and causes of such insolvency. The board shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes of insolvency of a particular insurer, and may adopt by reference any report prepared by such other associations.

Section 13. Credits for Assessments Paid (Tax Offsets) - OPTIONAL

A. A member insurer may offset against its (premium, franchise or income) tax liability (or liabilities) to this state an assessment described in Section 9H to the extent of twenty percent of the amount of such assessment for each of the five calendar years following the year in which such assessment was paid. In the event a member insurer should cease doing business, all uncredited assessments may be credited against its (premium, franchise, or income) tax liability (or liabilities) for the year it ceases doing business.

B. Any sums which are acquired by refund, pursuant to Section 9F, from the Association by member insurers, and which have theretofore been offset against (premium, franchise or income) taxes as provided in Subsection A above, shall be paid by such insurers to this state in such manner as the tax authorities may require. The Association shall notify the Commissioner that such refunds have been made.

Comment: Subsection A provides an offset against future premium, franchise or income taxes of assessments, over a five-year period. The timing of the credit is dependent on the year the assessment is paid. It also allows the member insurer to select the applicable tax (premium, franchise or income) against which the credit may be applied and it permits member insurers going out of business to make use of the credit in their final year of operations.

The NAIC model insolvency guaranty bill for property and casualty insurance provides, in Section 16, that rates "shall include amounts sufficient to recoup a sum equal to the amounts paid to the Association ..." It is obvious that life insurance premiums, and premiums for certain forms of health insurance, cannot be changed on existing policyholders. Thus, recoupment is virtually unattainable through existing policy premium rates and building such assessments into rates for future policyholders is not only impractical but unfair to all policyholders. The only suitable and practical method of recoupment available to companies writing life and health insurance lies in offsets against premium or other taxes on such companies. The method suggested in this section is not only equitable to the companies involved but also reduces the impact on state revenue by the partial offset over a period of years. To the extent the recovery from the insolvent company exceeds the tax credit received, the state would be the ultimate beneficiary. Such equitable treatment of assessment for tax purposes would have additional positive effects: (1) the state legislature would have an additional incentive for providing adequate funds for insurance department personnel and administration, and (2) participation in the economic loss would be shared, to some degree, by the general public rather than solely by insureds, thus minimizing what might otherwise be a penalty on

thrift and savings. It may be advisable in some jurisdictions to provide a cross-reference to the premium or other tax statutes to avoid questions of conflicting statutory provisions.

Some states allow this credit and others do not. Accordingly, this section is optional, and the NAIC neither endorses nor rejects the tax credit concept. Each state will wish to consider this provision in the light of its own regulatory experience.

Section 14. Miscellaneous Provisions

A. Nothing in this Act shall be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

B. Records shall be kept of all negotiations and meetings in which the Association or its representatives are involved to discuss the activities of the Association in carrying out its powers and duties under Section 8. Records of such negotiations or meetings shall be made public only upon the termination of a liquidation, rehabilitation or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the Association to render a report of its activities under Section 15.

C. For the purpose of carrying out its obligations under this Act, the Association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the Association is entitled as subrogee pursuant to Section 8M. Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this Act. Assets attributable to covered policies, as used in this subsection, are that proportion of the assets which the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

D. (1) Prior to the termination of any liquidation, rehabilitation or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the Association, the shareholders, and policyowners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of such insolvent insurer. In such a determination consideration shall be given to the welfare of the policyholders of the continuing or successor insurer.

(2) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the Association with interest thereon for funds expended in carrying out its powers and duties under Section 8 with respect to such insurer have been fully recovered by the Association.

E. (1) If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under such order shall have a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of Paragraphs (2) to (4).

(2) No such distribution shall be recoverable if the insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(3) Any person who was an affiliate that controlled the insurer at the time the distributions were paid shall be liable up to the amount of distributions he received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared, shall be liable up to the amount of distributions he would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(4) The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(5) If any person liable under Paragraph (3) is insolvent, all its affiliates that controlled it at the time the distribution was paid, shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

Comment: Subsection A is intended to preserve the assessment liability of the insureds of assessment mutuals.

Subsection B requires that records be kept of negotiations and actions by the Association. The Association should be held publicly accountable for its actions. On the other hand, effective handling of the rehabilitation or liquidation effort requires minimum publicity. Thus, such records will be made public only after the liquidation, rehabilitation or conservation proceeding is terminated, the impairment or insolvency is terminated or there is a prior order by a court of competent jurisdiction.

Since this Act imposes the obligation upon the Association to continue coverage for policyholders of insolvent insurers, the assets of the insolvent insurer ought to be used, to the extent available, for the purpose of continuing such coverage. Subsection C is designed to accomplish this purpose.

Subsection D, in conjunction with Section 11A(2), is intended to prevent the shareholders of an impaired insurer from sitting back and doing nothing and then reaping the benefits of funds put up by the Association. These stockholders should not obtain a more advantageous position than they would have occupied in the absence of this Act. The court is empowered to modify and distribute the ownership rights of an impaired insurer in order to do equity as between the interested parties.

Subsection E is designed to recapture excessive dividend payments to affiliates that exercised control over the insolvent insurer. The NAIC Model Insurance Holding Company System Regulatory Act in large measure prevents improper distribution of dividends by an insurer to its holding company since extraordinary dividends are subject to the prior approval of the Commissioner, and ordinary dividends are required to be reported to the Commissioner. If, however, dividends are paid under circumstances that the insurer should have reasonably known that such payment could reasonably be expected to affect its ability to perform its contractual obligation to its policyholders, the holding company and affiliates should be required to repay such dividends subject to certain reasonable limitations.

If a state has the NAIC Insurance Model Holding Company System Regulatory Act, the definitions therein could be referred to by this subsection. States without the Model Act could incorporate the relevant definitions in this subsection.

Section 15. Examination of the Association; Annual Report

The Association shall be subject to examination and regulation by the Commissioner. The board of directors shall submit to the Commissioner each year, not later than 120 days after the Association's fiscal year, a financial report in a form approved by the Commissioner and a report of its activities during the preceding fiscal year.

Section 16. Tax Exemptions

The Association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.

Section 17. Immunity

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents or employees, the Association or its agents or employees, members of the board of directors, or the Commissioner or his representatives, for any action or omission by them in the performance of their powers and duties under this Act. Such immunity shall extend to the participation in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees.

Comment: Each state may wish to review its own statutes to determine whether its Tort Claims Act, if it has one, could be used as an alternative to this section insofar as it applies to the Commissioner or his representative.

Section 18. Stay of Proceedings; Reopening Default Judgments

All proceedings in which the insolvent insurer is a party in any court in this state shall be stayed sixty days from the date an order of liquidation, rehabilitation or conservation is final to permit proper legal action by the Association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict or finding based on default the Association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such suit on the merits.

Section 19. Prohibited Advertisement of Insurance Guaranty Association Act in Insurance Sales; Notice to Policyholders

A. No person, including an insurer, agent or affiliate of an insurer 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 any newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement, written or oral, which uses the existence of the Insurance Guaranty Association of this state for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by the [State] Life and and Health Insurance Guaranty Association Act. Provided, however, that this section shall not apply to the [State] Life and Health Insurance Guaranty Association or any other entity which does not sell or solicit insurance.

B. Within 180 days of the effective date of this Act, the Association shall prepare a summary document describing the general purposes and current limitations of the Act and complying with Subsection C. This document should be submitted to the Commissioner for approval. Sixty days after receiving such approval, no insurer may deliver a policy or contract described in Section 3B(1) to a policy or contract holder unless the document is delivered to the policy or contract holder prior to or at the time of delivery of the policy or contract except if Subsection D applies. The document should also be available upon request by a policyholder. The distribution, delivery, or contents or interpretation of this document shall not mean that either the policy or the contract or the holder thereof would be covered in the event of the impairment or insolvency of a member insurer. The description document shall be revised by the Association as amendments to the Act may require. Failure to receive this document does not give the policyholder, contract holder, certificate holder, or insured any greater rights than those stated in this Act.

C. The document prepared under Subsection B shall contain a clear and conspicuous disclaimer on its face. The Commissioner shall promulgate a rule establishing the form and content of the disclaimer. The disclaimer shall:

C. The document prepared under Subsection B shall contain a clear and conspicuous disclaimer on its face. The Commissioner shall promulgate a rule establishing the form and content of the disclaimer. The disclaimer shall:

(1) state the name and address of the Life and Health Insurance Guaranty Association and insurance department;

(2) prominently warn the policy or contract holder that the Life and Health Insurance Guaranty Association may not cover the policy or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in the state;

(3) state that the insurer and its agents are prohibited by law from using the existence of the Life and Health Insurance Guaranty Association for the purpose of sales, solicitation or inducement to purchase any form of insurance;

(4) emphasize that the policy or contract holder should not rely on coverage under the Life and Health Insurance Guaranty Association when selecting an insurer;

(5) provide other information as directed by the Commissioner.

D. No insurer or agent may deliver a policy or contract described in Section 3B(1) and excluded under Section 3B(2)(a) from coverage under this act unless the insurer or agent, prior to or at the time of delivery, gives the policy or contract holder a separate written notice which clearly and conspicuously discloses that the policy or contract is not covered by the Life and Health Insurance Guaranty Association. The Commissioner shall by rule specify the form and content of the notice.

Comment: Subsection A continues the prohibition of using the existence of the Association in the inducement of sale of insurance. However, Subsection B requires notification to new policyholders concerning the general parameters of the Association Article and responsibility thereunder.

The following form for the disclaimer notice is suggested:

LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION DISCLAIMER

The [insert name of the Life and Health Insurance Guaranty Association] provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned on residence in this state. Other conditions may also preclude coverage.

The Life and Health Insurance Guaranty Association or the insurance department will respond to any questions you may have which are not answered by this document. Your insurer and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association when selecting an insurer.

[Insert addresses of the Association and department.]

Insurers and agents should be required to deliver the document and disclaimer described under Subsections B and C when a customer is solicited if a "free look" period is not required by state law.

Section 20. Prospective Application

This act shall not apply to any insurer which is insolvent or unable to fulfill its contractural obligations on the effective date of this act.

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ATTACHMENT TWO

GUARANTY FUND (EX4) TASK FORCE'S
PROPOSED AMENDMENTS TO THE NAIC LIFE AND HEALTH
INSURANCE GUARANTY ASSOCIATION MODEL ACT
Draft 12/8/87

Amendment #1

Section 3. Coverage and Limitations

(B) (1) This Act shall provide coverage to the persons specified in subsection (A) for direct, non-group life, health, annuity and supplemental policies or contracts, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this Act. Annuity contracts and

# APPENDIX C

# ORIGINAL

At IAS Part 35 of the Supreme Court of the State of New York, held in and for the County of Nassau, at the Courthouse, 100 Supreme Court Drive, Mineola, New York, on the 16th day of April, 2012

PRESENT:
HON. JOHN M. GALASSO, J.S.C.

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In the Matter of the Rehabilitation of EXECUTIVE LIFE INSURANCE COMPANY OF NEW YORK.

Index No. 8023/91

Motion Sequence #s 109 and 111

**ORDER OF LIQUIDATION AND APPROVAL OF THE ELNY RESTRUCTURING AGREEMENT**

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The Superintendent of Financial Services (successor to the Superintendent of Insurance) of the State of New York (the "Superintendent"), through Eric T. Schneiderman, Attorney General of the State of New York, having moved this Court by order to show cause ("Order to Show Cause") for an order to convert the rehabilitation proceeding of Executive Life Insurance Company of New York ("ELNY") to a liquidation proceeding and having sought approval of the Agreement of Restructuring in Connection with the Liquidation of ELNY, and the Superintendent having provided ELNY claimants, creditors, policyholders, and other interested parties with notice of the relief sought, and upon reading the Superintendent's Verified Petition, duly verified on August 31, 2011 (the "Liquidation Petition"); the Memorandum of Law in Support of the Liquidation Petition; the Affidavit of Ivy Chang, sworn to on August 30, 2011, and the exhibits attached thereto; all answering and reply papers; all prior proceedings and papers in this proceeding; and said Liquidation Petition having duly come on to be ~~heard~~ submitted on the 29th day of March, 2012, this Court finds that:

A. ELNY was placed into rehabilitation and the Superintendent, and his successors in office, were appointed rehabilitator ("Rehabilitator") by order of this Court entered April 23, 1991 (the "Rehabilitation Order");

B. The Rehabilitation Order found that ELNY was in such condition that its further transaction of business would be hazardous to its policyholders, its creditors, and to the public;

C. ELNY is insolvent;

D. Further efforts to rehabilitate ELNY would be futile;

E. ELNY is subject to the New York Insurance Law (the "Insurance Law") and, particularly, to Article 74 thereof; and

F. It is in the best interest of all persons concerned that the Superintendent be vested with title to all of ELNY's property, contracts, and rights of action and directed to liquidate its business and affairs substantially in the manner provided in the Agreement of Restructuring in Connection with the Liquidation of ELNY, by and among the Superintendent, as Receiver of ELNY, the National Organization of Life and Health Insurance Guaranty Associations, and the Participating Guaranty Associations, and joined by NEWCO and The Life Insurance Guaranty Corporation existing under Insurance Law Article 75, and the Exhibits and Schedules attached thereto, as filed with the Court on March 6, 2012 (the "Restructuring Agreement").

NOW, THEREFORE, on motion of Eric T. Schneiderman, Attorney General of the State of New York, and after carefully considering the Restructuring Agreement, the applicable law, comments, suggestions, and/or objections to the Liquidation and the Restructuring Agreement, and the testimony, evidence, and arguments related thereto, it is hereby ORDERED as follows:

(1) The relief requested in the Liquidation Petition is granted and ELNY is found to be insolvent;

(2) The Rehabilitation of ELNY is hereby converted to a Liquidation effective as of the closing date of the Restructuring Agreement (which date shall also be the "Liquidation Date" under the Restructuring Agreement) and pending such effectiveness, the Rehabilitation Plan, as that term is defined in the Restructuring Agreement, and all prior orders of this Court remain in full force and effect;

(3) The Superintendent, and his successors in office, are hereby appointed, effective as of the Liquidation Date, liquidator ("Liquidator") of ELNY and are: (i) vested with all powers and authority expressed or implied under Insurance Law Article 74, in addition to the powers and authority set forth in this Order; (ii) vested with title to ELNY's property, contracts, rights of action and all its books and records, wherever located; (iii) authorized and permitted to conduct the business of ELNY as the Liquidator deems wise and expedient; and (iv) directed to liquidate ELNY's business and affairs in accordance with Insurance Law Article 74 and substantially in the manner provided in the Restructuring Agreement;

(4) The rights and liabilities of ELNY and of its creditors, policyholders, and all other persons interested in the estate of ELNY shall be fixed as of the Liquidation Date;

(5) All persons, other than the Receiver (as defined in the Restructuring Agreement) and his agents, are enjoined and restrained from: (i) dealing with, disposing of, or doing or permitting any act or thing that might waste ELNY's assets; (ii) transacting ELNY's business; (iii) interfering with this proceeding or with the Receiver in his possession, control, and management of ELNY's property, or in the discharge of his duties under Insurance Law Article 74; and (iv) obtaining any preferences, judgments, attachments, or other liens, and from making any levy against ELNY, its assets, or any part thereof;

(6) All persons are enjoined and restrained from commencing or further prosecuting any actions at law or other proceedings against ELNY or its assets, the Receiver or the New York Liquidation Bureau, or their present or former employees, attorneys, or agents, with respect to this proceeding or the discharge of their duties under Insurance Law Article 74;

(7) All parties to actions, lawsuits, and special or other proceedings in which ELNY is obligated to defend a party pursuant to an insurance policy, bond, contract, or otherwise are enjoined and restrained from proceeding with any discovery, court proceedings, or other litigation tasks or procedures, including, but not limited to, conferences, trials, applications for judgment, or proceedings on settlement or judgment, until further order of this Court;

(8) All persons or entities having property and/or information, including, but not limited to, insurance policies, claims files (electronic or paper), software programs, and/or bank records owned by or belonging to ELNY shall preserve such property and/or information and immediately, upon the Receiver's request and direction, assign, transfer, turn over, and deliver such property and/or information to the Receiver;

(9) The provisions, terms, and conditions of the Restructuring Agreement, filed with the Court on March 6, 2012, including all Exhibits and Schedules attached thereto, are hereby approved and the Restructuring Agreement is confirmed in such form and incorporated herein by reference (provided that such approval and confirmation shall not be deemed to preclude updating, adjustment and amendment of Schedule 1.15 prior to, contemporaneously with and subsequent to closing of the Restructuring Agreement, as provided in Section 1.15 of the Restructuring Agreement), including, but not limited to:

a. ELNY's restructuring of its liabilities in respect of the ELNY Contracts, as that term is defined in the Restructuring Agreement, pursuant to the terms of the Restructuring Agreement;

b. NEWCO's assumption of the obligation to pay ELNY benefit payments in accordance with the terms of the Restructuring Agreement;

c. The delivery, transfer and assignment to NEWCO of all of ELNY's right, title and interest in and to the Transferred Assets and the retention by ELNY of the Retained Assets as provided under the Restructuring Agreement, as those terms are defined in the Restructuring Agreement;

d. The form of the Assumption Certificates in substantially the form attached as Exhibit 1.6 to the Restructuring Agreement;

e. The terms and conditions of the ELNY Restructured Contracts;

f. The preservation of Retained Liabilities and priority of distribution of the Net Proceeds Transfer, as those terms are defined in the Restructuring Agreement; and

g. The requirement that all Contracts, as that term is defined in the Restructuring Agreement, shall remain in full force pending effectiveness of the Reinsurance and Assumption Agreement, and shall upon such effectiveness be fully discharged as obligations of ELNY other than to the

extent of the value of such obligations that are included in the Retained Liabilities, as that term is defined in the Restructuring Agreement;

(10) To the extent any comment, suggestion, and/or objection that was presented regarding the Liquidation Petition or the Restructuring Agreement, and/or any related document, is inconsistent with the Restructuring Agreement and/or any related document, that comment, suggestion, and/or objection is overruled and any relief requested therein is denied;

(11) The Receiver shall continue to direct the full payment of all benefits in respect of ELNY Contracts, in accordance with the terms of each ELNY Contract, until the closing of the Restructuring Agreement;

(12) Judicial immunity is extended to the Receiver and his successors in office, the New York Liquidation Bureau, and their respective attorneys, agents, and employees, and such immunity is extended to them for any cause of action of any nature against them, individually or jointly, for any action or omission by any one or more of them when acting in good faith, in accordance with this Order, or in the performance of their duties pursuant to Insurance Law Article 74;

(13) This Court shall retain subject matter jurisdiction over the Restructuring Agreement;

(14) The Receiver may at any time make further application to this Court for such further and different relief as he sees fit;

(15) In accordance with Insurance Law Section 7432(b), all claims against ELNY must be presented to the Receiver within four months of the Liquidation Date; however, in accordance with Insurance Law Section 7433(b)(1), all policyholders and holders of Claim-Overs (as defined in the Restructuring Agreement) who appear on ELNY's books and records as of the Liquidation Date are deemed to have duly filed proofs of claim;

(16) The Receiver shall provide notice of this Order to all creditors, policyholders and other interested parties by: (i) posting this Order on the Internet webpage maintained by the New York Liquidation Bureau at http://www.elny.org within thirty (30) days after the Liquidation Date; and (ii) publishing notice of this Order in the New York Times and the Wall Street Journal, once a week for two consecutive publication weeks, commencing within two weeks after the Liquidation Date, in a form substantially similar to the one attached hereto as Exhibit 1;

a. Such notice shall inform all creditors, claimants, and other interested persons that this Order has been entered; and

b. Such notice is sufficient notice to all persons interested in ELNY;

(17) Any distribution of assets shall be in accordance with the priorities applicable to life insurance companies set forth in Section 7435(a) of Insurance Law Article 74 and substantially in accordance with the terms of the Restructuring Agreement;

(18) Notwithstanding anything to the contrary contained in this Order or the Restructuring Agreement, neither this Order nor the Restructuring Agreement shall in any way limit, impair, prejudice or adjudicate any right or claim of any owner of or payee or beneficiary under any ELNY Contract, as that term is defined in the Restructuring Agreement, with respect to any coverage or benefits provided for under any Guaranty Association Act, as that term is defined in the Restructuring Agreement, or under Article 75 of the New York Insurance Law;

(19) Except as expressly set forth in this Order and in the Restructuring Agreement approved by this Order, nothing in this Order shall limit, impair, prejudice or adjudicate any rights or obligations of the Participating Guaranty Associations, as that term is defined in the Restructuring Agreement;

(20) At least two weeks prior to the proposed closing of the Restructuring Agreement, the Receiver will file a notice of the proposed closing date with the Court, and post a copy of such notice on the Internet webpage maintained by the New York Liquidation Bureau at http://www.elny.org. Within one business day of the closing of the Restructuring Agreement the Receiver will file a notice of the closing of the Restructuring Agreement with the Court and post a copy of such notice on the webpage http://www.elny.org; and

(21) The caption to this proceeding is hereby amended, effective as of the closing date of the Restructuring Agreement, as follows:

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU
----------X

In the Matter of
the Liquidation of

EXECUTIVE LIFE INSURANCE COMPANY OF NEW YORK.
----------X

ENTERED
APR 19 2012
NASSAU COUNTY
COUNTY CLERK'S OFFICE

ENTER:

J.S.C.

91-008023

NASSAU INDEX #_____
FILED

APR 19 2012

COUNTY CLERK OF
NASSAU COUNTY

# APPENDIX D

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*Attorneys for National Organization of Life and Health Insurance Guaranty Associations, as a representative of its member guaranty associations*

**SUPERIOR COURT OF THE STATE OF CALIFORNIA**

**FOR THE COUNTY OF LOS ANGELES**

INSURANCE COMMISSIONER OF THE STATE OF CALIFORNIA,

Applicant,

v.

GOLDEN STATE MUTUAL LIFE INSURANCE COMPANY, a California corporation,

Respondent.

Case No. BS123005
Assigned to Hon. Ann I. Jones, Dept. 86

**NOTICE OF ENTRY OF ORDER GRANTING JOINT APPLICATION FOR ORDERS APPROVING CLAIM HANDLING AGREEMENTS, RATE TABLES AND ISSUANCE OF ALTERNATIVE POLICIES**

Date: May 30, 2012
Time: 9:30 a.m.
Dept: 86

**TO THE LOS ANGELES SUPERIOR COURT AND ALL INTERESTED PARTIES.**

**PLEASE TAKE NOTICE,** hereby given, that on May 30, 2012, the Honorable Ann I. Jones, Judge Presiding, in Department 86 of the above-entitled Court, entered the attached Order granting the Joint Application For Orders Approving Claim Handling Agreements, Rate Tables And Issuance Of Alternative Policies jointly filed by Applicant Insurance Commissioner of the State of California in his capacity as Liquidator of Golden State Mutual Life Insurance Company and the National Organization of Life and Health Insurance Guaranty. A true and correct copy of the Order is attached hereto.

DATE: June 13, 2012

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Attorney General of California
FELIX E. LEATHERWOOD
W. DEAN FREEMAN
Supervising Deputy Attorneys General
LISA W. CHAO
Deputy Attorney General

EPSTEIN TURNER WEISS
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By: _____
MICHAEL R. WEISS
Attorneys for Applicant
INSURANCE COMMISSIONER OF THE STATE OF CALIFORNIA

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ORIGINAL

FILED
LOS ANGELES SUPERIOR COURT
MAY 30 2012
JOHN A. CLARKE, CLERK
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*Attorneys for National Organization of Life and Health Insurance Guaranty Associations, as a representative of its member guaranty associations*

**SUPERIOR COURT OF THE STATE OF CALIFORNIA**

**FOR THE COUNTY OF LOS ANGELES**

INSURANCE COMMISSIONER OF THE STATE OF CALIFORNIA,

Applicant,

v.

GOLDEN STATE MUTUAL LIFE INSURANCE COMPANY, a California corporation,

Respondent.

Case No. BS123005
Assigned to Hon. Ann I. Jones, Dept. 86

**~~[PROPOSED]~~ ORDER GRANTING JOINT APPLICATION FOR ORDERS APPROVING CLAIM HANDLING AGREEMENTS, RATE TABLES AND ISSUANCE OF ALTERNATIVE POLICIES**

[Filed concurrently with Notice, Memorandum, Declarations, Proof of Service]

Date: May 30, 2012
Time: 9:30 a.m.
Dept: 86

Epstein Turner Weiss
A Professional Corporation
633 West Fifth Street
Suite 3330
Los Angeles, CA 90071

On May 30, 2012, in Department 86 of the Los Angeles Superior Court for the State of California, County of Los Angeles, located at 111 N. Hill Street, Los Angeles, California 90012, the Honorable Ann I. Jones, Judge Presiding (the "Court"), held the hearing on the Joint Application For Orders Approving Claim Handling Agreements, Rate Tables And Issuance Of Alternative Policies ("Application"), filed jointly by Applicant Insurance Commissioner of the State of California in his capacity as Liquidator ("Liquidator") of Golden State Mutual Life Insurance Company ("Golden State") and the National Organization of Life and Health Insurance Guaranty Associations ("NOLHGA").

Michael R. Weiss appeared on behalf of the Liquidator. Franklin D. O'Loughlin appeared on behalf of NOLGHA. Other appearances, if any, are noted in the record.

The Court, having read and considered the Joint Application, the Notice, Memorandum of Points and Authorities, Declarations of Scott Pearce, Michael R. Weiss and Fred Buck, and evidence in support of the Application, and all documents and evidence submitted, and having heard and considered the arguments presented to the Court, and upon good cause shown,

IT IS HEREBY ORDERED that the Application is granted and that:

1. The Agreement for Handling of Claims and Potential Claims under Golden State's Group Life Policy And Non-Transferred Insurance Policies, by and between the Liquidator and NOLHGA on behalf of the participating Guaranty Associations, submitted with the Application as Exhibit A, is approved;

2. The Early Access Agreement, by and between the Liquidator and NOLHGA on behalf of the participating Guaranty Associations, submitted with the Application as Exhibit B, is approved;

3. The Liquidator, NOLGHA and the Guaranty Associations are authorized to use the following policy forms:

a. The Individual Single Premium Paid Up Whole Life Insurance Policy submitted with this Application as Exhibit C, to replace the term coverage provided under Golden State's Group Policy which is to be cancelled by the Guaranty Associations in accordance with their statutory Enabling Acts;

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Suite 3330
Los Angeles, CA 90071

b. The Individual Premium Paying Whole Life Insurance Policy submitted with this Application as Exhibit D, to replace the term coverage provided under Golden State's Group Policy which is to be cancelled by the Guaranty Associations in accordance with their statutory Enabling Acts;

c. The Disability Term to 65 Policy submitted with this Application as Exhibit E, to replace the term coverage provided under Golden State's Group Policy which is to be cancelled by the Guaranty Associations in accordance with their statutory Enabling Acts, and

d. The Dependent Term to 65 Policy submitted with this Application as Exhibit F, to replace the term coverage provided under Golden State's Group Policy which is to be cancelled by the Guaranty Associations in accordance with their statutory Enabling Acts.

4. The Liquidator, NOLGHA and the Guaranty Associations are authorized to use following rates and coverage amounts:

a. No premium will be charged for the Individual Single Premium Paid Up Whole Life Insurance Policy ;

b. The rates submitted with this Application as Exhibit H will be offered for the excess coverage stated to retirees under the Individual Premium Paying Whole Life Insurance Policy;

c. No premium will be charged for the Disability Term to 65 Policy; and

d. The rates submitted with this Application as Exhibit I will be charged for coverage offered under the Dependent Term to 65 Policy.

5. The Liquidator, NOLHGA and the Guaranty Associations are authorized to take any and all actions necessary to accomplish the purposes of these Orders.

DATED: 5/30/12

THE HONORABLE ANN I. JONES
Los Angeles Superior Court Judge

Epstein Turner Weiss
A Professional Corporation
633 West Fifth Street
Suite 3330
Los Angeles, CA 90071

PROOF OF SERVICE

**STATE OF CALIFORNIA** )
) **ss.**
**COUNTY OF LOS ANGELES** )

I am employed in the County of Los Angeles, State of California. I am over the age of 18 and not a party to the within action; my business address is 633 West Fifth Street, Suite 3330, Los Angeles, California 90071.

On **June 13, 2012,** I served the foregoing document described as **NOTICE OF ENTRY OF ORDER GRANTING JOINT APPLICATION FOR ORDERS APPROVING CLAIM HANDLING AGREEMENTS, RATE TABLES AND ISSUANCE OF ALTERNATIVE POLICIES** by placing [ ] the original [X] a true copy thereof **(as indicated on the attached service list)** enclosed in a sealed envelope(s) addressed as follows:

**SEE ATTACHED SERVICE LIST**

[X] **By Mail.** I am readily familiar with the firm's practice of collection and processing correspondence for mailing. Under that practice, it would be deposited with the U.S. Postal Service on that same day with postage thereon fully prepaid at Los Angeles, California in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation or postage meter date is more than one day after date of deposit for mailing in affidavit.

[ ] **By Fax.** I transmitted the foregoing document by telecopier transmission to the addressee(s) at the facsimile number(s) listed on the attached Service List, and received confirmation that the transmission was received at the facsimile number(s) listed on the attached Service List.

[] **By Personal Service.** I caused such envelope(s) to be personally delivered via messenger service to the addressee(s) indicated on the attached Service List.

[ ] **By Email.** I forwarded a copy of the above-described document(s) via e-mail to each of the individuals set forth above at the email addresses indicated therefor.

[ ] **By Federal Express.** I caused such envelope(s) to be deposited at a facility regularly maintained by FedEx at 633 West Fifth Street, Los Angeles, California 90071, with arrangements made for payment in full of the required charges, to the party(ies) listed on the attached Service List.

Executed on **June 13, 2012,** at Los Angeles, California.

[X] (State) I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

[ ] (Federal) I am employed by a member of the Bar of the State of California. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Angela Muse

Epstein Turner Weiss
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633 West Fifth Street
Suite 3330
Los Angeles, CA 90071

***Insurance Commissioner v. Golden State Mutual Life Ins. Co.***

**LASC Case No. BS 123005**
**[Dept. 86]**

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Pension Benefit Guaranty Corporation
Attn: Jon Chatalian
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Washington D.C. 20005

Certificate of Contribution Holders
[Addresses not included to maintain privacy]

Group Life Policy Certificate Holders
[Addresses not included to maintain privacy]

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# APPENDIX E

**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**

---

# DEFENDANTS' MEMORANDUM OF LAW IN OPPOSITION TO PLAINTIFFS' PRAYER FOR ISSUANCE OF A PRELIMINARY INJUNCTION

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**COZEN O'CONNOR, P.C.**
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*Counsel to Defendant Jessica K. Altman in her capacity as Statutory Rehabilitator of Senior Health Insurance Company of Pennsylvania in rehabilitation, and Defendant Senior Health Insurance Company of Pennsylvania in Rehabilitation*

Dated: January 7, 2022

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**Constitutions**



**Statutes**

**Rules**



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## I.
## INTRODUCTION

This Court should deny Plaintiffs' prayer for a preliminary injunction, part of an extraordinary collateral attack on a court-approved rehabilitation plan and the state officials implementing that plan. Indeed, Plaintiffs ask this Court to assert jurisdiction over out-of-state officials and enjoin those officials from exercising their statutory authority under the order and supervision of a Pennsylvania court, despite that Plaintiffs deliberately and voluntarily ignored every opportunity to stake out their position in the proper forum. Plaintiffs also ask this Court to assert authority over the rehabilitation of a financially-distressed insurer domiciled in Pennsylvania, despite that the insurer is already within the exclusive jurisdiction of a Pennsylvania court. This Court must decline Plaintiffs' invitation to enjoin a state-officer defendant and an insurer under the authority and control of a Pennsylvania state court, and this Court similarly must decline Plaintiffs' invitation to violate Full Faith and Credit principles and thereby create conflicting court decisions regarding the plan. Indeed, granting relief to Plaintiffs here could establish precedent and authority inviting others to challenge the authority of Pennsylvania courts and Pennsylvania officials, as well as the authority of Louisiana courts, officials, and agencies in its own receivership matters. Defendants respectfully ask that this Court refuse to endorse such a result through the drastic remedy of a preliminary injunction.

## II.
## STANDARD OF REVIEW ON PRAYER FOR PRELIMINARY INJUNCTION

Louisiana Code of Civil Procedure article 3601A provides that "[a]n injunction shall be issued in cases where irreparable injury, loss, or damage may otherwise result to the applicant, or in other cases specifically provided by law." La. Code Civ. Proc. art. 3601. A preliminary injunction is a "harsh, drastic remedy that should only issue where the petitioner is threatened with irreparable harm and has no adequate remedy at law." *Ballay v. Cormier*, 2017-0512 (La. App. 4 Cir. 12/13/17), 234 So. 3d 1013, 1020 (internal citation and quotation marks omitted). To obtain a preliminary injunction, the petitioner must establish by a preponderance of the evidence a *prima facie* showing that: "(1) it will suffer irreparable injury, loss, or damage if the motion for preliminary injunction is not granted and (2) it is entitled to the relief sought through at least a showing that it will likely prevail on the merits of the case." *Id.*; *see also Brookwood-Riverside, L.L.C. v. Baton Rouge Water Works Co.*, 2020-1173 (La. App. 1 Cir. 5/25/21), 327 So. 3d 1, 4.

An irreparable injury is "an injury or loss that cannot be adequately compensated in money damages, or is not susceptible to measurement by pecuniary standards." *Ballay*, 234 So. 3d at

1020. Mere inconvenience, even "great inconvenience," to the petitioner is not sufficient to show irreparable injury. *Hobbs v. Gorman*, 595 So. 2d 1264, 1266 (La. Ct. App. 1992). Further, "the proof of irreparable harm cannot be speculative or based upon some uncertain future event." *Faubourg Marigny Imp. Ass'n, Inc. v. City of New Orleans*, 2015-1308 (La. App. 4 Cir. 5/25/16), 195 So. 3d 606, 616. Additionally, in determining whether to issue a preliminary injunction, "the trial court should consider whether the threatened harm to the plaintiff outweighs the potential for harm or inconvenience to the defendant and whether the issuance of the preliminary injunction will disserve the public interest." *Harvey v. State*, 2014-0156 (La. App. 4 Cir. 12/16/15), 183 So. 3d 684, 700, *writ denied*, 2016-0105 (La. 3/4/16), 188 So. 3d 1060; *see also Kruger v. Garden Dist. Ass'n* (La. App. 4 Cir. 1/17/01), 779 So. 2d 986, *writ denied*, 2001-0733 (La. 5/4/01), 791 So. 2d 658 (instructing courts to conduct a "duty-risk analysis" in determining whether to issue a preliminary injunction).

## III.
## RELEVANT FACTUAL AND PROCEDURAL BACKGROUND

A "court may hear an application for a preliminary injunction . . . upon the verified pleadings or supporting affidavits, or may take proof as in ordinary cases." La. Code Civ. Proc. art. 3609. The arguments of counsel shall not be accepted as evidence. *E.g.*, *Perez v. Evenstar*, 2012-0941 (La. App. 4 Cir. 1/30/13), 108 So. 3d 898. For purposes of the hearing on the merits of the prayer for a preliminary injunction, Defendants rely on the pleadings, the Declaration of Special Deputy Rehabilitator Patrick H. Cantilo, and the exhibits filed herewith. To the extent Defendants cite or refer to the parties' stipulation of fact or any of Plaintiffs' seventeen exhibits, Defendants cite to that material for purposes of this Memorandum only and reserve their right to challenge the admission or use of such facts or exhibits for relevance, completeness, or other grounds beyond authenticity.

### A. SHIP is a Pennsylvania long-term care insurer in rehabilitation under the court-ordered and court-supervised authority of Defendant Altman.

SHIP is a long-term care insurance ("LTCI") company organized under the laws of the Commonwealth of Pennsylvania. (Declaration of Patrick H. Cantilo ("Cantilo Dec.") filed herewith, at ¶ 6.) On January 29, 2020, as a result of its long financial decline, the Commonwealth Court placed SHIP in rehabilitation under the Pennsylvania Insurance Department Act, 40 P.S. §§ 221.1–221.63 ("PID Act"). (*Id.* at ¶ 7; *see also* Rehabilitation Order, attached hereto as Exhibit 1.) By law, rehabilitation proceedings are designed "to protect the interests of insureds, creditors, and the public generally." 40 P.S. §§ 221.4–221.5. Louisiana has adopted a similar scheme with

a similar purpose. *See, e.g.*, *Donelon v. Shilling*, 2019-00514 (La. 4/27/20), ---So. 3d---, 2020 WL 2079362, at *7 (recognizing that a rehabilitator must consider the "public interest foremost in mind" and that a rehabilitator's responsibilities include as well the "protection of policyholders, creditors, and the insurer itself." (citations and quotation marks omitted)).

The PID Act establishes the Commonwealth Court of Pennsylvania as the exclusive forum for receivership matters, including judicial review of rehabilitation plans and plan implementation. *Foster v. Mut. Fire, Marine & Inland Ins. Co.*, 614 A.2d 1086, 1091 (Pa. 1992) (citing 40 P.S. § 221.4). The Commonwealth Court assumed jurisdiction over SHIP by placing it in rehabilitation January 29, 2020. (Cantilo Dec. at ¶ 8; *see also* Ex. 1.) That Court also affirmed the authority of Defendant Jessica K. Altman, Insurance Commissioner for Pennsylvania, to act as Rehabilitator for SHIP by "tak[ing] possession of the assets of the insurer" and "administer[ing] them under orders of the [Commonwealth Court of Pennsylvania]." 40 P.S. § 221.15(c). The Rehabilitator is granted broad powers to effectuate equitably the intent of rehabilitation—that is, "to minimize the harm to *all* affected parties"—under the PID Act. *Foster*, 614 A.2d at 1094 (emphasis in original). The PID Act further provides that the Rehabilitator "may appoint a special deputy who shall have all the powers of the rehabilitator" granted under the Act. 40 P.S. § 221.16. Patrick H. Cantilo was duly appointed as Special Deputy Rehabilitator pursuant to this authority. (Cantilo Dec. at ¶ 9; Ex. 1 at ¶ 14.)

**B. The Commonwealth Court approved a Rehabilitation Plan involving policy modifications following more than a year of comment and consideration by the interested parties.**

Upon being placed in rehabilitation, notice was provided to, *inter alia*, all policyholders (including those with policies issued in Louisiana) as well as insurance regulators across the country. (Cantilo Dec. at ¶ 10; *see also* Form of Notice, attached hereto as Exhibit 2.) Insurance regulators, including Commissioner Donelon and the Louisiana Department of Insurance, were already familiar with the possibility of rehabilitation, as Defendants and Mr. Cantilo made numerous outreach efforts prior to filing the application for rehabilitation in the Commonwealth Court. (Cantilo Dec. at ¶ 11.) On June 12, 2020, the Commonwealth Court of Pennsylvania ordered that any interested party could offer input on any proposed rehabilitation plans by submitting an Informal Comment or by filing a Formal Comment, and further ordered that any interested party could seek leave to intervene in the proceedings. (Cantilo Dec. at ¶ 12.)

Insurance regulators from five states filed formal comments, and insurance regulators from three states intervened. (Cantilo Dec. at ¶ 13.) Plaintiffs refused to participate in SHIP's rehabilitation proceeding in the Commonwealth Court (Cantilo Dec. at ¶ 14), instead electing to rely on the fact that three other regulators (the "Intervening Regulators") did choose to intervene in the Commonwealth Court of Pennsylvania and raise challenges to the plan. (Cantilo Dec. at ¶¶ 14-16.)[1]

On May 17, 2021, following a lengthy period in which the Rehabilitator made significant data available to parties and non-party regulators, the Commonwealth Court began a week-long hearing on the plan which included the Intervening Regulators presenting their arguments that the proposed plan did not benefit policyholders and improperly usurped state rate making authority. (Cantilo Dec. at ¶ 17.)

On August 24, 2021, the Commonwealth Court of Pennsylvania entered its order and opinion approving the proposed rehabilitation plan for SHIP ("Approved Plan") and authorizing the Rehabilitator to offer policyholders various options for modifying the premium rates and benefits associated with their policies.[2] (Opinion and Order, attached as Exhibit 3; *see also* Cantilo Dec. at ¶ 18.) Policyholder elections would be effected through one of two mechanisms: (1) states could actively or passively "opt-in" to the premium rate setting provisions of the Plan, in which case the Rehabilitator would offer a defined set of policy options determined by the actuarially justified methods described in the Approved Plan; or (2) states could "opt-out" of that portion of the Plan, in which case the chief insurance regulator of that state would be presented with premium rates for review and approval, and the options available to policyholders of policies issued in that state would be determined based on the rates approved by that insurance regulator. (*Id.* at ¶ 39.)

The deadline to "opt-out" of the Approved Plan was November 15, 2021. Plaintiffs chose not to opt-out, and, under the Commonwealth Court's opinion and the Approved Plan, Louisiana is an "opt-in" state. (Cantilo Dec. at ¶¶ 19, 20.) Policyholders were scheduled to receive the election packages for opt-in states in January 2022, but Plaintiffs and Defendants voluntarily agreed not to send election packages or otherwise communicate with policyholders of policies issued in Louisiana pending a decision on the motion for injunction. (Cantilo Dec. at ¶ 21.) Should

[1] The three intervening state insurance regulators are the chief insurance regulators of Maine, Massachusetts, and Washington, referred to herein as the "Intervening Regulators."

[2] The Plan Approval Opinion was amended in minor ways in November 2021; Exhibit 3 is the amended opinion.

no further injunction be entered, however, policyholder election material will be sent to the holders of policies issued in Louisiana, as will have been for nearly all of SHIP's policyholders. (Cantilo Dec. at ¶ 22.) Importantly, no policy would be modified until April 2022 at the earliest, following receipt of policyholder elections and the planned audit of the election process to ensure accuracy. (Cantilo Dec. at ¶ 22.)

The Commonwealth Court's order on the Approved Plan is now on appeal to the Supreme Court of Pennsylvania, but the matter has not been stayed pending appeal, and the Rehabilitator is moving forward with implementation with the Commonwealth Court's approval. (Cantilo Dec. at ¶ 23.) On October 1, 2021, the Intervening Regulators filed a motion in the Commonwealth Court of Pennsylvania seeking a stay of implementation of the Approved Plan pending appeal. (Cantilo Dec. at ¶ 24.) That motion was denied, and the Commonwealth Court found that a stay should not be entered because, *inter alia*, delay was damaging for policyholders and the prospects of the plan. (Cantilo Dec. at ¶ 25; Stay Denial Opinion, attached hereto as Exhibit 4.)

Then, on November 8, 2021, the Intervening Regulators filed a motion in the Supreme Court of Pennsylvania seeking a stay. (Cantilo Dec. at ¶ 27.) The Intervening Regulators primarily sought to prevent the Rehabilitator from sending and accepting opt-in and opt-out submissions by state regulators which were due by November 15, 2021. (Cantilo Dec. at ¶ 26.) The Intervening Regulators did not seek expedited relief, however, and the opt-in and opt-out deadline passed without an order of the Supreme Court staying implementation of the Approved Plan. (Cantilo Dec. at ¶ 28.) As the Intervening Regulators admitted in arguments joined by Plaintiffs here, any alleged harm to policyholders from receiving election packages and making policy elections consistent with opt-in or opt-out decisions is and would be reparable. (*See* Intervening Regulators' Application for Stay, attached hereto as Exhibit 5, at 40-41 (explaining how state opt-in/out process and policyholder elections could be undone if necessary).)

### C. Plaintiffs tried and failed to stop the Pennsylvania courts from even considering the proposed rehabilitation plan.

Plaintiffs did not file formal comments in the rehabilitation proceedings, and they did not seek to intervene despite receiving notice of the invitation to do so. Instead, Plaintiffs commenced a collateral attack on the plan by filing suit in federal court prior to plan approval, asking the federal court to intervene and issue declaratory and injunctive relief that would upend SHIP's rehabilitation and prevent the consideration and implementation of the proposed plan. *Donelon v. Altman*, No. 20-604, 2021 WL 4205654 (M.D. La. Sept. 15, 2021). Soon after the plan was

approved (Ex. 3), the federal court litigation matter was dismissed on the grounds that "the existence of a rehabilitation plan" that might impact Louisiana policyholders was "not a concrete and particularized injury" giving standing to Commissioner Donelon. *See Donelon*, 2021 WL 4205654, at *4 (granting defendants' motion to dismiss and finding as well that case was "not ripe" because there were too many contingencies). The case was dismissed without prejudice, but Plaintiffs did not refile in federal court at any point after plan approval. *Id.* at *5.

**D. Plaintiffs allowed the Issue State Rate Approval deadline to come and go without exercising their rights, yet now come before this Court alleging that the plan is illegal, bad for policyholders, and must be stopped immediately.**

Plaintiffs took no action in this court or in federal court to stop implementation of the plan prior to the Issue State Rate Approval deadline for opting-out, thus allowing Defendants to continue implementing in Louisiana. In fact, Plaintiffs did not act until just before the opt-out submissions were due, and then only to file a motion with certain other states seeking to be heard as *amici* on the Intervening Regulators' stay request filed four days earlier in the Supreme Court of Pennsylvania, and possibly on the merits. (Cantilo Dec. at ¶ 30; *see also Amici* Filing, attached hereto as Exhibit 6.)[3] The proposed *amici* brief regarding the stay was authored by counsel for Plaintiffs and for the chief insurance regulator of South Carolina. (*Id.*, Brief at 6.) As Plaintiffs and the other states explained in that *amici* filing, they joined entirely in the arguments set forth by the Intervening Regulators regarding the stay. (*Id.*, Motion at 4.)[4]

No stay was entered before the November 15 opt-in and opt-out deadline, and no stay has yet been entered in Pennsylvania. The deadline passed without an effective opt-out by Plaintiffs and implementation is proceeding as to nearly all SHIP policyholders; as noted, this deliberate decision by Commissioner Donelon and the Louisiana Department of Insurance made Louisiana an opt-in state under the premium rate setting provisions of the Plan. (Cantilo Dec. at ¶ 33.)

On December 3, 2021—*i.e.*, after failing to opt-out—Plaintiffs filed a new Complaint in this Court seeking to stop plan implementation in Louisiana by way of a permanent injunction. (*See generally* Compl.) Plaintiffs also sought a preliminary injunction that would stop Defendants

[3] Pennsylvania law does not contemplate *amici* briefs on matters outside of the merits or a request for permissive appeal. *See* Pa. R.A.P. 531 ("Participation by *Amicus Curiae*").

[4] The *amici* request did not specify which states would later file a brief on the merits, and no proposed brief was submitted. On December 22, 2021, the stay *amici* litigants (together with a number of new states) filed an *amici* brief on the merits brief. The motion to be heard as *amici* on the stay and on the merits remains pending. (Cantilo Dec. at ¶ 36; *see also Amici* Filing on the Merits, attached hereto as Exhibit 7.)

from sending election packages or modifying policies based on those elections, and that matter is currently before this Court. (*See generally* Pltfs' Preliminary Injunction filings.)

## IV.
## JURISDICTIONAL ARGUMENTS

The Petition seeking a preliminary injunction is flawed in numerous respects, but its fundamental defect is that it seeks an injunction from this Court despite the absence of jurisdiction over the subject matter or the defendants. Specifically, this Court lacks subject matter jurisdiction over Plaintiffs' claims seeking to invalidate or bar implementation of the court-approved rehabilitation plan, and this Court lacks personal jurisdiction over the Rehabilitator charged with implementing that plan or SHIP acting under her direction in implementing the plan. Without conclusive findings of jurisdiction on both fronts, this Court must refuse to enter a preliminary injunction.

### A. This Court lacks subject matter jurisdiction over Plaintiffs' claims seeking a declaratory order and injunction preventing implementation of the Rehabilitation Plan because the Commonwealth Court of Pennsylvania has exclusive jurisdiction over plan approval and implementation.

The Petition must be denied because Louisiana courts are without subject matter jurisdiction over the claims at issue in the Complaint. It is uncontroverted that under the respective laws of both Pennsylvania and Louisiana, the court overseeing an insurer's rehabilitation proceedings has *exclusive* jurisdiction over the rehabilitation and any plan of rehabilitation. It necessarily follows that any challenge to a rehabilitation plan ***must*** be made in the rehabilitation court that is exercising that exclusive jurisdiction (or to a higher court within that state through a direct appeal), regardless of the purported merit (or lack thereof) of that challenge. Thus, under both Pennsylvania and Louisiana law, the courts of any other state lacks jurisdiction and authority to interfere with a rehabilitation court's rehabilitation orders.

In order to enter a preliminary injunction, a court must have first resolved whether it has subject matter jurisdiction over the underlying claims at issue. *See Succession of Thompson*, 2020-0536 (La. App. 4 Cir. 7/14/21), ---So.3d---, 2021 WL 2956057, at *5 (Court must resolve whether it has subject matter jurisdiction "[b]efore we address the merits of the case"); *Louisiana Pub. Def. Bd. v. Dorroh*, 2015-1277 (La. App. 1 Cir. 5/12/16), 195 So. 3d 522, 528 (reversing trial court's order granting preliminary injunction where it "had no subject matter jurisdiction to grant the injunctive relief ordered"); *accord* 43A C.J.S. Injunctions § 314 ("A trial court may not grant a preliminary injunction if it lacks subject matter jurisdiction over the claim before it."); 42 Am. Jur.

2d Injunctions § 217 ("If a trial court lacks subject matter jurisdiction over a case, it similarly lacks jurisdiction to render even a temporary injunction.").

Plaintiffs seek a preliminary injunction to prevent Defendants from (a) "attempting to enforce against any Louisiana policyholders" the Rehabilitation Plan that was duly approved by the Commonwealth Court of Pennsylvania pursuant to its exclusive jurisdiction of SHIP's Rehabilitation, and (b) "soliciting any Louisiana policyholders of SHIP to select 'options' under" the approved Rehabilitation Plan. (*See* Plaintiffs' Memorandum ("Pltfs' Memo") at 26.) This Court lacks subject matter jurisdiction to enter any injunction because Louisiana courts are without jurisdiction to entertain a collateral attack on the Commonwealth Court of Pennsylvania's exclusive jurisdiction over SHIP's rehabilitation proceedings.

It is well established that the Commonwealth Court of Pennsylvania has exclusive jurisdiction over the rehabilitation of insurers domiciled in Pennsylvania, including the exclusive jurisdiction to approve a plan of rehabilitation. *See* 42 P.S. § 761(a)(3) and (b) (providing Commonwealth Court of Pennsylvania with original jurisdiction over all proceedings arising under the PID Act and recognizing that its jurisdiction is exclusive in this context); 40 P.S. § 221.16(d) (the Commonwealth Court of Pennsylvania may approve, disapprove, or modify a proposed rehabilitation plan); *FBT Bancshares, Inc. v. Mut. Fire, Marine, & Inland Ins. Co.*, No. CIV. A. 95-1702, 1995 WL 599039, at *4 (E.D. La. Oct. 11, 1995) (Pennsylvania's "statutory scheme establishes the Commonwealth Court as the forum for judicial review of the Rehabilitation proceedings."). As such, any challenges to the provisions of SHIP's Rehabilitation Plan or the authority of the Rehabilitator to implement that plan are within the exclusive jurisdiction of the Commonwealth Court of Pennsylvania. No other court may interfere with the Commonwealth Court of Pennsylvania's exclusive jurisdiction of SHIP's Rehabilitation proceeding and adjudicate the propriety of the Rehabilitation Plan or the scope of the Rehabilitator's authority. *See Ballesteros v. New Jersey Prop. Liab. Ins. Guar. Ass'n*, 530 F. Supp. 1367, 1371 (D.N.J. 1982) (recognizing that in insurer delinquency proceedings, "other courts, except when called upon by the court of primary jurisdiction for assistance, are excluded from participation") *aff'd sub nom. Appeal of Ballesteros*, 696 F.2d 980 (3d Cir. 1982); Indeed, "[t]he need for giving one state

exclusive jurisdiction over delinquency proceedings has long been recognized in the courts[.]" *Ballesteros*, 530 F. Supp. at 1371 (collecting cases).[5]

The same holds true in Louisiana—that is, Louisiana courts have exclusive jurisdiction over their own rehabilitation proceedings commenced pursuant to the RCLA. *See, e.g., Brown v. Associated Ins. Consultants, Inc.*, 97-1396 (La. App. 1 Cir. 6/29/98), 714 So. 2d 939, 942 (The RCLA's "statutory scheme for the liquidation and/or rehabilitation of insurers is comprehensive and exclusive in scope," and holding that "any attempt ... to enjoin the Commissioner (through the appointed liquidator) from performing his role as liquidator would clearly violate the exclusivity of the rehabilitation scheme provided by law."); *State ex rel. Guste v. ALIC Corp.*, 595 So. 2d 797, 799 (La. Ct. App. 1992) (The statutory scheme for "[r]eceivership proceedings for Louisiana insurance companies ... is comprehensive and *exclusive*."); *LeBlanc v. Bernard*, 554 So. 2d 1378, 1383 (La. Ct. App. 1989), *writ denied*, 559 So. 2d 1357 (La. 1990) (Louisiana's statutory scheme for liquidation and rehabilitation is an "exercise of the police power of the State of Louisiana," and the statutory scheme "is comprehensive and exclusive"); *see also Shilling*, 2020 WL 2079362, at *7 (The RCLA "grants the Commissioner the right to choose the forum for his action" and holding that Commissioner Donelon acting as rehabilitator may not be deprived of that right and compelled to arbitration because arbitration "would clearly violate the exclusivity of the rehabilitation scheme."). Just as a Louisiana court's rehabilitation plan of a Louisiana insurer may only be challenged in Louisiana courts, so too SHIP's Rehabilitation Plan may only be challenged in Pennsylvania's courts. Holding otherwise would open the door for chief insurance regulators of other states to challenge in their own state courts the decisions and actions of Commissioner Donelon and the Louisiana Department of Insurance, as well as this Court, in receivership matters. Such a result would defy logic—and, importantly, Louisiana law.

Louisiana law also recognizes a receiver's broad authority in rehabilitation to serve the public interest together with the interests of policyholders, creditors, and the insurer. *Shilling*,

[5] For this reason, federal courts generally abstain from exercising jurisdiction in cases involving ongoing rehabilitation proceedings. *See, e.g., Klein v. Fed. Ins. Co.*, Civ. A. No. 7:03-CV-102-D, 2012 WL 2886679, at *3 (N.D. Tex. July 14, 2012) ("[T]he insurance insolvency context presents the classic example [for abstention's] goal of preventing needless conflict with state policy," because states "have primary responsibility for regulating the insurance industry and have comprehensive receivership and liquidation regulations."); *accord Brandenburg v. Seidel*, 859 F.2d 1179, 1191 (4th Cir. 1988) (abstaining from exercising jurisdiction because Maryland's "comprehensive scheme for the rehabilitation and liquidation of insolvent state-chartered savings and loan associations" would be "greatly impeded by the involvement of more than one decision-making authority"), *overruled on other grounds by Quackenbush*, 517 U.S. 706 (1996). Plaintiffs offer this Court no reason to deviate from that practice.

2020 WL 2079362, at *2-*3. As in Pennsylvania, the RCLA authorizes the Commissioner as rehabilitator to "take such steps towards removal of the causes and conditions which have made such proceedings necessary as may be expedient." La. Rev. Stat. § 22:2009.A. In Louisiana—again as in Pennsylvania—the rehabilitator can take many steps, both enumerated and within his general powers, to effect a rehabilitation plan, including imposing liens on policyholders, "[t]o enter into such agreements or contracts as necessary to carry out the full or partial plan for rehabilitation, and "to affirm or disavow any contracts to which the insurer is a party." *Id.* at 2009.A, E. The laws of Pennsylvania and Louisiana are plainly similar on the question of a rehabilitators' broad authority—including to modify contracts—in rehabilitation.

In fact, as Plaintiffs concede, Louisiana treats Pennsylvania as a "reciprocal state" for purposes of the RCLA. (Pltfs' Memo at 7.) When a reciprocal state such as Pennsylvania exercises its exclusive jurisdiction in receivership proceedings, Louisiana courts lack subject matter jurisdiction to consider challenges to those matters. *See Steamship Mut. Underwriting Ass'n (Bermuda), Ltd. v. Sun Life Assur. Co. of Canada*, 2006-1082 (La. App. 1 Cir. 6/8/07), 965 So. 2d 883, 885, *writ denied*, 2007-1390 (La. 10/12/07), 965 So. 2d 400 ("It is clear, then, that Pennsylvania is exerting exclusive jurisdiction over the matters at issue before us. Accordingly, we lack subject matter jurisdiction to consider them."); *Chavers v. Bright Truck Leasing*, 2006-1011 (La. App. 3 Cir. 12/6/06) 945 So. 2d 838, 844 (Louisiana courts "divested of subject matter jurisdiction over the claims against Reliance" where "liquidation proceedings involving Reliance were instituted in the state of Pennsylvania, the domiciliary state of Reliance's incorporation"); *see also ALIC Corp.*, 595 So. 2d at 802 (only the court in which the receivership proceeding was brought had jurisdiction over claims against the insurer, and "any other district court was without subject matter jurisdiction to hear any claims against that company").

Despite this clear statutory authority, Plaintiffs seek to reopen and relitigate the Commonwealth Court's findings and conclusions of law regarding the Rehabilitator's authority, questions this Court is not authorized to consider or address.[6] Indeed, both the RCLA and Pennsylvania law, expressly allow for rehabilitation courts to issue restraining orders and injunctions to ***prevent*** precisely what Plaintiffs now ask this Court to do—interfere with a rehabilitation court's exclusive jurisdiction over rehabilitation proceedings commenced in that

[6] Plaintiffs' impermissible effort to conduct parallel rehabilitation proceedings is evident through their discussion of the scope of Pennsylvania law.

state. *Compare* La. Rev. Stat. § 22:2006 (Louisiana courts may issue restraining orders and injunctions to "prevent interference with the [rehabilitation] proceedings" commenced in Louisiana under the RCLA) and *Shilling*, 2020 WL 2079362 at *4 (RCLA grants Commissioner the ability "to seek to enjoin interference with rehabilitation proceedings"), *with* 40 P.S. § 221.5 (a)(iii) (Commonwealth Court of Pennsylvania may grant injunctions to prevent "interference with the receiver or with the [rehabilitation] proceeding").

SHIP's rehabilitation proceeding is an *in rem* proceeding. *See, e.g.*, *Ballestros*, 530 F. Supp. at 1370–71 ("A rehabilitation proceeding is an in rem action in which the state court generally has exclusive control over the assets of the impaired insurance company."); *In re Rehab. of Manhattan Re-Ins. Co.*, No. CIV.A. 2844-VCP, 2011 WL 4553582, at *4 (Del. Ch. Oct. 4, 2011) ("[T]his Court does possess original and exclusive jurisdiction over the in rem proceedings of the rehabilitation."); *Garamendi v. Exec. Life Ins. Co.*, 21 Cal. Rptr. 2d 578, 583–90 (Ct. App. 1993) (holding "A State Court Overseeing an Insurance Insolvency Proceeding Has In Rem Jurisdiction Over the Assets of Third Parties Which Have an 'Identity of Interest' With the Insolvent Insurer."). Plaintiffs do not—and cannot—dispute that they received adequate notice of SHIP's Rehabilitation proceedings, and Plaintiffs similarly do not—and cannot—show that there was any lack of due process for policyholders in Louisiana. Quite the contrary, Plaintiffs were apprised of SHIP's rehabilitation every step of the way and invited to fully participate in those proceedings. That Plaintiffs voluntarily elected not to participate does not somehow render the Commonwealth Court's *in rem* and exclusive jurisdiction ineffective. Such an illogical proposition would effectively eviscerate the comprehensive and exclusive nature of *all* rehabilitation proceedings—including in Louisiana.

The proper mechanism for Plaintiffs to challenge the Rehabilitation Plan or its implementation has always been for Plaintiffs to participate in the Rehabilitation Proceedings, not to collaterally attack those proceedings in their own state court. Indeed, Plaintiffs have implicitly recognized this by filing *amicus* briefs in the Pennsylvania Supreme Court in support of Plaintiffs' proxies, the Intervening Regulators, on their stay motion and on the merits. What Plaintiffs appear to be doing is tactically seeking two bites of the proverbial apple: that is, (1) collaterally attacking the Rehabilitation Plan in their own state court by claiming the Pennsylvania court cannot bind Louisiana policyholders, while (2) advancing Plaintiffs' very same claims and legal arguments in the Rehabilitation Proceedings on appeal as an *amicus* supporting the arguments of the Intervening

Regulators. The RCLA and PID Act—as well as the very nature of rehabilitation proceedings—prohibit these improper collateral attacks on Pennsylvania's ongoing rehabilitation proceedings.

### B. The Court lacks personal jurisdiction over the Rehabilitator, a government officer exercising statutory authority under Pennsylvania law and under the supervision and appointment of the Pennsylvania courts.

Similarly, the Court lacks personal jurisdiction to enjoin the Rehabilitator from implementing the court-approved rehabilitation plan for SHIP. *See Overstreet v. Tangipahoa Par. Sheriff's Off.*, No. CIVA 06-2425, 2007 WL 756440, at *4 (E.D. La. Mar. 8, 2007) ("In order to have jurisdiction to issue an injunction ... a district court must have *in personam* jurisdiction over the person to whom the injunction is directed."); *accord* 43A C.J.S. Injunctions § 329 ("[U]nless a court has acquired personal jurisdiction over a defendant by service of process, a court may not use its contempt power against the defendant to enforce a temporary injunction.").

Under Louisiana's Long-Arm Statute, La. Rev. Stat. § 13:3201, the exercise of personal jurisdiction over non-residents must not exceed the limits of the Louisiana State Constitution and the Due Process Clause of the Fourteenth Amendment to the United States Constitution. La. Rev. Stat. § 13:3201(B); *Lewis v. Pine Belt Multipurpose Cmty. Action Acquisition Agency, Inc.*, 48,827 (La. App. 2 Cir. 4/9/14), 138 So. 3d 776, 781, *writ denied*, 2014-0965 (La. 8/25/14), 147 So. 3d 1119 (Louisiana long-arm statute is "coextensive" with constitutional due process). "The exercise of personal jurisdiction over a non-resident defendant comports with due process when the following two prongs are satisfied: (i) the defendant has certain 'minimum contacts' with the forum state; and (ii) as a result of those contacts, the maintenance of the suit would not offend traditional notions of fair play and substantial justice." *Ohle v. Uhalt*, 2016-0569 (La. App. 4 Cir. 2/1/17), 213 So. 3d 1, 6. As the party asserting that jurisdiction is proper, Plaintiffs bear "[i]nitial burden of providing sufficient minimal contacts to establish personal jurisdiction" (*id.* at 7), and in doing so, "may not aggregate factual allegations concerning multiple defendants in order to demonstrate personal jurisdiction over any individual defendant." *Id.* at 9 (internal quotation marks omitted).

Plaintiffs make no claim of general jurisdiction over the Rehabilitator; they cite no substantial "continuous and systematic" contacts which would justify the exercise of general jurisdiction. *Lewis*, 138 So. 3d at 782. Thus, this Court can grant relief to Plaintiffs only if it finds specific jurisdiction, yet Plaintiffs fail to identify *a single act* of the Rehabilitator (or SHIP) directed to Louisiana sufficient to establish specific jurisdiction with respect to Plaintiffs' claims

arising out of the rehabilitation. Instead, Plaintiffs tersely conclude that because the Rehabilitator "stands in the shoes of SHIP's former managers," the Court may exercise personal jurisdiction over the Rehabilitator based exclusively on SHIP's pre-existing and current contacts with Louisiana. But as explained above, Plaintiffs "may not aggregate factual allegations concerning multiple defendants" to demonstrate personal jurisdiction (*Ohle*, 213 So. 3d at 9), which is precisely what Plaintiffs now seek to do.

Moreover, Plaintiffs are wrong that the Rehabilitator in this lawsuit "is not a state officer" and simply "stands in the shoes of SHIP's former managers." (Pltfs' Memo at 11.) Plaintiffs are not claimants against the assets of SHIP; Plaintiffs are challenging the very nature of the Rehabilitator's statutory powers conferred by the Pennsylvania legislature, as well as the power and jurisdiction of the Commonwealth Court and the Rehabilitator, to adopt the Approved Plan. The Pennsylvania legislature has granted the Rehabilitator the broad authority to "take such action as [s]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." *Foster*, 614 A.2d at 1091 (citing 40 P.S. § 221.16(b)). As the Pennsylvania Supreme Court has recognized, "[t]his mandate explicitly defers all actions to the skill of the Rehabilitator and implicitly recognizes her expertise in these matters." *Id.* In her capacity as Rehabilitator, Commissioner Altman is afforded broad discretion to use these statutory powers for "the protection of the interests of insureds, creditors, and the public generally." 40 P.S. § 221.1(c).[7] It is for this exact reason that the Louisiana Supreme Court has recognized that Commissioner Donelon, when acting as rehabilitator, "does not stand precisely

[7] The cases cited by Plaintiff do not overcome these principles. In *Di Loreto v. Costigan*, 600 F. Supp. 2d 671 (E.D. Pa. 2009), *aff'd*, 351 F. App'x 747 (3d Cir. 2009), a Pennsylvania federal court refused to recognize specific personal jurisdiction over the New York Insurance Department and certain insurance department officials based on their efforts to enforce a civil jury verdict to recover assets for the insolvent estate of Nassau Insurance Company. On the jurisdictional issue, *Di Loreto* involved an imputation analysis of the New York Liquidation Bureau ("NYLB") as to the agency and official defendants. *Id.* at 677-683. The court relied on New York's own analysis of the government defendants and NYLB, not any analysis of Pennsylvania agencies or officers. *Di Loreto*, 600 F. Supp. 2d at 684. The NYLB is a "unique" entity not truly analogous to the Rehabilitator herself or the PID Office of Liquidations and Rehabilitation. *See* Home Page, New York Liquidation Bureau, https://www.nylb.org/home.htm (last visited Jan. 7, 2022). The remaining Pennsylvania cases cited by Plaintiffs are similarly inapplicable here, because none of those cases examined the status of a Rehabilitator in an out-of-state challenge to the Rehabilitator's authority to implement under Pennsylvania law or Louisiana law. *See In re Reliance Grp. Holdings, Inc.*, 273 B.R. 374 (Bankr. E.D. Pa. 2002) (analyzing whether Commissioner as rehabilitator or liquidator is a "governmental unit" and the real party in interest when seeking to recover assets within the meaning of federal bankruptcy statutes); *Kelly v. Commw. Mut. Ins. Co.*, 299 A.2d 604 (Pa. 1973) (addressing estoppel of liquidator's authority to assess members of mutual insurance company); *Koken v. Cologne Reinsurance (Barbados), Ltd.*, 34 F. Supp. 2d 240, 253 (M.D. Pa. 1999) (recognizing authority of Pennsylvania to assert exclusive jurisdiction over the interpretation of a rehabilitation plan or the rehabilitation itself).

in the shoes of [the insurer]." *Shilling*, 2020 WL 2079362, at *3 (internal quotations omitted). The Rehabilitator's implementation of SHIP's Approved Plan "is the exercise of the police power" of the Commonwealth of Pennsylvania. *See LeBlanc*, 554 So. 2d at 1383. It is that exercise of the Rehabilitator's police power that Plaintiffs challenge, and as such, the Rehabilitator does not stand in the shoes of SHIP for purposes of this lawsuit.[8]

Plaintiffs conflate the proper exercise of the Commonwealth Court of Pennsylvania's undisputed exclusive *in rem* jurisdiction over SHIP's assets with requisite minimum contacts on which personal jurisdiction over the Rehabilitator may be based. This proper exercise of power by a state court or state officer does not equate to minimum contacts upon which personal jurisdiction over ***the Rehabilitator*** can be grounded. *Cf. Burger King Corp. v. Rudzewicz*, 471 U.S. 462, 476 (1985) (describing exercise of jurisdiction over "commercial actor" directing actions to resident of another state); *Trump v. Committee on Ways and Means, United States House of Representatives*, 415 F. Supp. 3d 98 (D.D.C. 2019) (state official engaged in official business was not conducting the type of commercial or business-related activities within the meaning of the phrase "transacting business" under District of Columbia long-arm statute).

Plaintiffs' suggestion of personal jurisdiction has been rejected in analogous cases involving nonresident state officials performing official duties because exercising jurisdiction in such circumstances would exceed constitutional limits. For example, the Fifth Circuit found insufficient contacts for a Texas federal court to exercise jurisdiction over the commissioner of the Arizona Department of Real Estate. *Stroman Realty, Inc. v. Wercinski*, 513 F.3d 476, 480–81, 484 (5th Cir. 2008). Even the Arizona commissioner's act of reaching out to Texas and directing communications to Texas to identify violations of Arizona law were insufficient to reasonably anticipate being haled into the forum state's federal court to defend the non-forum state's statutes. *Id.* at 484–86. Other courts addressing this question have reached similar results. *See, e.g., Shotton v. Pitkin*, No. CIV-15-0241-HE, 2015 WL 5091984, at *1 (W.D. Okla. Aug. 28, 2015) (no personal jurisdiction over Connecticut officials sending communications to plaintiff in Oklahoma); *Berry*

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[8] Plaintiffs' citations to *Green v. Group Programs, Inc.*, 622 So.2d 275 (La. Ct. App. 19931 Cir 7/2/93), 622 So.2d 275, and *Washington v. Baker Petrolite Corp.*, No. 09-07926, 2010 WL 3430494 (E.D. La. Aug. 24, 2010), are plainly inapposite. *Green* involved a paid, out-of-state private entity sued by the Insurance Commissioner for recovery of assets lost as a result of the entity's mismanagement of a Louisiana insurance trust. 622 So.2d at 276, 277. Similarly, *Washington* involved an out-of-state private entity—which had previously admitted to the existence of jurisdiction in Louisiana—sued by a Louisiana resident over injuries suffered at a Louisiana oil refinery owned by the private entity's predecessor-in-interest. *Washington*, 2010 WL 3430494, at *1-*3.

*Coll., Inc. v. Rhoda*, No. 4:13-CV-0115-HLM, 2013 WL 12109374, at *11 (N.D. Ga. June 12, 2013) (Tennessee officials were not "nonresidents" because they were functional equivalent of Tennessee and the officials' "attempt[] to perform their regulatory duties" was not purposeful availment of Georgia's benefits and laws, notwithstanding communications directed at plaintiff in Georgia); *Steelman v. Carper*, 124 F. Supp. 2d 219, 223–24 (D. Del. 2000) (holding that "subjecting out of state officials to personal jurisdiction for actions taken out of state, even if done at the request of [in-state] officials," would violate "traditional notions of fair play and substantial justice").

Louisiana state courts take the same approach. In *Drake v. Hammon Square*, the Louisiana Court of Appeal refused to find personal jurisdiction over the Commissioner of Insurance of Oregon, acting as liquidator of an insolvent insurer, because the Commissioner did not have sufficient minimum contacts with Louisiana in her capacity as liquidator. 525 So. 2d 261, 263 (La. App. 1 Cir. 1998). The Court of Appeal found that neither (1) traveling to Louisiana to assume control over the insurance company's subsidiary, nor (2) traveling to Louisiana in her capacity as a Receiver for the insurance company in rehabilitation to meet with Louisiana policyholders were sufficient to exercise jurisdiction. *Id.* As receiver, the Oregon Commissioner did not benefit from Louisiana laws and "did not have fair warning that she might eventually be subject to Louisiana jurisdiction." *Id.* at 265. Ultimately, haling the Rehabilitator into this Court to answer the complaints of another state's regulator—based solely on the Rehabilitator's filings in Commonwealth Court—offends "traditional notions of fair play and substantial justice" (*see id.*) and does not comport with due process.

Plaintiffs do not identify any authority in Louisiana or elsewhere permitting them to sue and enjoin state officials performing their official authority.[9] Indeed, by Plaintiffs' logic, the Rehabilitator should anticipate being haled into ***nearly any court in the country***—notwithstanding her contacts (or lack thereof) with the relevant state—solely because SHIP is licensed to operate in 46 states, as well as the District of Columbia and the U.S. Virgin Islands. The Rehabilitator has only taken action in the Commonwealth of Pennsylvania and seeks only to implement the orders

[9] The same is true for SHIP in rehabilitation acting under the control of the Rehabilitator in her implementation of the plan. SHIP should not anticipate being haled into those same courts on claims challenging the authority of the Rehabilitator to implement the court-approved plan, particularly when SHIP, its business, and its assets are all within the exclusive jurisdiction, control, and supervision of the Pennsylvania courts.

of the Commonwealth Court of Pennsylvania. The Rehabilitator did not purposefully avail herself of Louisiana's laws and benefits, and could not reasonably anticipate being haled into a Louisiana Court. Requiring the Rehabilitator or SHIP to answer the complaints of another state's regulator based solely on the performance of the Rehabilitator's statutory duties pursuant to the Commonwealth Court of Pennsylvania's proper exercise of its exclusive *in rem* jurisdiction "would offend traditional notions of fair play and substantial justice," *Delahoussaye v. Boelter*, 2015-1790 (La. App. 1 Cir. 7/28/16), 199 So. 3d 633, 638, *writ denied*, 2016-01626 (La. 11/18/16), 210 So. 3d 290and does not comport with due process.

**C. Plaintiffs' reliance on statutory provisions purporting to provide for jurisdiction over insurers operating in the ordinary course does not cure the jurisdictional defects here.**

In their Memorandum, Plaintiffs deny that the Rehabilitator is a state actor for purposes of the jurisdictional analysis, and that, together with SHIP in rehabilitation, Defendants are merely transacting the business of insurance such that they are within the jurisdiction of this Court under La. Rev. Stat. §§ 22:868 and 22:971.1. Not so. In their Complaint and related filings, Plaintiffs challenge the Rehabilitator's implementation of SHIP's Approved Plan, an act that "is the exercise of the police power" of the Commonwealth of Pennsylvania rather than the act of a private entity. *LeBlanc*, 554 So. 2d at 1383. As explained herein, Louisiana law—like Pennsylvania law—recognizes that a court-appointed statutory rehabilitator "does not stand precisely in the shoes of [the insurer]." *Shilling*, 2020 WL 2079362, at *3 (internal quotations omitted). Accordingly, neither La. Rev. Stat. § 22:868 or § 22:971.1 places Defendants within the jurisdiction of this Court.

La. Rev. Stat. § 22:868 establishes certain mandatory provisions in any "insurance contract[s] delivered or issued for delivery *and* covering subjects located, resident, or to be performed in this state, or any group health and accident policy insuring a resident of this state regardless of where made or delivered." The statute does not *create* jurisdiction in Louisiana or even establish any exclusive jurisdiction within Louisiana; rather, it prohibits policy forms from adopting out-of-state law as controlling and from eliminating jurisdiction in Louisiana. Specifically, the statute states that a policy may not include terms "[r]equiring it to be construed according to the laws of any other state or country" or "[d]epriving the courts of this state of the jurisdiction or venue of action against the insurer." *Id.* at 868.A(1) and (2). Here, however, Plaintiffs have not alleged that any SHIP policy was "delivered" or "issued for delivery" with any such provisions, nor have Plaintiffs even alleged that Defendants intend to modify SHIP's policies

in a way that assigns some other governing law or eliminates jurisdiction in Louisiana. Controlling law and questions of jurisdiction are established by other principles, not this statute.[10]

La. Rev. Stat. § 22:971.1 addresses the "Regulation of health insurers." It purports to provide for a presumption of jurisdiction for the Commissioner of Insurance over entities issuing or providing health insurance coverage, and Plaintiffs interpret its language as giving this Court personal jurisdiction over the Defendants here. Notably, however, § 22:971.1 is silent as to regulation of or jurisdiction over state actors and agencies, court-appointed statutory rehabilitators, insurers in rehabilitation, or insurers operating under the exclusive control and supervision of another court. The statute is also silent as to any jurisdiction of this Court, providing only that the Commissioner would have jurisdiction over covered entities, and later describing the types of actions permitted by the statute to include the Commissioner's authority to examine the insurer. La. Rev. Stat. § 22:971.1.B(4). Absent any statutory language actually applying to the facts here, Plaintiffs go too far in their interpretation of the jurisdictional language of § 22:971.1.

## V.
## ARGUMENTS ON THE MERITS OPPOSING A PRELIMINARY INJUNCTION

This Court can and should refuse Plaintiffs' prayer for a preliminary injunction because Plaintiffs have not established that this Court has jurisdiction over Plaintiffs' claims. At a minimum, Defendants have demonstrated that there are sufficient and significant jurisdictional questions yet unresolved that should preclude the entry of a preliminary injunction. Should this Court turn to the merits, however, it nevertheless will find that Plaintiffs have not carried their burden of showing irreparable harm, the lack of any adequate remedy, the need for an injunction to maintain the status quo, or a likelihood of success on the merits.

### A. Plaintiffs cannot establish that they will suffer irreparable injury in the absence of a stay, and accordingly no injunction should be entered.

1. Plaintiffs must show that irreparable injury will result absent a stay.

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[10] *Bonura v. United Bankers Life Insurance Co.*, (La. App. 1 Cir. 11/14/89) 552 So. 2d 1248, cited by Plaintiffs, does not require a different result. In *Bonura*, the Court found that it could exercise subject matter jurisdiction over a claim for policy benefits by a Louisiana resident against a Texas insurer in liquidation. Importantly, however, *Bonura* found that Texas was not a reciprocal state and conducted its analysis based on that finding. 552 So. 2d at 1251-52. In contrast, Plaintiffs have admitted that Pennsylvania is a reciprocal state (Pltfs' Memo at 7), and therefore Louisiana law would require all claims against SHIP in liquidation—including claims like the one at issue in *Bonura*—to be asserted in the Pennsylvania courts. La. Rev. Stat. § 22:760. Moreover, *Bonura* involved a claim by an insured seeking to enforce her policy against the insurer in liquidation and against special deposits located in Louisiana. 552 So. 2d at 1251-53. Here, Plaintiffs are seeking to enforce a purported right to regulate; they are not seeking to recover any funds from SHIP or a special deposit in Louisiana, and they have alleged no facts supporting a finding that they are suing on behalf of one or more actual policyholder.

The arguments set forth in Plaintiffs' Memorandum begin with a sleight of hand. After acknowledging that a preliminary injunction requires a showing of irreparable harm to the applicant (*i.e.*, to Commissioner Donelon and the La. DOI), Plaintiffs quietly seek to excuse themselves from that burden by asserting that "absence of irreparable injury need not be shown when the act sought to be enjoined is unlawful as in this case." (Pltfs' Memo at 2.) Tellingly, Plaintiffs omit any discussion of the elements required to allow the exception, and Plaintiffs therefore fail to establish any right to a preliminary injunction in the absence of irreparable harm.

Plaintiffs specifically rely on the limited-scope jurisprudential exception to the irreparable harm requirement recognized by the Supreme Court of Louisiana in *Jurisich v. Jenkins*, 99–0076, p. 4 (La. 10/19/99), 749 So.2d 597, 599. In *Jurisich*, the Court explained that "a petitioner is entitled to injunctive relief without the requisite showing of irreparable injury when the conduct sought to be restrained is unconstitutional or unlawful, *i.e.*, when the conduct sought to be enjoined constitutes a *direct* violation of a prohibitory law and/or a violation of a constitutional right." *Jurisich*, 749 So. 2d at 599 (emphasis added).[11] Plaintiffs must allege facts to support—and this Court must reach—three findings: (1) "that the conduct that is sought to be enjoined violates a prohibitory law (whether an ordinance or a statute or the constitution)," (2) that the injunction is prohibitory and does not mandate action, and (3) that Plaintiffs have made the necessary allegations of a violation of the prohibitory law. *See, e.g.*, *Faubourg Marigny Improvement Ass'n.* 195 So. 3d at 616. (finding that exception did not apply where plaintiff did not show that the allegedly unlawful statute as applied violated any prohibitory law). Plaintiffs cannot carry this burden.

The centrality of irreparable harm to Plaintiffs' burden on a preliminary injunction—and Plaintiffs' failure to address the applicability of the unlawfulness exception issue in any meaningful way—should bar Plaintiffs from addressing it in detail for the first time in their reply. Even if Plaintiffs had addressed the requirements for applying this exception, however, this Court

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[11] In so holding, the Supreme Court was creating new law by interpreting and applying *South Central Bell Telephone Co. v. Louisiana Public Service Commission*, 550 So.2d 1370 (La. 1990), which found that a showing of irreparable harm "is not necessary when the deprivation of a constitutional right is involved." *S. Cent. Bell Tel.*, 550 So.2d at 1372, and a Court of Appeals decision regarding ongoing violations of the Comprehensive Environmental Response, Compensation and Liability Act. *See Ouachita Parish Policy Jury v. American Waste and Pollution Control Co.*, 606 So.2d 1341 (La. Ct. App. 1992), *writ denied*, 609 So. 2d 234 (La. 1992) (affirming injunction prohibiting defendant from violating federal environmental law). The Supreme Court of Louisiana has not applied the exception since *Jurisch* was decided twelve years ago.

would find them unsatisfied. *First*, the conduct Plaintiffs seek to enjoin is the implementation of the rehabilitation plan approved in Pennsylvania for an insurer with policies issued in Louisiana. Plaintiffs have only those "powers and duties authorized by [the Louisiana Constitution] or provided by law," but there are no constitutional or statutory provisions authorizing the Commissioner or Department to interfere with the implementation of an approved rehabilitation plan. *See* LA. CONST. ART IV, § 11 ("Commissioner of Insurance; Powers and Duties"). Louisiana law gives Commissioner Donelon certain duties and authority in the event he is appointed as a rehabilitator (La. Rev. Stat. § 22:2009), and Louisiana law defines how to address receiverships opened in other states, but no order has been entered here granting any powers to Commissioner Donelon as to SHIP. Even assuming Plaintiffs could establish this Court's jurisdiction to reconsider or challenge plan approval, Plaintiffs do not and cannot identify any law or constitutional prohibition on implementing a rehabilitation plan properly approved in the court having jurisdiction over the matter. Plaintiffs' failure to identify a direct violation of law is fatal here. *Jurisich*, 749 So. 2d at 599; *Barber v. La. Workforce Comm'n*, 2017-0844 (La. App. 1 Cir. 10/19/18), 266 So. 3d 368, *writ denied*, 2018-1878 (La. 2/18/19), 264 So. 3d 451 (citing *Jurisich* exception and requirement of a "direct violation of a prohibitory law"); *see also Broadmoor, L.L.C. v. Ernest N. Morial New Orleans Exhibition Hall Auth.* 2004-0211 (La. 3/18/2004) 867 So.2d 651, 656 (applying exception in case involving bids to municipal authority and recognizing that exception applied only where specific threatened action—accepting a bid—was in direct violation of a prohibitory law).

Plaintiffs not only fail to identify any prohibitory law, they also fail to overcome the impact of the broad grant of powers to rehabilitators in Pennsylvania and Louisiana. *See Foster*, 614 A.2d at 1091 (rehabilitator may "take such action as [s]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." citing 40 P.S. § 221.16(b)); La. Rev. Stat. § 22:2009.A (rehabilitator may "take such steps towards removal of the causes and conditions which have made such proceedings necessary as may be expedient."). Louisiana courts recognize that the statutory schemes governing receiverships are specifically targeted to rehabilitation and liquidation, and, given this specificity and the importance of orderly and equitable receiverships, a statutory scheme for rehabilitation and liquidation can overcome general statutory provisions or other law that may be in conflict with receivership law "or the purposes behind it." *See, e.g.*, *Shilling*, 2020 WL 2079362, at *7 (statute

governing choice of forum for rehabilitation and liquidation matters pre-empted arbitration requirements); *Crist v. Benton Casing Serv.*, (La. App. 1 Cir. 10/16/90) 572 So.2d 99 (rehabilitation and liquidation statutes prevailed as to general contract law); *see also* La. Rev. Stat. § 22:2005. At best, Plaintiffs have shown a potential and theoretical violation of Louisiana law on a complex question not properly addressed at this early stage. *Cf. Two Canal Street Investors, Inc. v. New Orleans Bldg. Corp.*, 2015-0924 (La. App. 4 Cir. 4/20/16), 193 So. 3d 278 (recognizing that violation must be direct and clear rather than arguable). Accordingly, Plaintiffs can satisfy neither the first nor third elements required for the unlawfulness exception.

*Second*, even if Plaintiffs had alleged the existence and violation of a prohibitory law, the exception would remain inapplicable because the injunction seeks to mandate action by Defendants. The Pennsylvania courts have not entered a stay, and thus the status quo is plan implementation, meaning that nearly all policyholders have received election packages and an invitation to make an election under the plan. (*See* Stipulated Exhibit 17 (election materials).) Should Plaintiffs succeed in obtaining an injunction that bars implementation of the plan as to policies issued in Louisiana, Defendants will be forced to honor the Louisiana policies as written even if those policies are underpriced. Moreover, Pennsylvania law and the orders of the Commonwealth Court limit the Rehabilitator's authority to use assets outside of the Approved Plan, and, in the event of a future liquidation, Pennsylvania specifically prohibits the creation of subclasses and requires equal treatment of all claimants. 40 P.S. § 221.44. Accordingly, if most of the 30,000 policies are modified in accordance with the plan, any claims payment or continuation of coverage on unmodified policies issued in Louisiana will create risk of an unlawful preferential payment, which in turn could be challenged in court and result in remedies being sought against Louisiana policyholders.

*Third*, had Plaintiffs briefed this issue, they likely would have argued that Plaintiffs only seek to enjoin specific actions: (a) soliciting Louisiana policyholders to select from amongst certain plan options approved by the Pennsylvania court and (b) modifying the Louisiana policies in accordance with policyholder elections or any applicable default procedure.[12] (*See* Pltfs'

[12] As discussed *infra*, Commissioner Donelon elected against sending an opt-out notice even after the Rehabilitator assured him that sending the notice would not be understood as a waiver of his jurisdictional arguments. (Cantilo Dec. at ¶ 45; *see also* Pltfs' Ex. 10 (Rehabilitator letter responding to Non-Decision Letter from Plaintiffs).) Policyholders of policies issued in Louisiana are therefore entitled to choose from amongst one of the five options provided in the Approved Plan.

Proposed Preliminary Injunction Order at 2.) Whether timely or belated, however, this argument would be insufficient to excuse Plaintiffs from the irreparable harm requirement. In fact, Plaintiffs remain bound by the irreparable harm requirement unless they demonstrate that that the code provisions on which they rely apply to the Rehabilitator and SHIP in rehabilitation, *and* that the applicable code provisions prohibit acts taken or proposed to be taken by Defendants. Plaintiffs can do neither. As noted, Defendants are implementing a court-approved rehabilitation plan, not conducting the business of insurance such that they fall within the general requirement to comply with the Insurance Code in Title 22 or any of the related jurisdictional provisions cited by Plaintiffs.

But even assuming jurisdiction and the general obligation to comply with the Louisiana insurance codes could be established in the first instance, Plaintiffs still cannot cite any law prohibiting the acts covered by the proposed preliminary injunction. With respect to their purported authority over policy modifications in rehabilitation, Plaintiffs appear to rely primarily on the rate filing provisions of La. Rev. Stat. § 22:1091 *et seq*., along with related regulations in LAC 37:46.19.1901 *et seq*. and part of the Insurance Code covering long-term care and appearing at La. Rev. Stat. § 22:1181 *et seq*. (*See* Pltfs' Memo at 17.) But none of these cited sections are prohibitory as to the actions in the proposed injunction: these laws and regulations do not prohibit a Rehabilitator or insurance company in rehabilitation from soliciting elections from policyholders or modifying policies by agreement with policyholders or otherwise according to an approved rehabilitation plan under the supervision of a court with jurisdiction over the proceedings and over the assets of the insurer.

In fact, there is no rule cited by Plaintiffs which would prohibit absolutely a Rehabilitator or insurer in rehabilitation—or even an insurance company in the ordinary course—from changing the rates it charges or the benefits it offers. La. Rev. Stat. § 22:1092 requires only that "health insurance issuer[s]" file the "proposed rate[s] to be used in connection with all of its particular products." The remaining regulations cited by Plaintiffs explain how rate increases may be sought and how rates should be calculated when seeking a rate increase. Knowing that benefit modifications are part of the plan the Rehabilitator has been directed to implement, Plaintiffs seek to force Defendants to comply with the rules specifying how rate increases requests shall be submitted in the ordinary course as a prerequisite to that implementation, making clear that Plaintiffs seek a mandatory injunction. Moreover, despite having full access to the actuarial

analyses on which the Rehabilitator has acted, there is no allegation that the rates or benefits to be offered by the Rehabilitator under the plan would not satisfy any governing regulations addressed to whether the rates associated with various options would be actuarially justified. (Cantilo Dec. at ¶ 44.) Plaintiffs' allegation is limited to the claim that Defendants failed to comply with certain mandatory process requirements as part of the plan implementation authorized by the Pennsylvania court, not that the rates or benefits or policies are themselves unlawful.[13] On these facts, the Court cannot find that Plaintiffs seek to enforce a prohibitory law enacted in Louisiana such that they are excused from the irreparable harm requirement.

B. **Plaintiffs fail to establish irreparable harm.**

Irreparable injury is "the most important requirement for an injunction," and it must be "substantial" as well as "likely and not merely possible." 42 Am. Jur. 2d Injunctions § 35. In Louisiana, "[i]rreparable means an injury that cannot be adequately measured or compensated by money." *Jarquin v. Blanks*, 2018-0157 (La. App. 4 Cir. 8/15/18), 254 So. 3d 10, 12. Here, Plaintiffs' Memorandum fails to even *attempt* to prove irreparable injury, relying instead on their unsupported claim that the unlawfulness exception applies here. This is fatal to the Petition—and any conclusory assertions that Plaintiffs will suffer irreparable injury are insufficient to resuscitate it. *See Concerned Citizens for Proper Plan., LLC v. Par. of Tangipahoa*, 2004-0270 (La. App. 1 Cir. 3/24/05), 906 So. 2d 660, 665 (overturning trial court's judgment issuing a preliminary injunction where "we can find no evidence of irreparable harm, merely speculation").

Nor could Plaintiffs show irreparable injury even if they had chosen not to ignore this requirement, and for several reasons. As threshold matter, the actions which could impact Plaintiffs in theory have already taken place: that is, the Commonwealth Court approving a Rehabilitation Plan for SHIP that would provide for policy modifications through the plan's centralized process or through the Issue State Rate Approval option. The Rehabilitator's implementation of the Plan through sending election packages to policyholders and reviewing those materials is merely complying with the prior orders of the Commonwealth Court. "[T]he purpose of injunctive relief is to prevent future action, not to overturn an action that has already taken place." *Jarquin*, 254 So. 3d at 12 (upholding lower court's dismissal of application for

[13] Plaintiffs assume but do not establish that the rate regulation process requirements apply to SHIP's policies. The governing regulations for long-term care insurance are set forth in LAC 37:46.19.1937 and LAC 37.46.19.1939, but those provisions apply only to policies issued after 2005. *See* LAC 37:46.19.1937 (rules and process applicable to policies issued after 2005 but before 2018) and LAC 37.46.19.1939 (rules and process applicable to policies issued after 2018).

injunctive relief where the action complained of—a meeting where plaintiff alleged he was illegally removed from his position as manager of an LLC—had already taken place).[14] Plaintiffs cannot circumvent this requirement by framing their injunctive relief against the instrument carrying out the Rehabilitation court's orders—that is, the Rehabilitator—when the true object they complain of is the Approved Plan itself. Because the Plan has already been approved, Plaintiffs cannot show irreparable injury.

More fundamentally, Plaintiffs cannot show that allowing policyholders to exercise their right to make an election under the Plan constitutes irreparable harm. By speaking about policyholders as a whole, Plaintiffs make no showing of actual, definitive harm to anyone at all—only the mere *possibility* of harm for some *unknown* policyholder or policyholders who might voluntarily choose to pay actuarially-justified premiums in excess of that which Plaintiffs would have approved. Plaintiffs offer no discussion of what premiums or benefits Commissioner Donelon might allow, nor is there any analysis of why requiring all policyholders to accept Commissioner Donelon's preferred premium rate or benefit package would be better for any specific policyholder, let alone all policyholders collectively.

Indeed, Plaintiffs ignore the obvious: there is no harm in—and indeed the public interest is served by—giving policyholders choice and agency in deciding which policy option might best suit their needs. For example, a policyholder who wishes to stop paying premiums entirely but keep at least some coverage will be served better by a plan option rather than the choices available outside of the plan. (Cantilo Dec. at ¶ 47.)[15] Moreover, the alternative to rehabilitation that Plaintiffs appear to advocate for—immediate liquidation—will *also* result in premium increases, limitations to benefits; unlike with rehabilitation, however, liquidation offers little to no flexibility and deprives policyholders of any last opportunity to select a better mix of benefits and premiums. (Ex. 4, Order Denying Stay at 6.) There is no irreparable injury to Plaintiffs (or anyone else) from the Rehabilitator exercising the discretion granted to her by the Pennsylvania legislature and

[14] As a result, no injunction could enter which would undo Plaintiffs' deliberate decision not to opt-out of the plan.

[15] Should the Court enter an order enjoining Defendants from communicating with policyholders regarding the plan, notice and an opportunity to be heard must be provided to any and all policyholder impacted by the injunction, as many or all of those policyholders may dispute Plaintiffs' position and seek to learn about and exercise their right to make plan option elections. The Petition and related filings lack any evidence demonstrating any harm to policyholders supported by information from actual policyholders or an analysis of policyholder interests.

making the policy determination that rehabilitation, rather than liquidation, is in the best interests of all policyholders.

Even if policies are modified in April of 2022—the earliest date by which such changes could be made according to policyholder elections—policyholders are not inherently damaged by paying actuarially justified premiums, and Plaintiffs make no showing to the contrary. (Cantilo Dec. at ¶ 22.) And, even if those changes *could* be a harm to policyholders, that harm is plainly reparable, as Plaintiffs effectively admitted by joining the Intervening Regulators' assertion in their motions for a stay that undoing the elections is possible. (Cantilo Dec. at ¶ 35.)

**C. The status quo is preserved by permitting implementation to proceed, not by the entry of a preliminary injunction.**

Plaintiffs also fail to satisfy the requirement than an injunction be entered only to maintain the status quo. "A preliminary injunction is an interlocutory procedural device designed to preserve the status quo as it exists between the parties, ***pending trial on the merits.***" *Hyman v. Puckett*, 2015-0930 (La. App. 4 Cir. 5/4/16), 193 So. 3d 1184, 1189 (emphasis in original). No policy modifications will be made until, at the earliest, April of 2022, providing enough time for the Court to hear the merits of Plaintiffs' claims should jurisdiction be properly exercised in this Court. (Cantilo Dec. at ¶ 22.) This Court cannot enjoin operation of the plan without a finding that the plan violates Louisiana law and that Plaintiffs have the authority to launch a collateral attack barring implementation and approval of a rehabilitation plan within the jurisdiction of another court. Importantly, however, a finding on that issue at this time would be improper as it would fail to preserve the parties' positions pending a decision on the merits.

Here, the status quo is plan implementation nationwide pursuant to the Commonwealth Court's order approving the plan. Absent the Petition, policyholders in Louisiana—like policyholders nationwide—were set to receive information on options available to them under the plan in January 2022 so that they could make an election. An injunction upending this process would disturb the status quo, not preserve it, and thus should not be entered.

**D. Plaintiffs chose not to opt-out of the plan, and Plaintiffs cannot pursue relief from plan implementation that results from that decision.**

As explained above, injunctions are proper only when necessary to prevent the threat of irreparable injury necessary to the moving party. The moving parties in this case, however, lack any interest in the Approved Plan or policyholder elections whatsoever: they do not allege that Commissioner Donelon is a policyholder or that he will suffer any personal harm from plan implementation, only that he will not have an opportunity to review rates for policies issued in

Louisiana. But as Plaintiffs admit, even that harm is non-existent: Plaintiffs *had* an opportunity to approve rates, and they deliberately ignored it. The Approved Plan and approval order provided for an opt-out procedure for the plan's premium rate-setting provisions through the Issue State Rate Approval option, in which state regulatory authorities could elect to receive rate increase filings and then exercise their purported authority over those requests by approving or rejecting the rates requested. (Pltfs' Memo at 21.) Commissioner Donelon and the Department elected *not* to exercise that right—despite knowing that it would cause Louisiana policyholders to be considered opt-in states, despite knowing that Plaintiffs would not have an opportunity to review the rate increase filing before policyholder elections were sent under the Approved Plan, and despite knowing that the Commonwealth Court had refused to stay the plan's implementation. Having failed to avail themselves of this opportunity, there are no "rights" held by Plaintiffs which an injunction can, should, or must protect. *See* 43A C.J.S. Injunctions § 87 ("[a]n injunction is not available if the petitioner personally has an adequate means of redress"). Plaintiffs exercised their regulatory authority by refusing to opt-out of the plan, and no additional order is necessary.

To the extent Plaintiffs claim that the opt-out procedure is coercive or damages policyholders by limiting the available options, that argument is mooted by Plaintiffs' decision not to opt out. Indeed, the effect of Plaintiffs' inaction is to make all policy options available to Louisiana policyholders, the very harm Plaintiffs claim to be caused by Defendants here. Plaintiffs should not be permitted to obtain an injunction against out-of-state government officials for the alleged purpose of protecting Louisiana from Plaintiffs' own actions and inaction.

**E. <u>Plaintiffs—and policyholders—had and have adequate remedies at law.</u>**

Similarly, Plaintiffs' Petition also fails because they have always had an adequate remedy at law: participation in SHIP's rehabilitation proceedings. The same is true for SHIP's policyholders, none of whom have appeared in these proceedings—because, it seems, none have even received notice that Plaintiffs seek to deprive Louisiana policyholders of their right to exercise elections under the Approved Plan and to deprive other policyholders of the right to be treated fairly. Plaintiffs cannot dispute that they intentionally chose not to formally participate in SHIP's rehabilitation proceedings, nor can they dispute that Plaintiffs and SHIP's policyholders were provided with adequate notice. (*See* Ex. 2 (Notice form); Cantilo Dec. at ¶¶ 10, 43 (regarding notice).) Indeed, Plaintiffs and policyholders had the ability to participate in SHIP's rehabilitation proceedings, and thus the ability to participate in any appeal or address the question of a stay

pending appeal as a party, but they chose not to exercise that right.[16] To the extent an adequate remedy is *not* available, Plaintiffs have voluntarily released and relinquished any rights they may have held, and this Court should not permit an injunction to enter where the moving party has manufactured the very exigent need on which it seeks relief.

**F. The non-existent harm to Plaintiffs does not outweigh the potential for harm to Defendants, and issuance of an injunction is against the public interest.**

"Before issuing a preliminary injunction, the trial court should consider whether the threatened harm to the plaintiff outweighs the potential for harm or inconvenience to the defendant and whether the issuance of the preliminary injunction will disserve the public interest." *Harvey*, 183 So. 3d at 700. Here, the potential for harm and inconvenience to Defendants and the public interest cannot be overstated—granting an injunction presents an existential threat to Pennsylvania's comprehensive statutory scheme of rehabilitation. Rather than having a rehabilitation plan approved, or disapproved, exclusively and comprehensively in the Commonwealth Court—the single, exclusive forum for resolving this issue, *see* 40 P.S. § 221.16(d)—courts across the country would instead resolve the same legal question in potentially inconsistent ways. That would necessarily threaten the prospects for rehabilitating SHIP, and indeed, any financially distressed insurers domiciled in Pennsylvania.

Moreover, an injunction would prevent the Rehabilitator from taking the necessary steps to effectuate the Rehabilitation, delaying implementation of the Approved Plan and potentially harming SHIP's other policyholders. As the Commonwealth Court explained, the Approved Plan "is designed to be implemented as quickly as possible so that policyholders can minimize any potential loss or burden from SHIP's receivership," and "any harm to policyholder interests caused by a delay in implementing the Plan will be irreparable." (Ex. 4, Order Denying Stay at 9–10.) An injunction as applied to only Louisiana policyholders would also perpetuate the discriminatory premium rate structure—that is, similarly situated policyholders in different states paying radically different prices for the same benefits—that the Plan was designed to correct. (*See* Ex. 3, Order Approving Plan at 67–69.) This would further harm the public interest.

**G. No injunction should be entered because Plaintiffs are unlikely to prevail on the merits of claims which were resolved or could have been resolved in the Pennsylvania courts.**

[16] Their *amicus* filing reflects Plaintiffs' attempt to pursue this collateral attack while simultaneously (and mistakenly) asserting that the Pennsylvania orders are not binding because Plaintiffs did not join the rehabilitation as a party.

The Commonwealth Court of Pennsylvania found that the Rehabilitator has the authority to implement the plan as proposed, including the opt-out process and the rate and benefit setting mechanisms. (*See generally* Ex. 3.) In this collateral attack, Plaintiffs cannot establish that the plan should not have been approved or that the plan should not be implemented in Louisiana, and, accordingly, Plaintiffs fail to show a likelihood of success on the merits.

1. The plan approval order is entitled to full faith and credit and thus cannot be undone by a Louisiana court.

Under the United States Constitution, "Full Faith and Credit shall be given in each state to the public acts, records and judicial proceedings of every other state." U.S. CONST. ART. IV, § 1. Full faith and credit generally requires that "a foreign judgment is entitled to at least the res judicata effect to which it would be entitled in the state that rendered the judgment." *Munnerlyn v. Munnerlyn*, 2015-739 (La. App. 3 Cir. 11/4/15), 179 So. 3d 747, 750. The validity and effect of a foreign judgment must be determined by the laws of the state which rendered the judgment—*i.e.*, Pennsylvania. *See Total Minatome Corp. v. Patterson Servs., Inc.*, 1999-0422 (La. App. 1 Cir. 5/12/00), 762 So. 2d 175, 177, *writ denied*, 2000-1721 (La. 9/15/00), 769 So. 2d 544 (Full faith and credit principles "mandate that we apply Texas' res judicata in order to determine whether our court should give the [foreign] judgment ... preclusive effects in the Louisiana litigation."); *Anderson v. Collins*, 26,142 (La. App. 2 Cir. 1/6/95), 648 So. 2d 1371, 1381, *writ denied*, 95-0629 (La. 4/21/95), 653 So. 2d 576, and *writ denied*, 95-0783 (La. 4/21/95), 653 So. 2d 576 (Louisiana courts permit collateral attacks on foreign judgments only "where the rendering state would have permitted such an attack"). "One seeking to escape the operation of a judgment rendered in another state has the burden of proof." *In re Succession of Aguilera*, 2007-77 (La. App. 3 Cir. 5/2/07), 956 So. 2d 718, 721, *writ denied*, 2007-1090 (La. 9/14/07), 963 So. 2d 998

Here, Plaintiffs' tersely conclude that the Commonwealth Court's Approved Plan is not entitled to full faith and credit because it is "not a final order" and because that court lacked "adjudicatory authority over the subject matter and persons governed by the judgment." (Pltfs' Memo at 16.) Plaintiffs are wrong on both accounts. *First*, the Commonwealth Court's Approved Plan *is* a final order entitled and must be given full faith and credit in courts throughout the country. The question of whether the Plan is a "final order" for purposes of full faith and credit is a question Pennsylvania law. *Total Minatome Corp.*, 762 So. 2d at 177. And under Pennsylvania law, the Pennsylvania Supreme Court has made clear that "[a] judgment is deemed final for purposes of *res judicata* or collateral estoppel unless or until it is reversed on appeal." *Shaffer v. Smith*, 673

A.2d 872, 874 (Pa. 1996). Thus, unless and until enforcement of the Commonwealth Court's Approved Plan is stayed or otherwise overturned by the Pennsylvania Supreme Court (or United States Supreme Court) on appeal, it must be considered final and "qualifies for recognition throughout the land." *V.L. v. E.L.*, 577 U.S. 404, 407 (2016). It is likely for this very reason that Plaintiffs are now actively seeking to participate as *amicus curiae* in the Pennsylvania Supreme Court alongside their proxies, the Intervening Regulators.

*Second*, Plaintiffs' assertion that the Commonwealth Court lacked jurisdiction to enter the Approved Plan is utterly meritless. Plaintiffs ignore that the Commonwealth Court's final order approving the Plan "is entitled to full faith and credit—even as to questions of jurisdiction—when the second court's inquiry discloses that those questions have been fully and fairly litigated and finally decided in the court which rendered the original judgment." *See Underwriters Nat. Assur. Co. v. N. Carolina Life & Acc. & Health Ins. Guar. Ass'n*, 455 U.S. 691, 706 (1982) (quotations omitted); *id.* at 706–07 (explaining that if an Indiana rehabilitation court "fully considered and finally determined [the question of subject matter jurisdiction] in the rehabilitation proceedings, the judgment was entitled to full faith and credit in the North Carolina courts"). Any "jurisdictional inquiry" on full faith and credit questions "is a limited one." *V.L.*, 577 U.S. at 407. "[I]f the judgment on its face appears to be a record of a court of general jurisdiction, such jurisdiction over the cause and the parties is to be presumed unless disproved by extrinsic evidence, or by the record itself." *Id.* (quotations omitted).

Here, the Commonwealth Court fully considered and finally determined the precise jurisdictional issues raised by Plaintiff—whether the Rehabilitator may implement a national plan of rehabilitation for SHIP without state-by-state approval of rate increases and/or policy modifications, subject to the opt-out provisions in the Plan. Indeed, Plaintiffs cannot seriously dispute that the Commonwealth Court considered this issue *at length*, and repeatedly. (*See* Ex. 3, Order Approving Plan at 48–61, 74; Ex. 4, Order Denying Stay at 7–10.) Once these issues were fully and fairly litigated "in the rehabilitation proceedings, the judgment [is] entitled to full faith and credit in the [Louisiana] courts." *Underwriters Nat. Assur. Co.*, 455 U.S. at 706.

Moreover, there is no basis for Plaintiffs to assert that the Commonwealth Court lacked jurisdiction over SHIP's policyholders in Louisiana. As explained above, SHIP's rehabilitation proceeding is an *in rem* proceeding that is necessarily binding on all out-of-state policyholders. *See, e.g., Ballestros*, 530 F. Supp. at 1370–71 ("A rehabilitation proceeding is an in rem action in

which the state court generally has exclusive control over the assets of the impaired insurance company."); *In re Rehab. of Manhattan Re-Ins.*, 2011 WL 4553582, at *4 ("[T]his Court does possess original and exclusive jurisdiction over the in rem proceedings of the rehabilitation."); *Garamendi*, 21 Cal. Rptr. 2d at 583–90 (holding "A State Court Overseeing an Insurance Insolvency Proceeding Has In Rem Jurisdiction Over the Assets of Third Parties Which Have an 'Identity of Interest' With the Insolvent Insurer."). Because of the *in rem* nature of the proceedings, it is well established that "[a]s a general rule, 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 INS. § 5:31.

The mere fact that all of Louisiana's policyholders did not appear in the rehabilitation proceedings after receiving notice regarding the matter and having an opportunity to intervene is simply not a basis to overcome the exacting full faith and credit requirements. Importantly, the due process clause does not provide the same protections for potential claimants—such as policyholders here—as it would for potential defendants. *See, e.g.*, *Phillips Petroleum Co. v. Shutts*, 472 U.S. 797, 812 (1985) (addressing due process rights of absent class-action plaintiffs and finding that "the plaintiff must receive notice plus an opportunity to be heard and participate in the litigation, whether in person or through counsel. The notice must be the best practicable, reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections.") (internal quotations omitted). To hold otherwise for rehabilitations and liquidations would undermine and eviscerate the efficiency and uniformity sought by receivership laws around the country.

Like policyholders, Plaintiffs cannot voluntarily choose to forego formally participating in the Rehabilitation proceedings and then raise the same arguments as the Intervening Regulators in a separate and improper forum based on the alleged rights of those policyholders. If Plaintiffs believed they had the right and obligation to protect policyholders from the plan options, Plaintiffs should have intervened in the proceedings, made an opt-out election, or taken some other affirmative step to do so. Instead, Plaintiffs and other states engaged in a coordinated effort to have a proverbial second bite at the apple by again raising the same arguments already considered by the Rehabilitation Court in other jurisdictions, even if doing so risked waiving or relinquishing any right to protect that regulators' policyholders. Plaintiffs cannot avoid the preclusive effect of any final judgment in the Commonwealth Court of Pennsylvania, and the constitutional

requirement that any such final judgment be given full faith and credit, by simply by electing not to formally participate in the rehabilitation proceedings as parties. *See United States v. Obaid*, 971 F.3d 1095, 1098–105 (9th Cir. 2020) (recognizing "minimum contacts" is not a required component of in rem jurisdiction); *United States v. Real Prop. Located in Los Angeles*, 4:20-CV-2524, 2020 WL 7212181, at *4 (S.D. Tex. Dec. 4, 2020) (same); *F.D.I.C. v. De Cresenzo*, 616 N.Y.S.2d 638, 639 (N.Y. App. Div. 1994) (recognizing a judgment stemming from application of in rem jurisdiction is entitled to full faith and credit); *Denny v. Searles*, 143 S.E. 484, 493 (Va. 1928) (same). This is especially true where Plaintiffs avoided the rehabilitation proceedings during the review phase only to appear as purported *amici* on appeal.

Finally, any effort by Plaintiffs to attack the merits of the Commonwealth Court's Order is misguided for purposes of any full faith and credit analysis, and is thus immaterial. "[T]he full faith and credit clause of the Constitution precludes any inquiry into the merits of the cause of action, the logic or consistency of the decision, or the validity of the legal principles on which the judgment is based." *Milliken v. Meyer*, 311 U.S. 457, 462 (1940); *accord Brown v. Brown*, 377 So. 2d 438, 441 (La. App. 2d 1979) (The decision as to whether the Arkansas policy is good or bad and whether we desire to follow it is one we are not empowered to make. It is of the essence of Full Faith and Credit that one state may not inquire into the rightness or wrongness of another state's policy when enforcing the judgment."), *writ granted sub nom.*, 379 So. 2d 1101 (La. 1980), *and aff'd*, 387 So. 2d 565 (La. 1980).

2. The Commonwealth Court's order is preclusive as to any challenge in this Court.

The Commonwealth Court's decision precludes reconsideration of the rate setting and benefit modification issues under Louisiana law, even setting aside principles of reciprocity or full faith and credit. The concept of "res judicata" under Louisiana law, as codified in La. Rev. Stat. § 13:4231, includes "both claim preclusion (res judicata) and issue preclusion (collateral estoppel)." *Mandalay Oil & Gas, L.L.C. v. Energy Dev. Corp.*, 2001-0993 (La. App. 1 Cir. 8/4/04), 880 So. 2d 129, 135, *writ denied*, 2004-2426 (La. 1/28/05), 893 So. 2d 72. "Thus, res judicata used in the broad sense has two different aspects: (1) foreclosure of relitigating matters that have never been litigated, but should have been advanced in the earlier suit; and (2) foreclosure of relitigating matters that have been previously litigated and decided." *Id.* "Inherent in the concept of *res judicata* is the principle that a party had the opportunity to raise the claim in the first

adjudication." *Bourgeois v. Select Oilfield Servs., LLC*, 2020-0170 (La. App. 4th Cir. 10/7/20), ---So. 3d---, 2020 WL 5939216, at *5.

Issue preclusion applies where there is: "(1) a valid and final judgment; (2) identity of the parties; and (3) an issue that has been actually litigated and determined if its determination was essential to the prior judgment." *Glob. Mktg. Sols., L.L.C. v. Chevron U.S.A. Inc.*, 2018-1765 (La. App. 1 Cir. 9/27/19), 286 So. 3d 1054, 1061, *writ denied*, 2019-01886 (La. 2/10/20). Parties do not have to be identical for issue preclusion or res judicata to apply. Rather, "[i]dentity of parties exists whenever the same parties, their successors, or others appear, so long as they share the same 'quality' as parties." *Mandalay Oil & Gas*, 880 So. 2d at 140; *accord Glob. Mktg. Sols.*, 286 So. 3d at 1062.

All of these factors are met by the rehabilitation proceedings. The Commonwealth Court decision addressed the proposed rehabilitation plan in its entirety following a five-day hearing with factual and legal argument presented, and the Court found that the Rehabilitator has the authority to (a) propose a nationwide rate-setting mechanism, (b) accept opt-out and opt-in decisions, and (c) modify benefits down for opt-out policies. (*See generally* Ex. 2.) Plaintiffs knew of the rehabilitation proceedings, received notice of the rehabilitation, and were invited to intervene—yet they deliberately chose not to do so. Instead, as made plain by the *amici* filings and other filings in support, Plaintiffs relied on the Intervening Regulators to serve as a proxy by advancing the very same legal arguments on their behalf as they now raise in this collateral attack. Under such circumstances, Plaintiffs had a full and fair opportunity to litigate these issues and should be precluded from re-litigating them.[17]

Similarly, any dispute over the Rehabilitator's authority over policyholder premiums and benefits was resolved in the Commonwealth Court such that *res judicata* (or claim preclusion) bars relitigation of that issue here. To establish res judicata, the following elements must be shown:

> (1) the judgment is valid; (2) the judgment is final; (3) the parties are the same; (4) the cause or causes of action asserted in the second suit existed at the time of final judgment in the first litigation; and (5) the cause or causes of action asserted in the second suit arose out of the transaction or occurrence that was the subject matter of the first litigation.

[17] At a minimum, there are questions of fact precluding a finding of likelihood of success on the merits (and thus precluding a preliminary injunction) because Defendants are entitled to examine the degree of coordination between Plaintiffs and other regulators to address the preclusion issues raised here.

*Myers v. Nat'l Union Fire Ins. Co.*, (La. App. 4 Cir. 5/19/10), 43 So. 3d 207, *writ denied*, 2010-2049 (La. 11/12/10), 49 So. 3d 892. Parties are the "same" for purposes of res judicata where they appear in the same capacity or are in privity. *E.g.*, *E.g.*, *Burguires v. Pollingue*, 2002-1385 (La. 2/25/2004) 843 So.2d 1049, 1054. Here, Plaintiffs' claims related to plan approval and implementation, and specifically the regulatory authority over rates and benefits, were addressed and decided in the Commonwealth Court proceedings. Indeed, the Intervening Regulators purported to advocate for the interests of regulators and policyholders nationwide. (Cantilo Dec. at ¶ 16.) Plaintiffs are not permitted to assert the rights of policyholders simply because they deliberately avoided participating in the proper proceedings after the Intervening Regulators advanced arguments on their behalf.

1. The Full Faith and Credit Clause does not entitle Plaintiffs to injunctive relief.

Plaintiffs' attempt to argue that the Rehabilitator is prohibited from implemented the Commonwealth Court's orders and judgments under the Full Faith and Credit Clause is fundamentally flawed. (Pltfs' Memo at 14–16.) As has been repeatedly recognized, the United States Supreme Court "differentiates the credit owed to laws (legislative measures and common law) and to judgments" under the Full Faith and Credit Clause. *Baker by Thomas v. Gen. Motors Corp.*, 522 U.S. 222, 232 (1998). "Whereas the full faith and credit command is exacting with respect to [a] final judgment ... rendered by a court with adjudicatory authority over the subject matter and persons governed by the judgment, it is less demanding with respect to choice of laws." *Franchise Tax Bd. of California v. Hyatt*, 538 U.S. 488, 494 (2003) (internal quotations omitted). As such, "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 concerning which it is competent to legislate." *Id.* (internal quotations omitted).

Accordingly, Plaintiffs turn the Supreme Court's interpretation of full faith and credit on its head. The Full Faith and Credit Clause is "exacting" with respect to judgments, and as such, it is the Commonwealth Court's final judgment approving the Rehabilitation Plan that must be recognized by this Court. In contrast, the full faith and credit owed to Louisiana's laws is "less demanding," and Louisiana cannot now seek to compel Pennsylvania to substitute Louisiana's statutes in the place of Pennsylvania comprehensive statutory scheme of rehabilitation. *See Succession of King*, 170 So. 2d 129, 131–32 (La. Ct. App. 1964), *writ refused*, 171 So. 2d 666 (La. 1965) ("[I]t is quite clear that the presence of the tangible subject property within the territorial

jurisdiction of Louisiana gives the courts of this state jurisdiction In rem, sovereignty prevents the use of the full faith and credit clause of the Federal Constitution to compel any state to substitute the laws of another state for its own laws in dealing with such a subject matter, and the state having jurisdiction In rem may make a binding distribution to legatees." Once again, the Commonwealth Court addressed and rejected Plaintiffs' very same argument—made nearly verbatim by the Intervening Regulators—in the course of approving the Rehabilitation Plan. (Ex. 3, Order Approving Plan at 56–57; Ex. 4, Order Denying Stay at 19–20.)

2. The Commonwealth Court correctly approved the plan, and Defendants reserve all rights to contest Plaintiffs claims on the merits.

This Court should not—and cannot—revisit the issues decided in the rehabilitation proceedings, and Defendants do not address them in depth here. Should the Court examine this question, however, it must follow the existing authority recognizing that a rehabilitation plan may modify policy benefits and increase premiums through a centralized plan. *See, e.g.*, *Underwriters Nat'l Assurance*, 455 U.S. at 696-97 (discussing approved rehabilitation plan where rehabilitation court increased premiums and reduced benefits despite state regulatory requirements); *Brooks v. AIG SunAmerica Life Assur. Co.*, 480 F.3d 579, 581 (1st Cir. 2007) (New Jersey rehabilitator could offer out-of-state policyholders the option to receive cash value or have their policies restructured); *Ballestros*, 530 F. Supp. at 1372 (overruling objections to policy restructuring in rehabilitation by out-of-state policyholder); *Mathias v. Lennon*, 474 F. Supp. 949, 957 (S.D.N.Y. 1979) (rejecting argument that New York rehabilitation court "lacked jurisdiction to affect the property interests of the Illinois policyholders").

Moreover, this Court would need to address clear authority under Pennsylvania law—largely ignored by Plaintiffs—that the discretion and authority granted to the Rehabilitator under 40 P.S. § 221.16 is necessarily broad, and that "[i]t is well settled that [a legislature] may enact a statute in broad outlines, leaving to the executive officials the duty of arranging the details." *Application of People, by Van Schaick*, 268 N.Y.S. 88, 96 (App. Div. 1933), *aff'd sub nom. People, by Van Schaick, v. Nat'l Sur. Co.*, 191 N.E. 521 (N.Y. 1934) (citing *Field v. Clark*, 143 U. S. 649 (1892); *Buttfield v. Stranahan*, 192 U. S. 470 (1904); *Trustees of Village of Saratoga Springs v. Saratoga Gas, Electric Light & Power Co.*, 83 N. E. 693 (N.Y. 1908)). Accordingly, it is properly, and exclusively, within the Rehabilitator's domain to determine how the law should be reasonably interpreted and applied. *See Starr v. Dep't of Envtl. Res.*, 607 A.2d 321, 323 (Pa. Commw. Ct. 1992) ("[T]he construction given a statute by those charged with its execution and application is

entitled to great weight and should not be disregarded unless it is clear that the agency's interpretation is incorrect.") (citing *T.R.A.S.H., Ltd. v. Department of Environmental Resources*, 574 A.2d 721 (Pa. Commw. 1990), *appeal denied*, 527 Pa. 659, 593 A.2d 429 (1990); *Slovak–American Citizens Club of Oakview v. Pennsylvania Liquor Control Board*, 549 A.2d 251 (Pa. Commw. Ct. 1988)); *In re Ambac Assur. Corp.*, 841 N.W.2d 482, 495 (Wis. Ct. App. 2013) (holding a rehabilitator's interpretation of a governing statute will be affirmed if it is "reasonable, even if . . . another interpretation is more reasonable."); 44 C.J.S. § 268 ("The courts will defer to the insurance commissioner's interpretation and application of statutes governing rehabilitation."). As such, the Rehabilitator as Commissioner is not constrained by other states' laws. *See Ferrelli v. Commonwealth*, 783 A.2d 891, 894 (Pa. Commw. Ct. 2001) ("'[T]he Full Faith and Credit Clause does not require a state to subordinate public policy within its borders to the laws of another state'" (citation omitted)); *Neyman v. Buckley*, 153 A.3d 1010, 1018 (Pa. Super. Ct. 2016) ("[W]e recognize that the legal principle of comity should only be utilized when the application of another state's law contradicts no public policy of Pennsylvania."); *Foster*, 614 A.2d at 1091-1094 (recognizing "the significant interest on behalf of the state to regulate the fiscal affairs of its insurers for the welfare of the public" and that "it is not the function of the courts to reassess the determinations of . . . public policy made by the Rehabilitator"). Should this Court enter an injunction, Defendants reserve the right to make arguments on the substance of any governing law.

In any event, Defendants briefly address here certain misleading and otherwise incorrect assertions in Plaintiffs' Memorandum for the benefit of the Court. *First*, as discussed above, the Court need not delve into the merits of Plaintiffs' assertions, but even a cursory review of Plaintiffs' claims reveals that they are without merit. The regulations cited by Plaintiff are notably silent as to their application in the rehabilitation context, where both Pennsylvania and Louisiana recognize that the Rehabilitator "does not stand precisely in the shoes of [the insurer]" because she must perform her duties "with the public interest foremost in mind" and broadly consider the "protection of the policyholders, creditors, and the insurer itself." *See Shilling*, 2020 WL 2079362, at *3; *accord* 40 P.S. § 221.1(c). Indeed, the Pennsylvania Supreme Court has addressed in detail precisely why rehabilitation alters the ordinary regulatory landscape, explaining that "the exigencies attendant to a major commercial insolvency and the goals of rehabilitation necessitate the reality that individual interests may need to be compromised in order to avoid greater harm to a broader spectrum of policyholders and the public." *Foster*, 614 A.2d at 1094 (internal quotation

marks omitted); *see also Schilling*, 2020 WL 2079362 and *Crist*, 572 So.2d 99 (recognizing that rehabilitation scheme can overcome laws in conflict with the language or purpose behind that scheme).

Moreover, nowhere do Plaintiffs identify any statute or regulation that prohibits the Rehabilitator from modifying policy benefits. Instead, Plaintiffs attempt to equate any modification in policy benefits with a rate increase—and notwithstanding that Louisiana's LTCI regulations make clear that "[a] reduction in benefits shall ***not*** be considered a premium change." LAC 37:46.19.1909(F)(3) (emphasis added). But as explained above, it is widely recognized that the powers of the Rehabilitator necessarily include restructuring and modifying policies[18]—as they must, in order to effectuate the "equitable apportionment of any unavoidable loss." 40 P.S. § 221.1(c). Plaintiffs offer no reasoned basis—and certainly no statutory authority—depriving the Rehabilitator of this inherent power conferred by the Pennsylvania legislature.

*Second*, as the Commonwealth Court correctly addressed at length, the Approved Plan's opt-out provision cures any purported "harm" and preserves all of the regulatory authority Plaintiffs may have otherwise possessed under Louisiana law. (Ex. 3, Order Approving Plan at 58, 69–74; Ex. 4, Order Denying Stay at 8.) If Plaintiffs did not agree that Louisiana policyholders should be afforded the flexibility to choose the most appropriate level of coverage and premiums for their policies going forward, and if Plaintiffs believed the dubious proposition that they must formally approve any policy changes for an insurer in rehabilitation, the Plan provided them with the means to simply opt-out and retain that regulatory authority. They chose not to exercise that authority.

Plaintiffs' assertion that the opt-out provision is "coercive" overlooks several important points. As a threshold matter, there is nothing "coercive" in having all policyholders pay actuarially justified rates for their insurance coverage. As the Commonwealth Court explained, the opt-out provision is not "coercive" because "it provides the issue state with a meaningful way

[18] *See also Foster*, 614 A.2d at 1094 n.4, 1105 (affirming the approval of a rehabilitation plan restructuring the contractual rights of the insurer's creditors); *Koken v. Legion*, 831 A.2d 1196, 1241–42 (Pa. Commw. Ct. 2003), *aff'd sub nom.*, 878 A.2d 51 (Pa. 2005) (recognizing that "Article V authorizes reformation and novation [of contracts through a rehabilitation plan] where appropriate to avoid prejudice to policyholders"); *Ballesteros*, 530 F. Supp. at 137; *In re Executive Life Ins. Co.*, 38 Cal. Rptr. 2d 453 (Ct. App. 1995) ("[T]he police power of the state exercised by the Commissioner as [Rehabilitator] permits modification of insurance contracts issued by an insolvent insurer."); *Kentucky Cent. Life Ins. Co. v. Stephens*, 897 S.W.2d 583, 587 (Ky. 1995) ("The policyholders' contracts as well as others with interest in the company, are subject to a reasonable exercise of state police power [in receivership]."); 44 C.J.S. § 270 ("[C]ourt approval of a rehabilitation plan is not precluded because policyholder benefits are modified.").

to control the mix of benefit reductions and premium rate increases" while also preventing "the opt-out state from interfering with Pennsylvania's ability to rehabilitate SHIP." (Ex. 3, Order Approving Plan at 58.) More fundamentally, Plaintiffs cannot identify with any precision the specific "regulatory authority" that the opt-out provision actually fails to preserve. All of their rate-setting oversight is maintained through the opt-out provision, to the extent it is even applicable in the rehabilitation context, including their alleged right to approve of any increase in rates. In any event, this precise issue was already decided after a week-long evidentiary hearing in the proper forum—that is, of the Commonwealth Court.

*Third*, the Approved Plan does not "reject" guaranty association protection. (*See* Pltfs' Memo at 23.) Again, the Commonwealth Court addressed this identical argument, explaining that "the Plan does not impair any policyholder's Guaranty Association coverage." (Ex. 4, Order Denying Stay at 8.) Policyholders have no right to guaranty association coverage in rehabilitation, only in the event of liquidation, and, as the Commonwealth Court further explained, under the Plan, "[a]ll policyholders have an option to retain the full measure of their Guaranty Association coverage." (*Id.*)

Plaintiffs' argument regarding guaranty association coverage ignores that Pennsylvania public policy generally *favors* the rehabilitation of an insurer over liquidation. *E.g.*, *Foster*, 614 A.2d at 1094 ("the benefits of rehabilitation ... [are] preferable to and distinct from, the ordinary procedures of liquidation"). And with good reason: by attempting to rehabilitate SHIP through the Approved Plan, the Rehabilitator ensures that policyholders will have greater options to retain their full benefits at actuarially justified rates, keep their existing premiums to the extent possible, or strike a balance between premiums and coverage, all while retaining full guaranty association for those very same benefits if in the event SHIP is liquidated. In a liquidation, the guaranty associations would *still* seek rate increases and limit policyholders to the coverage amounts provided by state law—while also "having little or no choice for their coverage." (Ex. 4, Order Denying Stay at 6.) Accordingly, for this and several other policy reasons, the Rehabilitator determined that rehabilitation was preferable over immediate liquidations, and the Commonwealth Court upheld that determination as a proper exercise of the Rehabilitator's discretion. (Ex. 3, Order Approving Plan at 44–48.) To be clear, ***none*** of these considerations are appropriate for this Court to consider—rather, they were already properly considered by the Commonwealth Court in accordance with its exclusive jurisdiction to approve the Plan. Defendants are simply

highlighting the fact that Plaintiffs' "disagreement with the Rehabilitator's exercise of discretion" (*see id.* at 67) is not a basis to collaterally attack the Plan or the Rehabilitator's authority to implement the Plan outside of the rehabilitation proceedings, in a court that lacks jurisdiction to consider these issues, as Plaintiffs seek to do here.

*Finally*, Defendants reiterate that the very nature of Plaintiffs' present lawsuit is one designed to circumvent the exclusive and comprehensive jurisdiction of the rehabilitation court. Permitting such an attack to succeed, even on a preliminary basis, sets a dangerous precedent, one that could upend Pennsylvania's comprehensive statutory scheme for the rehabilitation of distressed or insolvent insurers as well as Louisiana's own corresponding statutory scheme. Any challenges to the propriety of the Plan—and thus, the Rehabilitator's authority to implement the Plan—should have been brought in the Commonwealth Court in the course of the Rehabilitation proceedings. Plaintiffs instead have deliberately stood on the sidelines knowing that their proxies, the Intervening Regulators, would advance the same arguments on their behalf in the Rehabilitation proceedings and on appeal in the Pennsylvania Supreme Court, with Plaintiffs even filing *amicus* briefs in those proceedings. Plaintiffs cannot not now avoid the exclusive jurisdiction of the Rehabilitation court by having their own state courts sit in collateral review of the Commonwealth Court's decision and conduct an analysis of the propriety of the now-Approved Plan. Doing so will necessarily mean that *every* state's court could have the ability to approve, or disapprove, of the Approved Plan's provisions or the provisions of any plan approved an implemented in Louisiana, all of which will necessarily eviscerate the comprehensive nature of rehabilitation and, as a practical matter, make it impossibly costly and inefficient.

Plaintiffs already tried and failed to have a federal court enjoin the Approved Plan. This Court should likewise reject Plaintiffs' improper attempt to collaterally attack the plan, the Commonwealth Court's authority to approve the plan, and the Rehabilitator's authority to implement the court-approved plan.

3. Plaintiffs have not established a likelihood of success on the merits with respect to their claim that plan implementation will violate Louisiana law.

Even if Plaintiffs could overcome these significant defects, Plaintiffs still must establish a likelihood of success on merits of their claim that implementation of the Approved Plan violates Louisiana law and that Plaintiffs are permitted to enjoin implementation as a result. As explained, however, Plaintiffs have no basis for asserting that plan implementation itself or solicitation of policyholder elections is unlawful, and their arguments that the plan should not have been

approved were already addressed in the proper forum and should not be revisited here. Accordingly, Plaintiffs are left with only one viable argument on which they could succeed: that implementation of policyholder elections would lead to violation of certain rate and benefit provisions of Louisiana law. But the rate-setting provisions, by their own terms, do not even apply to SHIP's policies. Thus, this argument fails as well.

Louisiana is an opt-in state, and as a result Louisiana policyholders will receive the full menu of plan options when the plan is implemented. Although Plaintiffs loudly complain about rate increases, they ignore the actual impact of the plan elections once made:

- **Option 1:** Benefit downgrade to align the premium with the If Knew premium rate.
- **Option 2:** Benefit and premium downgrade to a basic policy.
- **Option 2A:** Benefit and premium downgrade to an enhanced version of the basic policy.
- **Option 3:** Enhanced non-forfeiture option reducing benefits and eliminating premiums.
- **Option 4:** Premium increase to match the If Knew rate for existing policy benefits.

Put differently, policyholders can elect to reduce their benefits and/or premiums (Options 1, 2, and 2A), eliminate premiums through a non-forfeiture option (Option 3), or voluntarily pay a premium increase to keep their existing coverage (Option 4). (Cantilo Dec. at ¶ 46.)

As the Rehabilitator has argued, Louisiana law does not define the authority of the Rehabilitator or that of the Commonwealth Court of Pennsylvania with respect to the plan. Assuming *arguendo* that the plan must comply with existing Louisiana law, however, it is far from clear that Plaintiffs will succeed on the merits because Plaintiffs have not alleged facts or presented governing law showing that Defendants must comply with the rate requirements or that the plan options do not comply with those requirements. For example, policyholders have an inherent right to reduce their coverage, lower their premiums, or select a non-forfeiture option, as occurs in Options 1 through 3, *See* La. Rev. Stat. § 22:1188; LAC 37:46.19.1953; LAC 37:46.19.1955. Importantly, however there are no allegations or analysis by Plaintiffs showing that Defendants' proposed options—which follow the widely-accepted If Knew premium methodology, satisfy the 60% loss ratio requirements of Louisiana, and offer a generous non-forfeiture option—cannot not satisfy these regulations for policyholders choosing to reduce their coverage or select a non-forfeiture. (Cantilo Dec. at ¶¶ 41, 44.) In part, this is true because Plaintiffs do not know which policyholders will elect to reduce their coverage or elect a non-forfeiture option because Plaintiffs

refuse even to allow Defendants to ask policyholders their preferences, but Plaintiffs do not attempt to address the issue regardless of that limitation.

Only Option 4, the voluntary payment of the additional premiums required to maintain existing coverage at an actuarially justified rate, may require a rate increase. Yet Plaintiffs still fail to show that the rate increase process requirements would apply here, either because the rate increase would be adopted as a part of a rehabilitation plan or because the policies issued before the effective date of the rate statutes they rely on. The regulations governing rate increases for long-term care policies appear in LAC 37.46.19.1937 and 1939, but by their own terms those regulations apply only to policies issued after 2005. *See* LAC 37.46.19.1937 (rate increase requirements for policies issued between August 19, 2005 and January 1, 2018) and LAC 37.46.19.1939 (rate increase requirements for policies issued after January 1, 2018). All of the policies impacted by Plaintiffs proposed preliminary injunction were issued *prior* to August 19, 2005. (Cantilo Dec. at ¶ 40.) The Louisiana Department of Insurance issued guidance on this very issue, setting forth specific rules that apply to policies issued before or after August 19, 2005; for policies issued before August 19, 2005, there are no rate increase requirements and policies are required to do no more than have a loss ratio "of at least 60%," a standard satisfied by Defendants' proposed If Knew premium. *See* La. Department of Insurance, FILING AND REPORTING REQUIREMENTS – LTC – LA (Sept. 2, 2015), at FILING FOR FORMS AND RATES, Rate Increase Filings (post-8/19/2005 requirements); *id.* at FILING FOR FORMS AND RATES, Loss Ratios for Policies Issued Before Effective Date (requirements for policies issued before 8/19/2005). (*See also* Cantilo Dec. at ¶ 41.) On this record, Plaintiffs have failed to show such a likelihood of success on the merits because Plaintiffs do not draw any factual or legal connection between the Approved Plan options as proposed, the rate requirements, and the options as they may be implemented based on elections.

## VI.
## CONCLUSION

For the reasons set forth herein, Defendants respectfully ask that this Court deny Plaintiffs' request for a preliminary injunction.

Dated: January 7, 2022

Respectfully submitted,

/s

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**CERTIFICATE OF SERVICE**

**I HEREBY CERTIFY** that a true and correct copy of the foregoing has been e-mailed on this 7th day of January, 2022. to the following:

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Received 1/27/2022 10:40:18 AM Supreme Court Middle District

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71 MAP 2021

# IN THE SUPREME COURT OF PENNSYLVANIA

| | | |
|---|---|---|
| In Re: Senior Health Insurance Company of Pennsylvania (In Rehabilitation)<br><br>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 |

## PROOF OF SERVICE

I hereby certify that this 27th day of January, 2022, I have served the attached document(s) to the persons on the date(s) and in the manner(s) stated below, which service satisfies the requirements of Pa.R.A.P. 121:

**Service**

| | |
|---|---|
| Served: | Dorothy Alicia Hickok |
| Service Method: | eService |
| Email: | alicia.hickok@faegredrinker.com |
| Service Date: | 1/27/2022 |
| Address: | Faegre Drinker Biddle & Reath<br>One Logan Square, Suite 2000<br>Philadelphia, PA 19103 |
| Phone: | 215-988-3364 |
| Representing: | Appellee National Organization of Life and Health Insurance Guaranty Associations |

| | |
|---|---|
| Served: | Georgianna Parisi |
| Service Method: | Email |
| Email: | ggparisi@hotmail.com |
| Service Date: | 1/27/2022 |
| Address: | |
| Phone: | 937-305-4191 |
| Pro Se: | Appellee Georgianna Parisi |

| | |
|---|---|
| Served: | James F. Lapinski |
| Service Method: | Email |
| Email: | lapinskipatricia706@gmail.com |
| Service Date: | 1/27/2022 |
| Address: | |
| Phone: | 703-362-7795 |
| Pro Se: | Appellee James F. Lapinski |

## IN THE SUPREME COURT OF PENNSYLVANIA

## PROOF OF SERVICE

*(Continued)*

| | |
|---|---|
| Served: | James Steven Gkonos |
| Service Method: | eService |
| Email: | jgkonos@saul.com |
| Service Date: | 1/27/2022 |
| Address: | Saul Ewing LLP<br>Centre Square West, 1500 Market Street, 38th Floor<br>Philadelphia, PA 19102 |
| Phone: | (21-5) -972-8667 |
| Representing: | Appellee Primerica Life Insurance Company |

| | |
|---|---|
| Served: | John P. Lavelle Jr. |
| Service Method: | eService |
| Email: | john.lavelle@morganlewis.com |
| Service Date: | 1/27/2022 |
| Address: | Morgan, Lewis & Bockius LLP<br>1701 Market Street<br>Philadelphia, PA 19103 |
| Phone: | 215-963-4824 |
| Representing: | Appellee Anthem, Inc., et al. |

| | |
|---|---|
| Served: | Joseph M. Donley |
| Service Method: | eService |
| Email: | jdonley@clarkhill.com |
| Service Date: | 1/27/2022 |
| Address: | 2001 Market Street<br>Suite 2620<br>Philadelphia, PA 19103 |
| Phone: | 215--64-0-8525 |
| Representing: | Appellee ACSIA Long Term Care, Inc., et al. |

| | |
|---|---|
| Served: | Scott Brandon Galla |
| Service Method: | eService |
| Email: | SCOTTGALLA@GMAIL.COM |
| Service Date: | 1/27/2022 |
| Address: | 2001 Market Street<br>Suite 2620<br>PHILADELPHIA, PA 19103 |
| Phone: | 608--34-7-6758 |
| Representing: | Appellee ACSIA Long Term Care, Inc., et al. |

## IN THE SUPREME COURT OF PENNSYLVANIA

## PROOF OF SERVICE

*(Continued)*

| | |
|---|---|
| Served: | Stephen G. Harvey |
| Service Method: | eService |
| Email: | steve@steveharveylaw.com |
| Service Date: | 1/27/2022 |
| Address: | 1880 JFK Blvd<br>PA - Pennsylvania<br>Philadelphia, PA 19103 |
| Phone: | 215-438-6600 |
| Representing: | Appellant Maine Superintendent of Ins., Massachusetts Commissioner of Ins. and Washington Ins. Cor |

**Courtesy Copy**

| | |
|---|---|
| Served: | James Joseph Lawless Jr. |
| Service Method: | Email |
| Email: | jim.lawless@butlersnow.com |
| Service Date: | 1/27/2022 |
| Address: | |
| Phone: | 610-420-6304 |
| Representing: | Amicus Curiae State Insurance Regulators |

/s/ Michael John Broadbent

*(Signature of Person Serving)*

| | |
|---|---|
| Person Serving: | Broadbent, Michael John |
| Attorney Registration No: | 309798 |
| Law Firm: | Cozen O'Connor |
| Address: | 1650 Market St Ste 2800<br>Philadelphia, PA 19103 |
| Representing: | Appellee Jessica K. Altman, Insurance Commissioner of the Commonwealth of PA<br>Appellee Senior Health Insurance Company of Pennsylvania |