STATE OF SOUTH CAROLINA **RICHLAND COUNTY**	**IN THE COURT OF COMMON PLEAS** **FIFTH JUDICIAL CIRCUIT**
Raymond G. Farmer, as Director of the South Carolina Department of Insurance, and the South Carolina Department of Insurance, Plaintiffs, vs. Jessica K. Altman, as Rehabilitator of Senior Health Insurance Company of Pennsylvania, Patrick H. Cantilo, as Special Deputy Rehabilitator of Senior Health Insurance Company of Pennsylvania, and Senior Health Insurance Company of Pennsylvania in Rehabilitation, Respondents.	Civil Action No. 2020-CP-40-05802 **PLAINTIFFS' MOTION FOR TEMPORARY INJUNCTION AND MEMORANDUM IN SUPPORT** **A Priority Matter Pursuant To Rule 40(H), SCRCP**

PLEASE TAKE NOTICE that Plaintiffs Raymond G. Farmer, as Director of the South Carolina Department of Insurance, and the South Carolina Department of Insurance, by and through the undersigned counsel, hereby move the Court, pursuant to Rule 65, SCRCP, for an Order issuing a temporary injunction prohibiting Defendants Jessica K. Altman, as Rehabilitator of Senior Health Insurance Company of Pennsylvania, Patrick H. Cantilo, as Special Deputy Rehabilitator of Senior Health Insurance Company of Pennsylvania, and Senior Health Insurance Company of Pennsylvania in Rehabilitation from taking any action in furtherance of their expressed plans to, without first obtaining required regulatory approval from the State, raise premium rates and/or reduce benefits under certain binding contracts of insurance issued in the State of South Carolina or held by residents of this State, including, but not limited to, notifying policyholders of proposed rate or benefit changes or requesting that they select rates or benefits different from those authorized by the

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

The grounds for the temporary injunction sought by Plaintiffs are (1) Plaintiffs are likely to prevail on the merits; (2) irreparable injury, loss or damage will result to policyholders and the State in the absence of a temporary injunction; (3) a temporary injunction is necessary to prevent (a) irreparable damage to Plaintiffs' ability to discharge their legislatively-charged duty to enforce the insurance laws of this State, (b) significant disruption of the insurance marketplace within this State and (c) unnecessary confusion among and harm to policyholders; and (4) no adequate remedy at law exists. The following facts and circumstances demonstrate that a temporary injunction is proper and necessary to enforce the insurance laws of this State and to protect policyholders:

1. Plaintiff Raymond G. Farmer is the Director of the South Carolina Department of Insurance (the "Director").

2. Plaintiff South Carolina Department of Insurance (the "Department") is an agency of the State of South Carolina created and charged by the South Carolina General Assembly to regulate the business of insurance in this State. *See generally* S.C. Code Ann. §§ 38-1-10 *et seq*. ("The Insurance Law").

3. Defendant Jessica K. Altman is the Commissioner of Insurance for the Commonwealth of Pennsylvania and has been appointed Rehabilitator of Senior Health Insurance Company of Pennsylvania (the "Rehabilitator") by order of the Commonwealth Court of Pennsylvania ("Commonwealth Court") dated January 29, 2020 (the "Rehabilitation Order").

4. Defendant Patrick H. Cantilo was appointed by the Rehabilitator as Special Deputy Rehabilitator (the "SDR") of Senior Health Insurance Company of Pennsylvania. He generally has the power to act on behalf of the Rehabilitator, subject to the control and direction of the

Rehabilitator.

5. Defendant Senior Health Insurance Company of Pennsylvania ("SHIP") is a stock limited life and health insurance company that administers a closed block of long-term care ("LTC") insurance policies. It is domiciled in the Commonwealth of Pennsylvania.

6. SHIP was issued a certificate of authority to conduct the business of insurance in South Carolina on April 8, 1988. Its book of business consists almost entirely of policies covering long-term care services. SHIP has not sold new policies since 2003, and only a fraction of its original LTC business remains in force.

7. The average SHIP LTC policyholder age is approximately 87 years of age, and the average claimant is approximately 90 years old. At present, there are approximately 300 policies issued in South Carolina by SHIP, and Plaintiffs are informed and believe that there may be other SHIP policyholders residing in South Carolina whose policies were issued in other states.

8. SHIP has been insolvent since at least December 31, 2018, when it reported a deficit of approximately a half-billion dollars as of that date. (Exhibit A, Transcript of Pa. Proceedings (excerpt) at p. 46 ln. 9-10.) Since then, SHIP's financial condition has continued to deteriorate, and the current deficit is approximately $1.2 billion. (Exh. A at p. 45 ln. 2-5, p. 240 ln 17-25, p. 292 ln. 11-12.)

9. Despite SHIP being hopelessly insolvent, the Pennsylvania Insurance Department ("PID") has not sought a declaration of insolvency, which would have triggered guaranty association coverage and protection for policyholders in the affected states.

10. PID did file an application to place SHIP into rehabilitation in the Commonwealth Court of Pennsylvania on January 23, 2020. *See generally* https://www.shipltc.com/court-documents.

11. Neither Plaintiffs nor SHIP policyholders were parties to these proceedings, and policyholders were not represented by class representatives or counsel.

12. A Second Amended Rehabilitation Plan (Plan) was filed on or about May 3, 2021 and approved by a single judge of the Commonwealth Court of Pennsylvania by order filed on August 24, 2021, which was amended by order entered on November 4, 2021. An appeal is pending before the Pennsylvania Supreme Court, as is an application for stay.

13. Central to the Plan is a scheme under which Defendants will impose rates for use nationwide, bypassing individual state regulatory approval statutes. These increases are extreme, in some cases more than doubling the amount of premium to be paid and can reasonably be expected to force unnecessary policy lapses. Policyholders may be able to avoid some of the increases, but only if they agree to lower their contractually-guaranteed benefits. (Exhibit B, Rehab. Plan (excerpt)).

14. The Plan contains a so-called "opt-out" process under which SHIP submits rates to individual states that "opt-out" of the nationwide rate under those states' respective rate approval statutes. However, it also contains the coercive proviso that if an "opt-out" state does not approve the rate demanded, that state's policyholders will be punished in the form of a further downgrade to their benefits. (Exh. B at p. 108-118.)

15. The punitive nature of the "opt-out" provision not only renders this feigned deference to state laws meaningless, but it also increases the already adverse effect of the Plan on affected policyholders. Moreover, the benefit reduction strategy described in the amended plan will adversely impact policyholder rights when the plan fails, and SHIP is eventually placed into liquidation.

16. Although Defendant Cantilo has characterized the receivership as involving a "workout plan," by definition, such plans are a negotiated agreement between the debtor (which in

this case would be SHIP) and its creditors (which would be policyholders). (Exh. B at p. 79 ln. 3-6.) Here, however, the so-called "workout plan" consists of the debtor *unilaterally* (a) dictating the new terms in a contract under which the creditors have fully performed, (b) imposing draconian terms on the creditors in the form of extreme premium increases and reduced benefits, both of which are likely to force policy lapses and (c) stripping out of those policies the statutory protections relating to those polices that became part and parcel of the contract at the time of its formation. *E.g., Nakatsu v. Encompass Indem. Co.*, 390 S.C. 172, 700 S.E.2d 283 (Ct. App. 2010) (statutory provisions relating to an insurance contract are part of the contract as a matter of law); *see also* S.C. Code Ann. § 38-61-10 (2015) (contracts of insurance on property, lives, or interests in this State and all contracts of insurance the applications for which are taken within the State are made within this State and are subject to its laws).

17. The Defendants have given states only until November 15, 2021, to provide written notice, under oath, of their decision to "opt-out" of a Plan they never opted in. (Exhibit C, SHIP Notice & FAQs, Notice at p.2 & State Opt-Out Election Form.)

18. Like all LTC insurers licensed in this State, SHIP has always submitted proposed rate increases to the South Carolina Department of Insurance for review and approval in accordance with South Carolina law. Over the past decade, SHIP has submitted proposed rate increases to the South Carolina Department of Insurance in 2011, 2012, 2013, 2017, and 2018, all of which were approved. The sole exception is the 2018 rate increase, which the Department disapproved in 2019 after it was clear that SHIP was hopelessly insolvent.

19. The Defendants acknowledge that the Plan places additional burdens on policyholders and is intended to decrease SHIP's deficit by increasing premium revenue and reducing policyholder benefits. (Exhibit B at p. 11-21).

20. Defendant Cantilo has admitted under oath that, "it is not likely that we will magically restore SHIP to solvency, but it is likely that the plan . . . would substantially reduce the deficit." (Exhibit A at p. 80 ln. 6-12.). The sole purpose of the Plan is not to honor its policyholder obligations but to reduce the liabilities of the Plan before it goes into liquidation.

21. The Defendants have also admitted that SHIP will benefit at the expense of policyholders and that the opt-out provision further harms policyholders: "In general, the Rehabilitator believes that states opting out is likely to help reduce SHIP's deficit more than states opting in. This is because it is anticipated that Opt-out States will approve lower rate increases than the Rehabilitator seeks. This will result in *additional downgrades which reduce the deficit faster than additional premium*. However, the Rehabilitator DOES NOT recommend that states *opt out* because that *is generally expected to be disadvantageous to affected policyholders*." (Italics supplied.) (Exhibit C, FAQ 9.)

22. The Defendant Cantilo has also admitted that the purpose of the Plan is to transfer the burden of insolvency from legislatively-crafted guaranty associations and their member insurers. (Exh. A at p. 78 ln. 19-23, p. 79 ln. 4, p. 83-84 ln. 20-18, p. 289 ln. 9-18 & p. 292 ln. 11-25.) Specifically, he spoke in terms of "taxpayers," however, this is a euphemistic and tangential reference to tax offsets for guaranty association assessments on large insurers. Provisions in some state guaranty association statutes provide for partial premium tax offsets for member insurers that are assessed by their guaranty association to pay claims against insolvent insurers. *E.g.*, 40 Pa. Stat. § 991.1711 (credits for assessments paid); S.C. Code Ann. § 38-29-160. The larger an insurer's market share in total premium, the larger its assessment. The larger the assessment, the larger the offset to premium tax. In attempting to disguise their desire to limit assessments on large insurers as anxious concern for taxpayers, Defendants make the unspoken (and speculative) assumption that

other taxpayers will be required to make up for any revenue lost to such premium tax offsets. Thus, Defendants have crafted a plan to circumvent not only state laws regulating rates and forms, but also legislatively-crafted mechanisms for the distribution of the costs of paying claims against insolvent insurers. In doing so, they elevate the interests of large insurance companies over those of policyholders and usurp the policy decisions of democratically-elected legislatures.

23. In other words, despite SHIP's inevitable liquidation, or perhaps because of it, Defendants are attempting to use the rehabilitation proceedings to coerce vulnerable elderly policyholders into paying confiscatory rates, accepting substantially less benefits than what they are entitled to under their contracts, or even lapsing on their policies altogether, all while skirting the laws of other states. The purpose of this otherwise feckless exercise is to permanently reduce the amount of guaranty association protection benefits each policyholder would receive in a liquidation, resulting in savings to large insurers in the form of substantially smaller guaranty association assessments.

24. Defendants estimate that the costs of administration of the rehabilitation plan are approximately $200,000,000, which costs are paid from SHIP's assets; however, the Pennsylvania proceedings do not provide for an accounting. (Exhibit B at p.28, Table 1, ln. 2.).

25. With the passage of the McCarran–Ferguson Act, 15 U.S.C. §§ 1011-1015, in 1945, "Congress . . . declare[d] that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States."

26. "The primary state insurance regulatory functions remain as they have been since the enactment of [the] McCarran-Ferguson [Act]. This allows . . . states to perform solvency oversight of

the U.S. insurance industry and to regulate insurer behavior in the marketplace." *State Insurance Regulation*, National Association of Insurance Commissioners (NAIC), Center for Insurance Policy and Research (CIPR) (2011), https://www.naic.org/documents/topics_white_paper_hist_ins_reg.pdf.

27. "State legislatures are the public policymakers that establish . . . broad policy for the regulation of insurance by enacting legislation providing the regulatory framework under which insurance regulators operate. They establish laws which grant regulatory authority to regulators and oversee state insurance departments and approve regulatory budgets." *Id*.

28. "State insurance regulatory systems are accessible and accountable to the public and sensitive to local social and economic conditions. State regulation has proven that it effectively protects consumers and ensures that promises made by insurers are kept. Insurance regulation is structured around several key functions, including insurer licensing, producer licensing, product regulation (review and approval of rates (including benefits) and forms), market conduct, financial regulation and consumer services." *Id*.

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

30. The South Carolina General Assembly has properly delegated regulatory authority under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, to the Department, prescribing and approving detailed and extensive statutes and regulations governing LTC policies and rates, including provisions for the approval of rates by the Department. S.C. Code Ann. §§ 38-72-10 *et seq.*; S.C. Code Regs. § 69-44.

31. In S.C. Code Ann. § 38-25-10, the South Carolina General Assembly makes the following Declaration:

> (a) The General Assembly declares that it is concerned with the protection of residents of this State against acts by insurers not authorized to conduct an insurance business in this State, by the maintenance of fair and honest insurance markets, by protecting authorized insurers which are subject to regulation from unfair competition by unauthorized insurers, and by protecting against the evasion of the insurance regulatory laws of this State. In furtherance of this state interest, the General Assembly herein provides . . . [for] proceeding[s] by the director or his designee to enforce or effect full compliance with the insurance laws of this State. In so doing, the state exercises its powers to protect residents of this State and to define what constitutes transacting an insurance business in this State and also exercises powers and privileges available to this State by virtue of Public Law 79-15, 79th Congress of the United States, Chapter 20, 1st Session, S. 340, 59 Stat. 33; 15 U.S.C., Sections 1011 to 1015, inclusive, as amended [the McCarran-Ferguson Act], which declares that the business of insurance and every person engaged therein are subject to the laws of the several states.

32. Pursuant to S.C. Code Ann. § 38-3-10 (2015), the General Assembly "established a separate and distinct department of this State, known as the Department of Insurance. The department must be managed and operated by a director appointed by the Governor upon the advice and consent of the Senate."

33. Pursuant to S.C. Code Ann. § 38-3-60 (2015), "The director or his designee must follow the general policies and broad objectives enacted by the General Assembly regarding the operation of the insurance industry in this State."

34. S.C. Code Ann. § 38-3-110 (2015) sets forth the Director's responsibilities, which include the duty to:

> (1) supervise and regulate the rates and service of every insurer in this State and fix just and reasonable standards, classifications, regulations, practices, and measurements of service to be observed and followed by every insurer doing business in this State. Nothing contained in this title authorizes or requires a review by the department or the director of any order of the director's designee or the deputy director under the Administrative Procedures Act. This item does not grant any additional authority to the director or his designee with regard to insurance rates

> other than the ratemaking authority specifically granted to the director or his designee, or the Department of Insurance for certain kinds of insurance in other provisions of this title;
>
> and to:
>
> (2) see that all laws of this State governing insurers or relating to the business of insurance are faithfully executed and make regulations to carry out this title and all other insurance laws of this State, the enforcement or administration of which is not otherwise specifically provided for.

35. Pursuant to S.C. Code Ann. § 38-61-10 (2015), "All contracts of insurance on property, lives, or interests in this State are considered to be made in the State and all contracts of insurance the applications for which are taken within the State are considered to have been made within this State and are subject to the laws of this State."

36. Pursuant to the Long-Term Care Insurance Act, S.C. Code Ann. §§ 38-72-10 *et seq.*, "All premium rate schedules for long-term care insurance must be filed with the [South Carolina Department of Insurance] and are subject to the prior approval of the director or his designee." S.C. Code Ann. § 38-72-75(A). An insurer may not charge a premium to an insured under a policy or contract of long-term care insurance before the applicable premium rate is filed and approved, and an insurer may not change the premium charged to an insured under a policy or contract of long-term care insurance until the applicable premium rate change has been filed with and approved by the Director or his designee. *Id.*

37. In addition, "the director or his designee may hold a public hearing or solicit public comments as a part of the process to review long-term care insurance rate filings received by the director or his designee." S.C. Code Ann. § 38-72-75(C). Each decision of the Director or his designee about premium rates is subject to review under the Administrative Procedures Act (APA), S.C. Code Ann. § 38-72-75(D).

38. S.C. Code Regs. 69-44 provides for the comprehensive regulation of LTC policies, including rates, forms and required market practices.

39. The public policy of this State is that because the authority to determine what insurance premium rates are just and reasonable is vested in the Department, not even courts should adjudicate what a reasonable rate might be in a collateral proceeding. *Cf. Temporary Services, Inc. v. American Intern. Group, Inc.*, 388 S.C. 348, 351, 697 S.E.2d 527, 529 (2010); § 2:34. Rates—Judicial review, 1 Couch on Ins. § 2:34 ("Ratemaking is generally not a judicial function. Indeed, many jurisdictions have adopted the filed rate doctrine which expressly prohibits courts from imposing rates different than those approved by the state insurance department.")

40. Pennsylvania's highest court has made clear that as a creature of statute, an insurance commissioner acting as a rehabilitator "'can only exercise those powers which have been conferred upon it by the Legislature in clear and unmistakable language.'" *Aetna Cas. and Sur. Co. v. Com., Ins. Dept.*, 638 A.2d 194 (Pa. 1994) (quoting *Commonwealth, Human Relations Commission v. Transit Casualty Insurance Company*, 478 Pa. 430, 438, 387 A.2d 58, 62 (1978)0. *See also Koken v. Legion Ins. Co.*, 831 A.2d 1196 (Pa. Commw. 2003), *aff'd sub nom. Koken v. Villanova Ins. Co.*, 878 A.2d 51 (Pa. 2005).

41. Defendants Rehabilitator and SDR have only those powers conferred upon them by 40 Pa. Stat. Ann. §§ 221.1 *et seq*., which are limited and equivalent to those of new management, and they and insurance companies in rehabilitation, including SHIP, must therefore obey the insurance laws of each the states in which they conduct the business of insurance. *See id*. ((Rehabilitator has "full power to direct and mange" the insurer"). Nowhere in the rehabilitation statutes is there "clear and unmistakable language" permitting a rehabilitator to unilaterally set new rates and policy terms.

42. Although "liquidation" contemplates the end of corporate existence, "rehabilitation" involves the continuance of corporate life and activities and is an effort to restore and reinstate the corporation to its former condition of successful operation and solvency. *Smalls v. Weed*, 293 S.C. 364, 360 S.E.2d 531 (Ct. App. 1987).

43. The Insurers Rehabilitation and Liquidation Act "provides for one procedure in actions involving a rehabilitator, and for a different procedure against a liquidator." *Id*.

44. Another state's rehabilitation proceedings do not grant that state jurisdiction over "the whole field." *See id*.

45. Although the Pennsylvania Commonwealth Court exercises in rem jurisdiction in the rehabilitation proceedings, the res over which that jurisdiction is exercised is the corporation itself, the fictitious entity, not all of the corporation's property for all purposes and certainly not the rights of all persons wherever situated. The Commonwealth Court may not, simply by reason of the *in rem* nature of the Pennsylvania rehabilitation proceedings, adjudicate the rights of South Carolina policyholders and claimants who are neither parties in the Pennsylvania proceedings nor subject to the jurisdiction of the Commonwealth Court.

46. "Before a court is bound by the judgment rendered in another State, it may inquire into the jurisdictional basis of the foreign court's decree" and "[i]f that court did not have jurisdiction over the subject matter or the relevant parties, full faith and credit need not be given." *Underwriters Nat'l Assurance Co. v. N.C. Life & Accident & Health Ins. Guar. Ass'n.*, 455 U.S. 691, 705 (1982).

47. Neither policyholders nor South Carolina were parties in the proceedings giving rise to this Plan, nor are they bound by the ruling of the Commonwealth Court.

48. The constitutional command of full faith and credit does not compel South Carolina

to defer to a Pennsylvania court's exercise of jurisdiction where, as here, the issue was neither fully and fairly litigated nor involved the same parties as the Pennsylvania litigation.

49. No state, including Pennsylvania, may bind a Nation, particularly as to matter on which the legislatures of each state have spoken. Pennsylvania's erroneous attempt to do so would represent a "policy of hostility to the public Acts" of each of the 45 affected states, resulting in a direct injury to their sovereignty in violation of the Full Faith and Credit Clause. *See Franchise Tax Bd. v. Hyatt,* 578 U.S. 171 (2016)*; Allstate Ins. Co. v. Hague*, 449 U.S. 302 (1981); *Carroll v. Lanza*, 349 U.S. 408 (1955).

50. "The very nature of the federal union of states, to which are reserved some of the attributes of sovereignty, precludes resort to the full faith and credit clause as the means for compelling a state to substitute the statutes of other states for its own statutes dealing with a subject matter concerning which it is competent to legislate." *Pacific Employers*, 306 U.S. at 501; *see also Alaska Packers Ass'n v. Indus. Accident Comm'n.*, 294 U.S. 532, 547 (1935).

51. In addition to being deprived of the opportunity to negotiate the so-called "workout plan," policyholders have had their contract rights stripped of them without the benefit of due process. Policyholders did not receive proper service of process and were not represented by class representatives or independent legal counsel. The Rehabilitator has offered no justification for why policyholders were literally denied their day in court before being stripped of their contractual and procedural rights.[1] Indeed, it is a case cited by the Rehabilitator's own attorneys that provides an

1 In contrast, several large insurers -- Anthem, Inc., Health Care Service Corporation, Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey, and UnitedHealthcare Insurance Company -- appeared as intervenors in the proceedings and were represented by counsel. Unsurprisingly, these companies fully supported the Plan. *See, e.g.*, Top 10 health insurance companies in the US, https://www.insurancebusinessmag.com/us/news/healthcare/top-10-health-insurance-companies-in-the-us-212292.aspx (23 Aug 2021); Horizon NJ Health, https://www.horizonnjhealth.com/aboutus/company-overview/company-information.

example of policyholders being represented by class representatives who engaged in "extensive negotiations" with the insurer and the receiver. *Underwriters Nat. Assur. Co. v. North Carolina Life and Acc. and Health Ins. Guar. Ass'n*., 455 U.S. 691 (1982).

52. Insurance commissioners as receivers and their deputies are fiduciaries, and as part of their responsibilities are charged with preserving and protecting the rights of policyholders. *E.g.*, *McPherson v. U.S. Physicians Mut. Risk Retention Group*, 99 S.W.3d 462 (Mo. Ct. App. 2003); *Green v. Louisiana Underwriters Ins. Co.*, 571 So.2d 610 (La. 1990); *see also* NAIC Receiver's Handbook for Insurance Company Insolvencies 333 (2018) ("A Receiver has a fiduciary responsibility to all of the receivership estate's creditors and is charged with protecting the interests of insureds, creditors and the public generally.") And yet, these policyholders, who number among the most vulnerable members of our society, now face having to shoulder a financial burden that would otherwise rest, as the legislatures of the affected states intended, with the insurance industry that created and sold the same kind of policies. It is impossible to reconcile the faithful performance of the Rehabilitator's fiduciary duty with the casual disposal of the contractual and constitutional rights of policyholders.

53. Notwithstanding the clear mandate of South Carolina law, the limited reach of the Pennsylvania proceedings, and the numerous and serious defects in those proceedings, Defendants have made clear their position that SHIP is no longer subject to South Carolina law and that they have no intention to obey it, and have instead given Plaintiffs the deadline of November 15, 2021 to deliver a binding decision regarding the "opt-out" provision and have otherwise evinced their intent to move forward immediately with implementing changes to policies and rates.

54. Plaintiffs seek an order temporarily enjoining Defendants from taking any measure that purports to bypass, impede, supersede, diminish or interfere in any manner with the State of

South Carolina's regulatory authority over changes to the terms of policies and review and approval of insurance rates in this State, and further temporarily enjoining Defendants from communicating in any form or manner with South Carolina policyholders regarding proposed changes to policy terms or rates without prior written approval by the State.

55. A preliminary injunction pursuant to Rule 65(a), SCRCP is warranted under the circumstances.

56. "A preliminary injunction should issue only if necessary to preserve the *status quo ante*, and only upon a showing by the moving party that without such relief it will suffer irreparable harm, that it has a likelihood of success on the merits, and that there is no adequate remedy at law." *Poynter Invs., Inc. v. Cent. Builders of Piedmont, Inc.*, 387 S.C. 583, 694 S.E.2d 15 (2010) (citing *AJG Holdings, LLC v. Dunn*, 382 S.C. 43, 674 S.E.2d 505 (Ct. App. 2009). 1984). "When *prima facie* showing has been made entitling plaintiff to injunctive relief, a temporary injunction will be granted without regard to the ultimate termination of the case on the merits." *Id.* (quoting *D.W. Alderman & Sons Co. v. Wilson*, 69 S.C. 156, 48 S.E. 85 (1904)).

57. A temporary injunction to preserve *the status quo ante* is necessary to prevent irreparable harm to South Carolina policyholders. Plaintiffs are specifically charged by the South Carolina General Assembly to uphold the insurance laws of this State. Those laws are designed to protect the policyholders, whose contracts were formed in this State and are subject to its laws and regulations. The State has a strong interest in protecting policyholders and ensuring that its laws are enforced. If those laws are not enforced, and Defendants are permitted to implement their Plan immediately, Plaintiffs will have not upheld their statutory duty and policyholders will be permanently denied basic contractual, procedural and constitutional rights and suffer permanent and substantial economic harm. Even if Plaintiffs were to fine SHIP or suspend or revoke its license,

such after-the-fact measures would not reinstate any permanent or temporary loss of benefits or premium overcharges. The same is true of any lawsuit to recover lost benefits or premium overcharges, which would also be impractical given the advanced age and typically limited means of the victims. They would also not undo the substantial confusion and disruption of the marketplace that would have occurred. Conversely, Defendants need do no more than refrain from violating South Carolina law. If they wish to file for a rate increase in accordance with the laws of the applicable state, including, this one, they have done so in the past and may do so again.

58. Plaintiffs are also likely to prevail on the merits. Defendants' Plan is founded on a clearly erroneous reading of the law that is likely to be overturned on appeal and suffers from several other underlying legal defects. Regardless, the order approving that Plan is not binding on Plaintiffs or policyholders. Both federal and State statutory law support Plaintiffs' position that insurers licensed by Plaintiffs must obey the laws of this State and those contracts issued in this state are subject to South Carolina law.

59. Plaintiffs have therefore made the necessary showing that they are entitled to a temporary injunction - irreparable harm, likelihood of success on the merits, and no adequate remedy at law, thereby establishing grounds for relief pursuant to Rule 65, SCRCP.

60. For the foregoing reasons, Plaintiffs respectfully request that the Court grant their Motion for Temporary Injunction prohibiting the Defendants taking any action that would result in prejudice to the rights of policyholders with respect to contracts of insurance subject to the laws of this State or from otherwise interfering with the orderly administration and enforcement of the insurance laws of this State.

61. This motion, and the relief sought herein, are based on and supported by the statutory and decisional law of this State and the United States, the South Carolina Rules of Civil Procedure,

the pleadings and filings in the underlying lawsuit, and such other submissions that may be filed with the Court.

62. Pursuant to Rule 11, SCRCP, the undersigned certifies that consultation with the attorneys for the Defendants prior to the filing of this motion would not serve any useful purpose.

WHEREFORE, Plaintiffs respectfully pray the Court for an order temporarily enjoining Defendants from implementing or enforcing the rehabilitation plan in this State, otherwise interfering with the rights of SHIP policyholders in South Carolina or otherwise violating the insurance laws of this State pertaining to long-term care insurance until the resolution of the appeal in Pennsylvania, with Plaintiffs given leave to apply for an extension upon a showing that it is necessary to protect policyholders and uphold the laws of this State.

Respectfully submitted,

November 12, 2021

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EXHIBIT A

IN THE COMMONWEALTH OF PENNSYLVANIA

- - -

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

- - -

Monday, May 17, 2021

- - -

Proceeding in the above-captioned matter held before THE HONORABLE MARY HANNAH LEAVITT, at the Commonwealth Court of Pennsylvania, 601 Commonwealth Avenue, Harrisburg, Pa., commencing at 10:00 a.m., on the above date, before Karen A. Nickel, Certified Realtime Reporter and Notary Public in and for the Commonwealth of Pennsylvania.

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So you can see that we are now at the point at which the volume of claims is outpacing the premium that the company is collecting, and what's more troublesome for us is that of the total premium that SHIP is expected to collect from the expiration of the policies in force, which is about $7.4 billion, we have already collected 7.1 billion. We only have about $300 million in premium we expect to collect.

On the other hand, we expect total claims to be paid during that period of, approximately, $11 billion, of which we have only paid about $7.7 billion so far. So we expect to be paying another $3 billion in claims or so in the absence of a plan, but only collecting $300 million in premium.

This is not atypical. Long-term care insurers expect to collect a lot of premium upfront, invest that money, put it aside, and then when the curve starts rising on the claim side -- because policyholders might be applying for benefits, and clearly you have a big part of money set aside from previously collected and invested premium.

Unfortunately, when you stop selling new business, as SHIP did 18 years ago, the premium curve starts flattening and the claim curve starts rising. And in the case of SHIP, the investment income has been much lower than anticipated, for reasons I will explain a little bit later on.

But as I said, right now the picture is a little bit grim because we are going to be paying ten times as much in claims as we are collecting in premium.

Q. What portion of SHIP's policyholders for LTC are on claim?

A. I think we are about 13 percent right now, which is a little bit above the industry average. But as you can see on Slide 21, which is also part of Exhibit 33, that curve is also expected to continue, so that by the time the block runs off, we are probably going to be about one in three policyholders on claim.

Q. Mr. Cantilo, I'm going to turn to the current financial condition of SHIP. Can you describe it for me, please?

A. Sure. If we can put up Slide 20 --

I'm sorry, 23. That table, which also appears on Exhibits 31 and Exhibit 55, which are two versions of the plan, summarizes the financial history of SHIP for the last 11 years, and you can see that back in 2009, shortly after it was spun off, it had reportedly serviced 193 million, run out before 2019 with a deficit and for 2020 that has gone up about 300 million to a deficit of 1.2 billion. It has been a steady decline, as you can see on this table, and I think the larger drop from 2014 to 2015, maybe even the one from 2013 to 2014, led the company to become a lot more concerned.

They started that special examination for 2016. By the time those numbers came in in 2017, you can see the company had halved its surplus from 55 million to 28 million.

And then that was cut in half again for the 2017 annual statement, which is actually filed in March of 2018, about the time I was involved. So it's been a little bit of a grim picture.

Slide 23 -- I'm sorry, 24 has more updated information. That actually has the

detailed numbers from last year, and you can see that now, we are at a little bit under $1.4 billion in assets with about $2.6 billion in liabilities, creating the $1.2 billion deficit that I described earlier.

That deficit has probably stabilized a little bit. It's even possible it's a little bit lower by the end of 2021 or projected to be a little bit lower by the end of 2021 than it is now, but either way, it's not going to be material to the plan.

On the next slide, Slide 25, I actually have a graph that is part of Exhibit 36, or proposed Exhibit 36, I should say, that tracks the relationship between assets and liabilities over the same 11-year period, and you can see how that relationship has grown, the gap has grown between the two.

And on the next slide, 26, you can see how the company's capital and surplus has dropped.

Now, these are reported numbers, and I emphasize that, Your Honor, because I don't want the Court to misinterpret my testimony as saying that we believe that the reported

surplus of 2009 or even 2016 is accurate. That's just a number the company was reporting.

It wasn't until 2017 that we have material influence in the way in which the company was reporting its financial condition. And by 2018, as I will explain in a few minutes, they have made some adjustments we requested, and that's why you saw the company go from a $12 million surplus to a half a billion dollar deficit in that one-year period.

Q. Mr. Cantilo, let's dig into the causes of the insolvency that SHIP faces. Can you summarize how we got here?

A. There are a number of factors. I think the most important factor in terms of volume is what we believe to be erroneous actuarial assumptions made when the policies were first issued and as reserves were calculated in the ensuing years.

The key actuarial assumptions to which I am referring are morbidity, the rate at which people become ill and require care, morbidity improvement, the rate at which they become healthier so they need less care, rate of mortality, how many people died in a given

year, and the rate of which policies terminate for any of a number of reasons.

So we suspect and have confirmed that the company was operating on understated morbidity assumptions, that is, they underestimated how many people would become ill and qualify for benefits. They overestimated how quickly people would become healthier and stop needing as much care. That's what the industry calls morbidity improvement. They overstated mortality which, as I say, ironically, mortality rates help the company because they remove insureds from the pool of people who can get benefits. They assume more people would die than actually died. And then they overstated or overestimated a number of policies that would lapse because of death or non-payment of premium.

Apart from the problems with the actuarial assumptions, of which I'm sure we will return, the company has had a pretty poor history with its investments. The problems are primarily in two categories. The broader capital markets have seen dramatic drops in yields from the time these policies were first

sold in the '70s and '80s to today, and, in addition, the company has made some unfortunate investment decisions that have also removed some capital from the picture.

There was a concern that the company's operating costs were also high, and we made some efforts working with management to reduce those operating costs. So although they were a factor, I would not say that those were a major factor.

And then the last big component, which, again, is common in the industry, is that when SHIP management realized that its premium rates were too low because of the understated or misstated actuarial assumptions and attempted to increase its premium rates, it received mixed responses from regulators around the company with twin bad effects of, A, not getting enough additional rate to help with the problems, and, B, creating a hopscotch of very different rates across the country so that two policyholders of similar characteristics with similar coverage, with policies issued in different states, might be paying widely different premiums, sometimes a factor of four

or five times the premium, just because different states reacted to rate requests in a different manner.

Q. So Mr. Cantilo, let's focus on certain of these causes of deterioration, the assumption. How big a problem were the actuarial assumption errors you described?

A. We have a slide, slide 29, in which we have aggregated what we think is the impact of just the actuarial assumptions and, as you can see, we projected it through 2040, which is when we think most of the block will have run off, and as of that date, we expect that the aggregate effect of these assumptions beginning only in 2012 is about the size of our deficit, $1.2 billion. We have not gone back to project the effect of the assumption before 2012.

Q. I think the next item on your list referred to investment performance projections.

A. Right. So SHIP, like everyone else investing in the American market, has experienced lower yields from its invested assets. If you look at Table 30, that -- those two graphs which come from Exhibit 40 are the United States Treasury bond curves for the

analysis was whether we should go into liquidation or rehabilitation or come to this Court, I should say, with a liquidation or rehabilitation plan. And for reasons that I can explain in more detail later, the decision was made that rehabilitation was appropriate here.

And the key components of that were, there is enough money left at SHIP to be able to provide fundamental coverage to our remaining 40,000 policyholders, albeit not the rich coverage that a lot of those policies provide, and this is, and it sounds a little counterintuitive, but this is a major factor; we knew that a lot of policyholders had been underpaying for their policies for a long period of time, decades, and we knew that if we came to this Court requesting a liquidation order, that a likely consequence is that the guaranty associations would be triggered, then, ultimately, the taxpayers would be asked to step up and contribute hundreds of millions of dollars to pay claims under those policies.

And the question that we were debating is, is it reasonable, if a

policyholder has been paying a quarter for a dollar's worth of insurance for decades, to adopt, as the workout plan, a plan in which the taxpayers step up to pay their remaining 75 cents.

And what we concluded is that we could right size the policy, and we could create a set of options for policyholders that would enable them to get fundamental LTC coverage but pay reasonable rates like the rest of the country for that coverage and not shift all that burden to the taxpayers.

I don't mean to minimize the policy because it made every penny -- whether that's the case or not, the fact is they were mispaying for the coverage and we thought the plan could have a proper goal the right size of the policy, so that the relationship between the premium and the benefits was reasonable.

That, after all, is a fundamental requirement of rate regulation. When regulators across the country approve rates for insurance policies, the key consideration is between rates and benefits are reasonable.

We concluded, for SHIP, that was no

longer the case and we thought a rehabilitation plan could be put together that would remedy that. And we thought if we did that, it would result in reduction of liabilities and it would offset the deficit to a large degree.

I will be very candid with the Court, as we always have been, it is not likely that we will magically restore SHIP to solvency, but it is likely that the plan that we were trying to design would substantially reduce the deficit and substantially improve the inequitable rate structure for the company.

That was the goal when we sat down to put a plan together.

Q. Did you consider any other options besides the plan?

A. Of course. There were things that we had considered earlier in the case of Penn Treaty and we thought maybe they would work here.

So the first thing we looked at is selling the company, but a company with a $1 billion deficit and a losing book of business and not selling any new business does not attract a lot of buyers.

So that one didn't get very far.

We looked at a good bank/bad bank structure, which is a structure we had worked a lot on in the Penn Treaty case, but, unlike Penn Treaty that had two licensed insurers, SHIP is only one licensed insurer and for good bank and bad bank to work, you have to have a good bank and bad bank around the country and that was --

Q. Can I just ask you to pause and explain for the record what good bank/bad bank would entail?

A. So it means a lot of different things to a lot of different people, but the context in which I am using good bank/bad bank is a scheme in which you separate the bad part of the insurance business and put in a liquidation vehicle and put the good part of the insurance business in a surviving vehicle that you hopefully will restore to solvency.

Q. So now, the third item, ancillary approval of modifications, what does that mean?

A. Well, we recognize that the only way a rehabilitation plan would work is to modify the insurance policies, and we anticipated that

there might be resistance, especially to premium rate increases from other states, not because we didn't think that we had the legal authority to do that, but because it is unprecedented.

The reality is that most companies that went to rehabilitation are not collecting premium, so the notion of premium increases doesn't come up in rehabilitation.

And we -- the first thing we decided is, look, everyone understands we can change the benefit, so surely if we can change the benefits, we can change the premium. So two sides of the same equation. We realized, even if that seemed logically the case, that regulators tend to feel strongly about the exercise of authority on rates, and so to avoid a fight on the issue, one of the things we considered early on is to subject the policy and rate modifications to each of the states as part of the rehabilitation plan.

But we concluded pretty early on that that approach overlooked all of the history where the company had the checkerboard experience from rate increase across the

country and it would take far too long for the plan to become effective in time to do much good. So we thought ancillary approval of the modifications just wasn't going to be an effective strategy for SHIP.

Then we thought about excluding the policies of states that didn't want this Court and Jessica Altman, the Insurance Commissioner, to modify. But that created an unfairness or inequity problem because we would have a plan that would benefit some and not others, and it wouldn't be the policyholders that get to make that choice; it would be regulators. So we thought of that option for the same reason.

We spent a lot more time on regulation and, as I said earlier, we concluded we could do a lot more good for policyholders and for the company with this plan than with a flat-out liquidation.

Q. I believe you testified earlier that a liquidation would shift a burden to the taxpayers. Can you just explain briefly how that worked?

A. Certainly. So if we were to place SHIP on a liquidation, as Penn Treaty has been,

for example, the guaranty associations and each of the states in which SHIP's policyholders reside would be triggered and required to guarantee, assume or reinsure, or cause to be guaranteed, assumed or reinsured, all of the policies in force in that state.

And the obligations of the guaranty associations would be capped at a stated dollar amount, typically $300,000, and the guaranty associations would first collect at least a portion or maybe all of SHIP's assets, and then assess other insurers around the country to pay those claims.

When they do that, the assessed insurers themselves, in turn, get to reduce their premium tax payments over, typically, a five-year period by the amount of the assessment, and they pay for failed insurers.

There are exceptions in California, for example, a set of premium tax offsets, the insurers get to surcharge on for the assessment.

But one way or another, the assessments are first borne by the insurance company and then passed on to taxpayers or

policyholders. If we put SHIP in the equation, that is who would pay 75 percent on the hypothetical underpricing.

Q. So we will return to a comparison of rehabilitation and liquidation, but first, I would like you to tell the Court how you and the others assisting the Rehabilitator in developing the plan, how did you come to the plan?

A. So we benefited from having had the experience of doing a lot of this work in Penn Treaty, so we were able to hit the ground running. Our group, including Oliver Wyman, some people from the department and from management, set out to define the broad strokes or the basic elements of the plan. As I said a little bit earlier, one of the keys was to be able to provide coverages to policyholders that the company could afford but would not be so expensive.

So we looked, for example, if we can look at Slide 55 -- I'm sorry, 59. My age is catching up with me.

This is an illustration of the things at which we were looking. This graph

Q. The exhibits that counsel just --
A. I do not.
Q. You don't. Okay. Well, with your indulgence, then, I would --
A. I have them on the screen.
Q. Do you recognize the Oliver Wyman actuarial report on the screen?
A. I do.
Q. Are you familiar with it?
A. Somewhat. I am not an actuary, but I have read it.
Q. As the special deputy liquidator, this actuarial report, would it be something you would read and --
A. Yes, sir.
Q. -- seek to understand?
A. Yes, sir.
Q. Okay. Let's go to Page 11 of this report, if we could. Can you see that on the screen, Mr. Cantilo?
A. I can.
Q. Okay. I draw your attention to the first line, there are two blocks of illustrations here, and I want to draw your attention to the first line entitled Current

Reserves in the topmost block.
Do you see that?
A. I do.
Q. So the gross premium reserve, can you explain what that is?
A. It is the projection for the total liabilities expected to arise under the policies in force in excess of the premium available to fund them.
Q. Is this a present value calculation of those obligations net of a present value of premium?
A. Yes.
Q. So present value underlies the calculation of the gross premium reserve?
A. Correct.
Q. And the next number is the funding gap, which is $1.2 billion. The uncovered reserve, what is that?
A. That is a portion of the projected liabilities that is expected to exceed the applicable guaranty association limits for those policyholders.
Q. Okay. So if we take the funding gap of $1.2 billion and subtract the $606 million

which exceeds the guaranty fund limits, does that leave you with a $600 million gap you would otherwise have to fill in order for the plan to fill and satisfy the funding gap?
A. It leaves 600 million.
Q. If the gross premium reserves reflect covered and uncovered liabilities, being the covered and uncovered liabilities of the guaranty funds, does that mean that approximately $600 million of covered benefits need to either buy the voluntary action of policyholders or through the operation of the plan have to be reduced?
A. If you are asking me in order to reduce the liabilities to fully cover liabilities, the $600 million in liabilities have to be eliminated, hypothetically, that makes sense.
Q. So the financial statements of SHIP, are they filed in accordance with statutory accounting principles?
A. They were before SHIP was placed under rehabilitation.
Q. When you filed the 2020 financials, were those prepared in accordance with

statutory accounting principles?
A. There were no 2020 financials filed.
Q. Filed. Okay. Could we draw up Exhibit RP 12. We'll be going back to this exhibit. Okay.
So when you used the word "filed," do you mean filed with the various states?
A. I interpreted your question to be asking about that, and that's the way in which I intended that response.
Q. This financial statement, was it prepared in accordance with statutory accounting principles?
A. I did not prepare that statement so I can't answer the question.
Q. Was it prepared under your supervision?
A. I requested it be prepared.
Q. Is this number critical to analysis of the financial condition of SHIP?
A. It is important.
Q. Doesn't this calculate the funding gap; isn't the funding gap dependent upon these financial statements?
A. The funding gap is not dependent on

Q. The pricing, the actuarial assumptions that underlay pricing assumed certain investment returns; correct?
A. Correct.
Q. And then there were actual investment returns, that's correct, too; right?
A. Correct.
Q. And the difference had an impact?
A. Correct.
Q. And that impact contributed to the funding gap?
A. Absolutely.
Q. Do you have a sense of whether that was material?
A. Yes, it was material.
Q. Okay. And do you have a sense of whether it was as material as the -- as the rate deficiency?
A. Because I don't have a quantity for that sum, I can't say whether it was more or less material than the underpricing, but it was definitely material.
Q. And yesterday you testified about a couple of investment decisions that had been made and the losses that SHIP endured from

those decisions.
A. Yes.
Q. I believe you estimated the range of those impacts as between 150 and $200 million; is that right?
A. It could even exceed that.
Q. And so would that also be contributing materially to the funding gap?
A. Absolutely.
Q. And so, you know, that 150 to 2 or $300 million, that number seems to correlate to the 300 or so of premium that was foregone as well through regulator action, so it's a material number that contributed to the gap; right?
A. Is your question whether it's similar or whether it's material?
Q. Was it material?
A. It was material.
Q. So $300 million of premium rate, premiums not approved, a material effect due to the drop in the capital markets and several hundred million dollars, a couple, 300, whatever, range due to investment decisions, all of that affecting materially the funding

gap?
A. Is there a question?
Q. I am asking you if you agree with that or not; is that correct?
A. Do I agree that those things affected the funding gap, yes.
Q. Materially?
A. Yes.
Q. Is it your opinion that the Rehabilitator of an insolvent life insurer has the discretion to impose the entire cost burden of the insolvency on the insurer's current policyholders and not trigger the guaranty associations?
A. Are you asking me if I think that's the law?
Q. Is that your opinion, yes.
A. My opinion is that the discretion of Rehabilitators and rehabilitation Courts can include that, yes.
Q. So if the policy -- so the policyholders of SHIP need to address through these options or -- let me try it a different way.
The five options made available

under Phase One of the plan, are they intended to reduce the funding gap of $1.2 billion?
A. The plan as a whole is intended to reduce the funding gap.
Q. Is the goal to -- is the purpose of the plan to eliminate the funding gap of $1.2 billion?
A. It would be good if it did that, but the plan would not fail, in my opinion, if it failed to do that, no.
Q. So the reduction of the funding gap, through the plan, who is bearing the burden of that reduction?
A. If you describe the adjustments of the policies as bearing the burden, the policyholders would.
Q. Is there anyone other than the policyholders that's bearing the burden of those adjustments?
A. Putting aside tax considerations, probably not.
Q. So that's about 20,000 policyholders based on your testimony earlier in this cross?
A. No.
Q. No? How many policyholders?

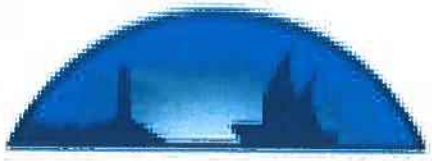
A. Well, if you eliminate the non-forfeiture options, 30,000.
Q. And you don't further reduce it for the policyholders already paying the If Knew Premium?
A. I think we already talked about that. Those policyholders will have the ability to voluntarily select Options 2, 2A or 3.
Q. Okay. But you would agree, then, that the $1.2 billion would be addressed by the 30,000 long-term care policyholders?
A. The projected $1.2 billion funding gap would be addressed by them, yes.
Q. Exclusively?
A. No.
Q. Okay. Who else?
A. As I said, the taxpayers.
Q. The taxpayers?
A. Yes.
Q. Who?
A. To the extent that our plan is successful, we will eliminate potentially hundreds of millions of dollars in federal income tax liability. Doing that, I suppose,

arguably shifts that burden to other taxpayers.
Q. I don't pretend to be a tax expert, and yesterday I believe you testified that you weren't either, for which you deserve credit, but I'm going to just stick with the $1.2 billion, because I don't believe it's net of any kind of tax benefit; is it?
A. I think we're mixing apples and oranges.
Q. I do, too.
A. $1.2 billion is the projected deficit for the company.
Q. And the policyholders of SHIP, the 30,000 long-term care policyholders of SHIP are going to bear that through higher premium or reduced benefits; right?
A. If the entire deficit is eliminated under the plan, the answer is yes.
Q. Any portion of the deficit eliminated by the plan is being borne by the policyholders; isn't it?
A. Yes.
Q. Rather than spread to the guaranty fund system?
A. Correct.

Q. Now, you're a highly experienced specialist in insurance company receiverships. Do you understand or could you tell us why the life and health guaranty funds were created?
A. I do understand why they were created.
Q. Why were they created?
A. They were created in part because there was a concern that in the absence of a state-based mechanism for the protection of policyholders of failed insurers, there was going to be a shift from state to federal regulation of the insurance industry.
Q. So the exclusive purpose for creating the life and health guaranty funds was to avoid federal guaranty fund statutes?
A. I don't think so.
Q. Was there a policyholder protective purpose expressed with regard to the creation of a life and health guaranty fund?
A. Absolutely.
Q. Okay. Do guaranty funds spread the loss beyond the policyholders of an insolvent insurance company?
A. Yes.

Q. You have testified that they spread that loss in ways that are borne by taxpayers; is that correct?
A. In part, yes.
Q. In part. So one of the purposes of the life and health guaranty fund system is to spread the loss of an insolvency broadly so as not to concentrate it on the policyholders, exclusively the policyholders of the insolvent insurer; do you agree with?
A. I think that's one of the effects. I'm not sure whether that was the purpose.
Q. Does it have that effect? Does the triggering of the guaranty association spread the loss broadly across the United States?
A. I just said I think that is the effect, yes.
Q. And so why did the Rehabilitator of SHIP decide that it was better to impose the burden exclusively on the policyholders of SHIP?
A. As I explained yesterday, there were several factors. One is that the plan offers policyholders benefits that would not be available in liquidation.

EXHIBIT B



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

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

HOW TO PROVIDE COMMENTS AND OBJECTIONS

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

Formal Comments were required to be made by September 15, 2020, in compliance with the June 12, 2020 Case Management Order of the Commonwealth Court of Pennsylvania, which is available at www.shipltc.com. No provision has been made by the Court for additional Formal Comments.

THIS PLAN DOCUMENT PROVIDES DETAILS ABOUT THE PLAN APPROVED BY THE COMMONWEALTH COURT OF PENNSYLVANIA ON AUGUST 25, 2021, FOR SHIP'S REHABILITATION (THE "PLAN"). IT DESCRIBES IN DETAIL THE OPTIONS FROM AMONG WHICH SHIP POLICYHOLDERS CAN CHOOSE UNDER THE PLAN. EACH LONG-TERM CARE ("LTC") POLICYHOLDER WILL RECEIVE PERSONALIZED INFORMATION BEFORE HE OR SHE IS ASKED TO CHOOSE AN OPTION UNDER THE PLAN. THIS INFORMATION WILL BE PROVIDED IN A SIMPLIFIED FORMAT.

This version dated September 30, 2021, corrects an omission on page 19 of the September 24 version regarding disposition of the agent's commissions issue left open in the Court's August 25, 2021, Memorandum Opinion approving the Plan.

in both general and policyholder-specific circumstances. The cost and delay attendant to making the calculations for every policyholder in advance are not justified given that the results will may not be sufficiently accurate to be meaningful. However, beginning at page 68 there are illustrations of Plan options for several representative policyholders. This Plan Document therefore provides relative and directional guidance about Plan options rather than precise policy-level details for each one.

UNTIL THE PLAN EFFECTIVE DATE POLICYHOLDERS WILL HAVE THE SAME RIGHTS, BENEFITS, OPTIONS, AND OBLIGATIONS AS THEY DO NOW UNLESS THE PLAN SPECIFICALLY PROVIDES OTHERWISE.

A. SUMMARY DESCRIPTION OF THE PLAN

The following description of the Plan is intended to provide policyholders the basic general information required for them to understand the options that will be available to them under the Plan. Much more detail about the Plan and related matters is provided in the sections that follow.

1. GOAL AND PHASES OF THE PLAN

Recognizing that SHIP faces a substantial Funding Gap (described on page 87), the aim of the Plan is to increase revenues and reduce liabilities so as to narrow or eliminate that gap through a combination of ***Policy Modifications*** for most of the approximately 39,000 policies in force as of the filing of this Second Amended Rehabilitation Plan. Although the Plan has certain default provisions that apply when policyholders fail to make effective choices, it is structured to maximize policyholder choice, based on each person's individual circumstances and preferences. In proposing the Plan, the Rehabilitator recognized that many policyholders have costly policies that provide far more coverage than the policyholders are reasonably likely to require. Accordingly, a key element of the Plan is to enable policyholders to remove coverages that are not essential or even necessary to cover reasonable long-term care expenses. That is expected to help narrow the Funding Gap and potentially reduce their own premium, or at least avoid part or all of a necessary premium rate increase.

The Plan is designed to operate in three phases. ***Phase One***, commencing now, is the principal phase and will strive to reduce substantially or eliminate the Funding Gap. In this phase it will be determined which policies require modification because their Current Premium is below the ***If Knew Premium*** for the benefits offered by the policies. The If Knew Premium is an accepted methodology for setting premiums for long-term care insurance ("LTCI") policies, more fully explained at page 27. Policyholders with Current Premium (see page 122) below the If Knew Premium will have to increase their premiums or reduce their benefits so that the premium will be adequate on an If Knew Premium basis. Policyholders whose Current Premium is at or above the If Knew Premium will not be required to modify their policies (increase their premiums or reduce their benefits) but may choose to make some such modifications if they prefer to do so, as explained below.

In ***Phase Two***, the results of Phase One will be evaluated and additional Policy Modifications may be necessary for certain policies. It is expected that modifications in Phase Two will largely be based on ***Self-sustaining Premiums*** as explained at page 27. The goal of Phase Two will be to eliminate any Funding Gap not eliminated in Phase One. Only policies that meet the following conditions may be modified in Phase Two:

a. Their premiums are not already Self-sustaining,

b. They are not ***Fully Covered*** (*i.e.*, they are not within the limits of, or otherwise not covered by, the applicable Guaranty Association - see page 123), and

c. The policyholders have not selected ***Option Two (a or b)*** or ***Option Three*** (described below) in Phase One.

In ***Phase Three***, the Company will complete the run-off of the LTCI business in force. If there are sufficient funds to do so, in Phase Three the Rehabilitator will make payments to policyholders and other creditors on account of any amounts owed to them apart from policy liabilities (addressed in Phase One and Two).

2. POLICYHOLDER ELECTIONS

This section describes the key elements of these policyholder options. They are described in full detail beginning on page 24. In Phase One every policyholder whose Current Premium (including the premium they would be paying but for a premium waiver) is below the If Knew Premium for the policy's benefits will be required to elect one of four options. Those whose Current Premium (including the premium they would be paying but for a premium waiver) is at or above the If Knew Premium may keep their current policies without modification or may elect Option Two or Option Three, described below.

a. Option One will be to continue paying the Current Premium or to maintain the premium waiver if one is in effect, but if Current or waived Premium is less than the If Knew Premium, have benefits reduced in accordance with Plan provisions so that the premium for the reduced benefits (including waived premium) is equal on an If Knew Premium basis to the Current Premium. The benefit reductions will be selected automatically by the Plan.

b. Option Two will be to select certain policy endorsements that provide selected essential benefits (sometimes greater than the benefits provided by Option One) at a lower premium than Option Four. This option, of which an enhanced alternative will also be available, will not be subject to further rate increases or benefit reductions in Phase Two of the Plan. Option Two is designed to provide reasonable coverage at reasonable premium rates.

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

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

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

Before being required to make an election, each policyholder will receive information detailing the premiums and benefits of each option. Special rules apply to policyholders who are not currently paying premium due to a Premium Waiver provision in their or their spouses' policies. These are explained fully beginning at page 31. Generally, such policyholders who elect Option Two or Option Four and whose Current Premium (the premium they would be paying but for the waiver) is lower than the If Knew Premium, will be required to pay a Differential Premium. The Differential Premium consists of the difference between (1) the premium they would be paying if there were not a waiver in effect (the Current Premium), and (2) the If Knew Premium corresponding to the policy. See Section II.E.7, page 29. If the Premium Waiver terminates, such policyholders will be required to pay the full applicable If Knew Premium (or Self-sustaining Premium if in Phase Two). Substantially the same options will be offered to policyholders on claim.

3. NO WORSE THAN LIQUIDATION

Every policyholder will be offered at least one option in Phase One that will provide him or her potential benefits equal to or exceeding those that would be available from the applicable Guaranty Association in the event of liquidation, but generally no more than the current policy benefits.

a. Policyholders with Current Premium (including the premium they would be paying but for a premium waiver) at or above If Knew Premium in fact will not be required to make any changes in their policies. Thus they will be treated at least as well as they would in liquidation, and perhaps better if their policies offer benefits in excess of those that would be offered by Guaranty Associations in liquidation.

b. Option Two will provide at least the benefit value that the Guaranty Association would provide in liquidation for every policyholder whose current policy provides benefits in excess of those limits. In many cases, other options will also provide the benefits that would be available from Guaranty Associations in liquidation. For policyholders with current benefits below Guaranty Association limits, Option Two will provide at least the current level of benefits.

In that respect, the Plan is designed to place policyholders in no worse off a position than they would face in a liquidation of SHIP.

4. DEFAULT OPTIONS

For every policyholder there will be a Default Option which will apply automatically if no proper election is made. In Phase One, for every policyholder whose Current Premium is at or above the If Knew Premium, the Default Option will be to leave the policy unchanged. However, if the Current Premium is below the If Knew Premium, there will be a Default Option that will be identified in the election materials (and is illustrated on page 67). In general, the Default Option will be Option One (the downgrade) for policyholders on Premium Waiver. However, if the Non-forfeiture Option (NFO) would provide these policyholders better benefits than the downgrade, the NFO will be the Default Option. For policyholders who are paying premium, Option Two (the Basic Policy Endorsements - see Section III.A.2.d, page 48) will be the Default Option.

In Phase Two, for every policyholder whose Current Premium is at or above the Self-sustaining level, the Default Option will be to leave the policy unchanged. However, if the Current Premium is below the Self-sustaining level, there will be a Default Option similar to Phase One. In general, the Default Option will be Option One (the downgrade) for policyholders on Premium Waiver. However, if the Non-forfeiture Option (NFO) would provide these policyholders better benefits than the downgrade, the NFO will be the Default Option. For policyholders who are paying premium, Option Two (the Basic Policy Endorsements) will be the Default Option.

The Default Option will apply if the policyholder fails to make an election by the applicable deadline or submits an election form that does not clearly identify the policyholder's election (for example because two or more options are elected). For a policyholder whose Current Premium is equal to, or higher than, the If Knew Premium (or Self-sustaining level in Phase Two), the Default Option will be to leave the policy unchanged, and no changes will be made to the policy unless specifically elected, even if the policyholder does not submit a proper completed election form. The Rehabilitator believes that between 25% and 40% of policyholders may be in this category in Phase One.

5. CHANGES IN POLICYHOLDER ELECTIONS

Policyholders will not have the opportunity to change their elections after the applicable ***Policyholder Election Date*** (the deadline for policyholder option elections under the Plan). Before the Policyholder Election Date, policyholders may change their elections by submitting new

Policyholder Election Forms if they are received before the applicable Policyholder Election Date. A new valid Policyholder Election Form received before the Policyholder Election Date will replace and invalidate a valid or invalid Policyholder Election Form submitted previously. If time permits, the Rehabilitator will attempt to reach policyholders who submit defective election forms (for example because they make no valid election or make more than one election) to attempt to correct the error. However, if there is insufficient time before the Policyholder Election Date, or if the Rehabilitator cannot reach the policyholder, the result of submitting a defective election form will be that the Default Option will be selected automatically under the Plan.

6. PHASE TWO ELECTIONS

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

7. EFFECT OF ELECTIONS

Policyholder Elections under the Plan will be permanent. This means that if the Plan does not succeed in rehabilitating SHIP fully and the Company has to be placed in liquidation, the policies to which guaranty association coverage and limits (see Section VI.J, page 92) will apply will be those as modified as a result of the Policyholder Elections. The elections are not intended to, and will not, eliminate the Unfunded Benefit Liability described in the discussion of policy restructuring (Section VI.H, page 91).

B. KEY CONSIDERATIONS FOR POLICYHOLDERS

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

In determining which option to elect, each policyholder should consider what is a reasonable level of benefits to be provided by his or her policy given his or her likely future needs, and the

ability of the policyholder to pay for such benefits. For example, there are very material differences between the costs of a policy that provides 5% compound Inflation Protection, one that provides 2% simple Inflation Protection, and one that provides no Inflation Protection at all. Similarly, there are material differences between the costs of a policy with lifetime benefits, one with a five-year benefit period, and one with a two-year benefit period. Moreover, features like Premium Waivers, Restoration of Benefits, Return of Premium, short Elimination Periods, indemnity rather than reimbursement, and "traditional" benefit triggers can all add materially to the cost of a policy but may not be indispensable to every policyholder.

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

For those fortunate policyholders who can afford material rate increases, Option Four might be attractive in that it would enable them to retain the most generous benefits, even at high premium rates. Many of these policyholders would face very large rate increases when selecting Option Four. This is because, in many cases, the premiums being paid for those policies are substantially lower than what they should be relative to the benefits promised. Moreover, policyholders selecting Option Four would face the possibility of additional substantial rate increases or benefit reductions in Phase Two of the Plan.

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

It is not practical to offer enough options to meet precisely every policyholder's expectations or preferences. Doing so would make the Plan too complicated and costly. The Special Deputy

Rehabilitator has led a team that has devoted intense efforts to the development of a manageable array of options that recognizes the major differences in policyholders' circumstances. While no one option may be ideal for a particular policyholder, the differences among the options are such that it is hoped that every policyholder will find at least one option that will enable that policyholder to emerge from SHIP's rehabilitation with adequate long-term care protection at reasonable premiums.

C. COVID-19

In December 2019, a new virus emerged in Wuhan, China, identified in due course as severe acute respiratory syndrome coronavirus 2, resulting in a pandemic of coronavirus disease 2019 ("COVID-19"). As of the filing of the Second Amended Plan, at least 140 million people had been infected worldwide, resulting in at least 3 million deaths. In the U.S., the first cases were reported in January 2020, with total estimates by then exceeding 32 million and fatalities exceeding 570,000. COVID-19 is particularly threatening to the elderly and those with impaired respiratory systems or other underlying health conditions. While intense work continues around the globe, no effective cure has yet emerged. There has been substantial progress in efforts to develop and distribute several effective vaccines. At the time the Second Amended Rehabilitation Plan was filed, more than one quarter of the U.S. population had been fully vaccinated, more than 40% having received at least one of two vaccines. The emphasis on vaccinating the older population first had resulted in nearly three quarters of those over 65 having received at least one dose, more than 60% having been fully vaccinated. As a result, COVID-19 mortality in nursing home and assisting living facilities has plummeted, approaching pre-pandemic levels after having peaked in December 2020. All told, more than 1.1 million residents and staff had by then been infected with the virus, and more than 133,000 succumbed to it.

The full impact of the COVID-19 pandemic on the U.S. insurance industry remains to be determined. The life insurance industry makes the following observations. Between March 2020 and February 2021, the number of actual deaths was 120% higher than the number of expected deaths.[1] This led to a 14% increase in mortality rates among group life claimants in the first quarter of 2020.[2] Excess deaths were concentrated "among those in the preferred underwriting class, particularly those ages 60 and older."[3] However, this has not increased life insurance premiums or decreased policy offerings.[4]

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[1] Susan Rupe, What Record Mortality Rates Mean for the Life Insurance Industry, INSURANCE NEWS NET (Apr. 14, 5:00 PM), https://insurancenewsnet.com/conference-post/what-record-mortality-rates-mean-for-the-life-insurance-industry.

[2] Id.

[3] Id.

[4] Andrew Keshner, Has COVID-19 Made Life Insurance More Expensive? MARKET WATCH, (Apr. 12, 12:00 PM), https://www.marketwatch.com/story/has-covid-19-made-life-insurance-more-expensive-these-researchers-say-they-have-the-answer-2020-12-07.

The impact on health insurers differs somewhat. Due to unemployment caused by COVID-19, between 3.1 and 27 million Americans lost employer-sponsored health insurance in 2020.[5] Health spending also dropped considerably, because of the cancellation of elective surgeries.[6] This loss was concentrated in the first half of 2020 but persisted enough to cause a 2.7% drop in non-prescription medical spending from 2019 to 2020.[7] This drop in spending could result in higher-than-average premium rebates for insureds.[8] Overall, health insurers fared well, with average gross margins at the end of the third quarter of 2020 for individual market and fully-insured group market plans almost 25% higher than in 2019.[9] Medicaid Advantage plans saw a 35% average gross margin increase over the same time period.[10] As a result, 2021 health insurance premiums are expected to remain largely unchanged.[11]

For long-term care insurance, the effects of the pandemic have been mixed. COVID-19 seemed to reduce long-term care insurance costs by (1) shortening the amount of time some insureds used benefits either because they died or because they left long-term care facilities, or (2) preventing some insureds from starting to use long-term care services.[12] A Fitch Ratings report indicates that the long-term care insurance industry gained roughly $2.5 billion in net operating profits from 2019 to 2020.[13] Actuaries are unsure about what effect COVID-19 will have on long-term care insurance over the long run, as COVID-19 could have "accelerated the deaths of people who were likely to die

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[5] Lola Butcher, How Health Insurance is Faring Under COVID, THE WEEK (Apr. 14, 2:00 PM), https://theweek.com/articles/975895/how-health-insurance-faring-under-covid.

[6] Cynthia Cox, Krutika Amin, and Rabah Kamal, How Have Health Spending and Utilization Changed During the Coronavirus Pandemic, PETERSON-KFF HEALTH SYSTEM TRACKER (Apr. 12, 1:00 PM), https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/#item-start.

[7] Id.

[8] Id.

[9] Daniel McDermott, et al., Health Insurer Financial Performance Through September 2020, KFF (Apr. 14, 4:00 PM), https://www.kff.org/private-insurance/issue-brief/health-insurer-financial-performance-through-september-2020/.

[10] Id.

[11] Cox, *supra* note 12.

[12] Long-Term Care Insurance Dashboard: 2020, FITCH RATINGS, (Apr. 14, 4:00 PM), https://www.fitchratings.com/research/insurance/long-term-care-insurance-dashboard-2020-improved-results-view-of-reserve-adequacy-unchanged-06-04-2021.

[13] Id.

soon . . . and spared healthier older people."[14] This would mean that the surviving elderly population could spend more time using long-term care services.[15]

However, this seems to vary from insurer to insurer. A Milliman survey covering April to September 2020 found that the overall use of long-term care benefits remained unchanged.[16] While active life mortality increased for most responding insurers, 40% of responding insurers saw a decrease or no change.[17] The death rate for insureds already receiving benefits decreased by 5% or more for two-thirds of responding insurers.[18] An American Academy of Actuaries issue brief suggests that the bulk of COVID-19 deaths in long-term care facilities "may be associated with Medicaid funded-homes, which might not house a meaningful number of insureds."[19]

The implications of COVID-19 for SHIP and the Plan fall in three major areas.

CASE MANAGEMENT: Restrictions on travel and personal contact imposed as preventive measures have cause SHIP to revise, at least temporarily, the manner in which it confirms eligibility for benefits and other aspects of case management. Although current protocols emphasize other means of communication, the Company remains attentive to the needs of its insureds as well as to the important function of preventing fraud, waste and abuse. At this juncture, these changes are not expected to have a material effect on the Plan or on the options it will offer to eligible policyholders.

MORTALITY AND MORBIDITY: Although sufficient reliable data is not yet available, preliminary data indicates that COVID-19 may be causing a decrease in the number of SHIP insureds filing claims and an increase in the number of deaths among the aging population insured by SHIP. While these unfortunate developments may combine to reduce slightly SHIP's deficit, it is possible that, at least in part, they are temporary. The Rehabilitator cannot yet project what, if any permanent impact, these consequences will have on the Plan but they are not expected to be material.

SUSPENSION OF PREMIUM PAYMENTS: Many SHIP policyholders had delayed making their required premium payment. While SHIP had delayed lapsing or cancelling policies for non-payment of premiums because of the exceptional circumstances, protracted delays in making these payments

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[14] Keshner, *supra* note 5.

[15] Id.

[16] Allison Bell, Long-Term Care Insurers Reveal Early COVID-19 Effects, THINK ADVISOR (Apr. 14, 3:30 PM), https://www.thinkadvisor.com/2021/03/18/long-term-care-insurers-reveal-early-covid-19-effects/ (of the 4 insurers that responded, one saw a 5-10% increase in benefit use, two saw a less than 5% decrease in benefit use, and one saw no change).

[17] Id.

[18] Id.

[19] Impact of COVID-19 on Long-Term Care Insurance, AMERICAN ACADEMY OF ACTUARIES (Apr. 15, 10:15 AM), https://www.actuary.org/node/14151

could have aggravated substantially SHIP's financial difficulties. Some regulatory agencies had requested or required that insurers (including SHIP) accommodate some premium deferrals, but many or most of these deferrals are also expiring or will soon expire. The net effect of the delays, therefore are also not expected to be material. Continued non-payment of premium beyond the expiration of the deferral period is expected to result in an increased number of policy terminations. The Rehabilitator has already observed a slight increase in the number of policy terminations that appear not to be the result of increased insured mortality. However, in the aggregate they are not expected to be material to the Plan.

D. TIMELINE

The order placing SHIP in rehabilitation required the Rehabilitator to submit to the Court a preliminary plan for SHIP's rehabilitation by April 22, 2020, and a subsequent case management order provided for policyholders and other interested parties to comment on the Plan through September 15, 2020. Over 100 people have submitted comments, some formal but most informal, and a few parties have also been admitted as intervenors. The Approved Rehabilitation Plan reflects the analysis of those comments and continuing work by the rehabilitation team.

At page 35 is a sequence of past and expected events in the presentation and implementation of the Plan. While it is difficult to predict future events in a matter of this complexity and under the current exceptional circumstances, a hearing on the Plan was held beginning on May 17, 2021. On August 25, 2021, The Court filed a Memorandum Opinion and Order approving the Second Amended Rehabilitation Plan with the exception of Section VI.N. relating to the suspension of agents' commissions, which was addressed in a separate hearing on September 8, 2021, and approved on September 13, 2021, along with a settlement between certain intervening agents and the Rehabilitator. Implementation of the Plan commenced following the entry of the Court's Memorandum Opinion and Order. We anticipate that most policyholders will be sent Policyholder Election Packages around year-end and be asked to make their elections by around mid March, 2022, becoming effective in April of next year. The details of options available to some policyholders and these dates may differ because of changes in their circumstances (see Subsection II.L.3, page 37) or decisions made by the senior insurance regulator of the states in which their policies were issued (see Section VI.V, page 108). It is also possible that changes in circumstances generally may result in changes in these dates. This matter is complex and delays in this timetable remain possible.

E. RATIONALE FOR THE PLAN

The Plan hinges on two essential assumptions: (1) in order to maximize policyholder protection, the Plan must strive to reduce the Funding Gap by increasing revenue and reducing liabilities; and (2) while premium rate increases can increase revenue by some increment, elimination by policyholders of long-term care coverage they may not truly need or be able to afford, especially at adequate premium rates, will go much further in remedying the Company's dire financial situation. The Rehabilitator believes that the Plan structure, which is the product of extended analysis by industry experts, offers a reasonable prospect of success based on sound principles.

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

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

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

4. It is important to note that Plan premium rate increases are not based on state of issue or state of residence. They are based exclusively on the characteristics of each individual policy, including the difference between Current Premium and If Knew Premium (in Phase One) or Self-sustaining Premiums (in Phase Two).

5. In every case, policyholders will have at least one option (Option Two) calibrated to provide outcomes no less favorable than liquidation, including applicable Guaranty Association benefits.

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

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

F. PLAN PROJECTIONS

The magnitude of SHIP's Funding Gap or deficit as of the Effective Date is difficult to predict because it is dependent on several changing circumstances over which the Rehabilitator has little or no control. However, the Rehabilitator believes that, depending on policyholder elections, Phase One of the Plan could greatly reduce, if not eliminate, the Funding Gap. Solely for purposes of directional guidance, the Rehabilitator has prepared some hypothetical results that could be expected from operation of the Plan. For purposes of these projections, it is assumed that SHIP's Funding Gap as of the Effective Date will be $1.2 billion. It should be emphasized that these are hypothetical projections dependent on future events that may evolve in a manner different from the assumptions in the projections. Subject to these caveats, it is the belief of the Rehabilitator that the Plan would produce the following results:

1. If 100% of disabled SHIP LTC policyholders and 80% of active SHIP LTC policyholders elect Option Four (retaining the current policy benefits and paying the rate increases necessary to reach If Knew Premium), the Funding Gap will be reduced by about $500

II.E.4.e, page 28. Again, for purposes of this determination "expected" consists of best estimate assumptions.

d. ***Allocable Assets*** is a notional determination consisting of the Company's invested assets less reserves for costs of administration, contingencies, and certain debts of higher priority. The ***Asset/Premium Ratio*** is the ratio of Allocable Assets to the aggregate Accumulated Premiums for all LTC policies. ***Accumulated Premium*** is the total Gross Premiums paid, and premiums waived, under a policy or group of policies from inception until the valuation date.

e. **Allocated Assets** are the portion of the Company's Allocable Assets notionally allocated to a particular policy in accordance with the terms of, and solely for the purposes of calculations described in, the Plan. Such asset allocations are nominal and do not give a policyholder a right to any Allocated Assets or any particular sum of money. The assets allocated to each policy equal the product of the policy's Accumulated Premium times the Asset/Premium Ratio. This approach is designed to allocate assets equitably among policyholders solely for the purpose of calculating Phase Two premiums.

TABLE 1: ILLUSTRATION OF ASSET ALLOCATION		
1	Total Invested Assets	$1,500,000,000
2	Reserve for Costs of Administration	-$200,000,000
3	Contingencies	-$10,000,000
4	Priority Debts	-$50,000,000
5	**Total Allocable Assets (L1 - (L2...L4))**	**$1,240,000,000**
6	Total Accumulated Premium	$3,480,000,000
7	**Asset/Premium Ratio (L5/L6)**	**35.63%**
8	Accumulated Premium - Hypothetical Policy	$50,000
9	**Allocated Assets Hypothetical Active Policy (L7 X L8)**	**$17,816**

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

6. Although this Plan Document assumes that in Phase Two determinations will be based on Self-sustaining Premiums, it is possible that, depending on the outcome of Phase One and other relevant considerations, in Phase Two the Plan will utilize an alternative premium

department of the opt-out state will make the rate increase determinations for those policies and the benefits under Plan provisions will be adjusted to correspond to the premium rates approved by the opt-out state. The Rehabilitator proposed this approach and it is now part of the Approved Rehabilitation Plan. Section VI.V, below at page 108, describes the basic elements of the mechanism for enabling states to make their own rate increases decisions within the context of the Plan. Note that, apart from the rate increase determinations, under this approach the policies issued in the opt-out state will still be administered by the Rehabilitator under the Plan so that the opt-out state will not have to provide that administration.

8. CONCLUSION

On balance, the Rehabilitator concluded that the best approach is the Plan as approved by the Court, with the component as described in alternative seven, above. Accordingly, the Approved Plan now includes the additional following section.

V. ISSUE-STATE RATE APPROVALS

This Section describes the issue-state rate approval alternative for states that object to the Rehabilitator and the Commonwealth Court modifying rates as part of the Plan for SHIP LTC policies issued in those states, and which elect to make their own determinations as to such rate increases themselves (***Opt-out States***).

While this Section was added to the Plan to accommodate that objection, the Rehabilitator makes an important observation. In order to reduce policyholder subsidization and overall burden, and in an effort to achieve the best result possible under the circumstances, the Rehabilitator has undertaken the development of a model that allows her to address each policy individually in a seriatim fashion. Most, if not all, material policyholder calculations under the Plan (including premium rate adjustments) are performed individually for each long-term care policy. As noted more fully below, if a state elects to make its own determination for the rates charged for the policies issued in that state in groups rather than individually, the result may be disadvantageous to many policyholders. In determining whether or not to "opt out" a state should consider carefully its ability to address the circumstances of each policy individually, as does the Rehabilitator. If a state is unable or unwilling to do this, it may want to evaluate whether the results of its premium rate increase decisions may prove to be inferior to those proposed by the Rehabilitator, all things considered.

1. SUMMARY

If the chief insurance regulator ("Commissioner") of an issue-state formally advises the Rehabilitator that his or her state elects to "opt-out" of the rate increase component of the Approved Rehabilitation Plan, the Plan will not apply in the same way to the policies issued in that state (the ***Opt-out Policies***). In that case, the Rehabilitator will file in the Opt-out State a premium rate increase request for the Opt-out Policies the Current Premiums of which are below If Knew

premiums. **Holders of Opt-out Policies with Current Premiums equal to or greater than If Knew Premium will be unaffected and will retain their current policies without modification.** The holders of the Opt-out Policies with Current Premium below If Knew Premium will not be able to elect from among the Plan options and will instead have the choices described below, determined by how the Opt-out State responds to the Rehabilitator's premium rate increase request.

THE INTENT OF THIS SECTION IS TO ENABLE STATES THAT OBJECT TO THE REHABILITATOR OR COMMONWEALTH COURT SETTING PREMIUM RATES UNDER THE PLAN WITHOUT THEIR APPROVAL TO REVIEW AND APPROVE (ENTIRELY OR PARTIALLY) OR DISAPPROVE THE PLAN'S PREMIUM RATES THEMSELVES. HOWEVER, THE EFFECTS OF A STATE "OPTING OUT" UNDER THIS SECTION MAY INCLUDE A REDUCED NUMBER OF MEANINGFUL OPTIONS FOR AFFECTED POLICYHOLDERS AND SOME OF THOSE POLICYHOLDERS PAYING HIGHER PREMIUMS THAN THEY WOULD UNDER THE PLAN. IN ADDITION, SOME POLICYHOLDERS WHO DO NOT MAKE AN ELECTION MAY FACE INVOLUNTARY BENEFIT REDUCTIONS.

IT SHOULD ALSO BE NOTED THAT THE DECISIONS OF OPT-OUT STATES WILL AFFECT POLICYHOLDERS RESIDING IN OTHER STATES WHOSE POLICIES HAD BEEN ISSUED IN THE OPT-OUT STATE. CONVERSELY, THOSE DECISIONS WILL NOT AFFECT POLICIES HELD BY RESIDENTS OF THE OPT-OUT STATES BUT ISSUED IN OTHER STATES.

2. OPT-OUT ELECTIONS

a. In the next few weeks, the Rehabilitator will provide every state in which SHIP policies in force (and not in NFO status) have been issued the opportunity to opt out of the rate approval provisions of the Plan. Every state that has not by the specified deadline (the ***Opt-out Deadline***) communicated to the Rehabilitator an election to opt out will be deemed to have opted into the Plan and the rest of this Section will not apply to the policies issued in that state. The Rehabilitator will endeavor to provide states at least thirty (30) days to make the Opt-out Election. States may, but are not required to, affirmatively opt into the Plan. States that do not timely communicate an appropriate Opt-out Election to the Rehabilitator will be deemed to have opted into the Plan.

b. The communication necessary to Opt Out (the ***Opt-out Election***) must be signed and sworn by the Commissioner, Director, Superintendent or other senior insurance regulatory official of the state. The communication need not take any particular form but must contain the following statement:

> *On behalf of the State [or Commonwealth] of [X], and in the exercise of my authority as [X]'s senior insurance regulatory official I hereby elect to withdraw from the premium rate increase approval provisions of the Rehabilitation Plan for Senior Health Insurance*

Company of Pennsylvania (SHIP) all of the in force long-term care insurance policies currently held by SHIP and first issued by SHIP or its predecessors in [X]. I have read the Plan and understand the consequences of this election.

c. The original signed and sworn Opt-out Election must be received by the Rehabilitator at the address specified no later than the Opt-out Deadline, but the Opt-out Election will be effective if an electronic form (including a facsimile) of the Opt-out Election is received by the Rehabilitator on or before the Opt-out Deadline and the original signed and sworn Opt-out Election is received by the Rehabilitator no later than ten days after the Opt-out Deadline. **It is recommended that states commence the evaluation of whether they want to opt out of the Plan as soon as possible so that they will have ample time to finalize and communicate their decision once they receive the opt-out election notice. The Rehabilitator will be pleased to answer any question that may assist a state in evaluating this matter. States have not been required to take any action under this Section before the Plan was approved.**

d. The Rehabilitator will acknowledge every Opt-out Election in writing. An Opt-out Election sent in advance of the Opt-out Deadline may be canceled by the Opt-out State in a communication sent in the same manner and received by the Rehabilitator no later than the Opt-out Deadline so long as it contains the following language:

*On behalf of State [or Commonwealth] of [X], and in the exercise of my authority as [X]'s senior insurance regulatory official, having first elected by communication dated [*Opt-out Election date*] to withdraw from the premium rate increase approval provisions of the Rehabilitation Plan for Senior Health Insurance Company of Pennsylvania (SHIP) as to all of the in force long-term care insurance policies currently held by SHIP and first issued by SHIP or its predecessors in [X], I hereby revoke the Opt-out Election. Accordingly, I request that all of the SHIP long-term care insurance policies issued in [X] be included in the premium rate increase approval provisions of SHIP's Rehabilitation Plan. I have read the Plan and understand the consequences of this revocation.*

e. Opt-out Elections may only be revoked after the Opt-out Deadline with the Rehabilitator's written consent. Generally, such consent will be provided unless the revocation will have an adverse effect on the Plan or opt-in policyholders.

f. An Opt-out Election will be effective as to all Opt-out Policies the Current Premium of which is below If Knew Premium, even if the Opt-out State determines to approve

some (but not all) of the premium rate increases sought by the Rehabilitator from the Opt-out State. A STATE MAY NOT OPT OUT AS TO ONLY SOME OF SHIP'S POLICIES ISSUED IN THAT STATE.

PHASE ONE

3. PREMIUM RATE INCREASE APPLICATION

a. Following receipt of a valid Opt-out Election, the Rehabilitator will file in each Opt-out State a request for approval of the full amount of actuarially justified rate increases (on an If Knew Premium basis) for the SHIP LTC policies issued in that state the Current Premium of which is below If Knew Premium. The rate increase application will be submitted on a seriatim basis (that is, policy-by-policy, not in the aggregate or by policy form), seeking a specific rate increase for each policy. No rate increases will be sought for Opt-out Policies the premiums of which are already equal to or above the If Knew Premium or which are on premium waiver (including those in NFO status). If an Opt-out State does not respond to the application for rate increases as to any policy within 60 days, the request as to that policy will be deemed denied. If an Opt-out State does not respond to the Rehabilitator's rate increase application within 60 days, the request will be deemed denied in its entirety. An Opt-out State may approve premium rate increases for Opt-out Policies in whatever amount it deems appropriate and the approved percentages may vary among the Opt-out Policies the Current Premium of which is below If Knew Premium. The Opt-out State's decision as to the requested rate increases will govern the choices available to the holders of Opt-out Policies the Current Premium of which is below If Knew Premium.

b. If the Opt-out State timely approves the requested rate increases in full for all Opt-out Policies, it will be treated as if it had not opted out of the Plan, it will be deemed to be an ***Opt-in State***, and its policyholders will be included in the Plan just as those whose policies were issued in states that did not opt out (Opt-in States). If the Opt-out State does not timely approve the full rate increase sought by the Rehabilitator for all Opt-out Policies, all of the policies (including those on premium waiver) issued in that state the Current Premium (whether or not waived) of which is below If Knew Premium will be deemed Opt-out Policies subject to the following provisions.

c. If the Opt-out State responds to the rate increase application in the aggregate or by group (such as by policy form) rather than seriatim (policy-by-policy), the Rehabilitator will apply the resulting increases on a policy-by-policy basis. Note that, for some policyholders, the state's approved rate might exceed the requested rate increase.

d. APPROVAL OF THE RATE INCREASES IN THE AGGREGATE RATHER THAN SERIATIM (POLICY-BY-POLICY) COULD RESULT IN SOME POLICYHOLDERS BEING REQUIRED TO PAY A HIGHER PREMIUM RATE THAN REQUESTED BY THE REHABILITATOR AND HIGHER RATES THAN THEY WOULD PAY UNDER THE PLAN.

e. ALSO, APPROVAL OF THE RATE INCREASES IN THE AGGREGATE RATHER THAN SERIATIM COULD RESULT IN SOME POLICYHOLDERS PAYING A LOWER PREMIUM RATE THAN REQUESTED BY THE REHABILITATOR AND RECEIVING BENEFIT DOWNGRADES UNDER THE DEFAULT OPTION (OPTION A).

f. PRELIMINARY MODELING BY THE REHABILITATOR SUGGESTS THAT, IF A STATE WERE TO MAKE A RATE DETERMINATION FOR ALL OF THE LTC POLICIES ISSUED IN THAT STATE (INCLUDING THOSE WITH PREMIUM AT OR ABOVE IF KNEW PREMIUM AS TO WHICH THE REHABILITATOR DID NOT SEEK A RATE INCREASE) AS A GROUP, AS MANY AS 65% OF POLICYHOLDERS WILL PAY HIGHER PREMIUM RATES THAN THEY WOULD IF THE RATES WERE DETERMINED SERIATIM.

g. IN ADDITION, RATE APPROVAL IN THE AGGREGATE OR BY GROUP, RATHER THAN SERIATIM, MAY RESULT IN A MATERIAL INCREASE IN THE SUBSIDIZATION OF SOME POLICYHOLDERS BY OTHERS.

h. OPT-OUT POLICYHOLDERS MAY BE ADVISED BY THE REHABILITATOR THAT THE RESULTING PREMIUM RATES ARE THE RESULT OF DECISIONS MADE BY THE OPT-OUT STATE.

4. TREATMENT OF OPT-OUT POLICIES IN PHASE ONE - PREMIUM PAYING POLICIES

a. Holders of Opt-out Policies with Current Premium below the If Knew Premium, will be able to choose from among several options described below. These options are designed to preserve as much choice as reasonably possible while giving effect to the Opt-out State's rate decision and avoiding or minimizing subsidies by other policyholders. Holders of Opt-out Policies with Current Premiums equal to or greater than If Knew Premium will be unaffected and will retain their current policies without modification unless the Opt-out State mandated a change in their premium rates. That could occur if such policies were part of a group for which the Opt-out State mandated a premium rate increase for the entire group.

b. In Phase One of the Plan, the choices for holders of Opt-out Policies with Current Premium below the If Knew Premium, and which are not subject to a premium waiver (*i.e.,* those paying premiums), will be:

OPTION A:

Pay the required premium (including approved premium rate increases) and keep the current policy. However, every opt-out policy with premiums below the If Knew level (after implementing the rate increase approved by the Opt-out State) will be downgraded to the benefit level supported (on an If Knew Premium basis) by the premium approved by the Opt-out State. The downgrade will be calculated using a method substantially similar to the Plan downgrade mechanism (see Section III.A.1.c, page 43). The Downgrade Process for Option A has fewer steps than the Plan downgrade mechanism for Opt-in policies in that Benefit Reductions Eight (extension of elimination period) and Ten (removal of waiver of premium) do not apply to Opt-out policyholders. The downgrade will be adjusted so that the resulting Maximum Policy Value (MPV) is no lower than the lesser of the policy's current MPV or the applicable guaranty association limits (the "MPV floor"). This will be accomplished by implementing the downgrade and extending the policy's Maximum Benefit Period (MBP) as necessary so that the resulting MPV satisfies that requirement. In the event that the MPV floor applies, Benefit Reductions Eight (extension of elimination period) and Ten (removal of waiver of premium) do not apply to Opt-out policyholders. Option A will be the default option for Opt-out Policies with Current Premium below If Knew Premium.

NOTE THAT, BECAUSE THIS IS THE DEFAULT OPTION, THE BENEFITS PROVIDED BY A POLICY FOR WHICH THE RATE APPROVED BY THE OPT-OUT STATE IS BELOW THE IF KNEW PREMIUM RATE WILL AUTOMATICALLY BE DOWNGRADED. POLICYHOLDERS CAN AVOID SUCH DOWNGRADES BY SELECTING OPTION D AND PAYING IF KNEW PREMIUMS.

Opt-out Policies as to which the premiums, taking into account the Opt-out State's decision on the Rehabilitator's rate increase application, are at or above the If Knew Premium will not be downgraded if they select Option A.

OPTION B:

In lieu of the approved rate increase, elect a specified benefit downgrade calibrated to the Current Premium (omitting approved premium rate increases) on an If Knew basis. The downgrade will be determined by a calculation substantially similar to the Plan downgrade mechanism and policyholders will not be able to select specific benefit changes. Unlike OPTION A, the downgrade in this case will not be "floored" at the lesser of the current MPV or applicable guaranty association limit. This option allows policyholders to avoid any rate increase.

OPTION C:

Select the Opt-out State-required reduced paid-up policy ("RPU") or Non-forfeiture Option ("NFO"). If the state does not require a particular RPU or NFO,

policyholders will be offered the RPU or NFO currently specified in their policies. If no RPU or NFO is specified in the policies, policyholders selecting this Option will be provided an NFO used by SHIP before the Plan. In all of these cases, this will be a paid-up policy of moderate benefits for which no premium need ever be paid again. OPT-OUT POLICYHOLDERS WILL NOT BE ABLE TO SELECT THE ENHANCED NFO OFFERED UNDER THE PLAN, WHICH GENERALLY OFFERS A LONGER BENEFIT PERIOD.

OPTION D:

Keep the current policy benefits and accept a premium increase to the If Knew Premium for the benefits provided by the policy even though such a rate increase has not been approved by the Opt-out State. This is strictly an elective option that will never apply by default and is intended to provide policyholders the ability to retain the current benefits when they are able and willing to pay the required premium. In other words, this option strives to avoid taking contractual benefits away from policyholders who are willing to pay for them. THIS PROVISION IS INTENDED TO REDUCE POTENTIAL DISADVANTAGES OF OPTING OUT.

5. TREATMENT OF OPT-OUT POLICIES IN PHASE ONE - POLICIES ON PREMIUM WAIVER

a. Every Opt-out Policyholder on premium waiver will retain the waiver as long as required by the policy, but if the Current (waived) Premium is below the If Knew level and the policy's current MPV is greater than the GA limit, the policy's MBP will be reduced to the longer of (1) what can be supported by the Current Premium (had it not been waived) on an If Knew basis, and (2) the MBP required to make the MPV no less than the GA limit. If the current MPV is lower than the GA limit, or if the waived premium is at or above the If Knew level, the MBP will be left unchanged. This is designed to provide substantially no less benefits than what would happen in liquidation while minimizing involuntary subsidies by other policyholders.

b. Once the waiver expires, such policyholders with waived premium below the If Knew level will be required to resume paying premium at the current rates and retain the reduced MBP (if it has been reduced as explained above).

c. In Phase One, Opt-out policyholders on premium waiver will not be subject to rate increases and will not be able to choose any other option.

PHASE TWO

6. IMPLEMENTATION OF PHASE TWO FOR OPT-OUT POLICIES

a. In general, if and when Phase Two of the Plan is implemented for policies issued in Opt-in States, it will also be implemented for Opt-out Policies. The implementation

will be similar to that described for Phase One, above but based on Self-sustaining Premiums rather than If Knew Premium. If the Rehabilitator adopts an alternative premium structure for Phase Two it will apply to Opt-out Policies as well. See Section II.E.6, page 28.

b. In Phase Two, the Rehabilitator will file in the Opt-out State a new premium rate increase request for the Opt-out Policies the Current Premiums of which are below Self-sustaining Premiums and which are not on premium waiver. As in Phase One, the Phase Two rate increase application will be filed on a seriatim basis. The Opt-out State's decision as to the requested rate increases will govern the choices available to the holders of Opt-out Policies in Phase Two.

c. Because the Opt-out State has already been deemed to have opted out in Phase One, timely approval of the Phase Two requested rate increases in full for all Opt-out Policies will NOT result in the state being treated as if it had not opted out of the Plan. All of the policies issued in that state have been deemed Opt-out Policies in Phase One and remain so in Phase Two.

d. If the Opt-out State responds to the Phase Two rate increase application in the aggregate or by group rather than seriatim (policy-by-policy), the Rehabilitator will apply the resulting increases on a policy-by-policy basis. AS IN PHASE ONE, THIS COULD RESULT IN SOME POLICYHOLDERS BEING REQUIRED TO PAY A HIGHER PREMIUM RATE THAN REQUESTED BY THE REHABILITATOR AND HIGHER RATES THAN THEY WOULD PAY UNDER THE PLAN. That would occur if the state's approval exceeded the requested rate increase for one or more policies.

e. OPT-OUT POLICYHOLDERS MAY BE ADVISED BY THE REHABILITATOR THAT THE RESULTING PREMIUM RATES ARE THE RESULT OF DECISIONS MADE BY THE OPT-OUT STATE.

f. Holders of Opt-out Policies with Current Premiums equal to or greater than Self-sustaining Premiums will be unaffected and will retain their current policies without modification unless the Opt-out State mandated a change in their premium rates. That could occur if such policies were part of a group for which the Opt-out State mandated a premium rate increase for the entire group. The holders of the Opt-out Policies with Current Premium below Self-sustaining Premiums would not be able to elect from among the Plan options and would instead have the choices described above but based on Self-sustaining Premiums, determined according to how the Opt-out State responds to the Rehabilitator's premium rate increase request.

g. For purposes of calculating the Self-sustaining Premiums of Opt-out Policies in Phase Two, the Rehabilitator will use a separate pool of assets from those used in the calculation of Self-sustaining Premiums for policies in Opt-in States. Assets will be

allocated between the two pools in proportion to accumulated premium paid by the then current policyholders of each group of states.

7. TREATMENT OF OPT-OUT POLICIES IN PHASE TWO - PREMIUM PAYING POLICIES

   a. If and when Phase Two is implemented for policyholders participating in the Plan, the process described above (with the same options) will be repeated for premium-paying Opt-out Policies using Self-sustaining Premiums instead of If Knew Premium. However, policies that would be fully covered by the applicable guaranty association if SHIP were placed in liquidation, are Self-sustaining, or have elected the NFO or RPU would not be affected in this second phase.

   b. NOTE THAT THERE CAN BE A MATERIAL DIFFERENCE IN PHASE TWO PREMIUMS BETWEEN POLICIES THAT ARE FULLY COVERED AND THOSE THAT ARE NOT, EVEN IF THEY ARE OTHERWISE SIMILAR AND THEIR MPV DIFFERS BY A SMALL AMOUNT.

8. TREATMENT OF OPT-OUT POLICIES IN PHASE TWO - POLICIES ON PREMIUM WAIVER

   a. Much as in Phase One, every Opt-out Policyholder on premium waiver will retain the waiver in Phase Two as long as required by the policy. If the waived premium is below the Self-sustaining Premium level and the policy's current MPV is greater than the GA limit, the policy's MBP will be reduced to the longer of (1) what can be supported by the Current Premium (had it not been waived) on a Self-sustaining Premium basis, and (2) the MBP required to make the MPV no less than the GA limit. If the current MPV is lower than the GA limit, or if the waived premium is at or above the Self-sustaining Premium level, the MBP will be left unchanged.

   b. Once the waiver expires, such policyholders with waived premium below the Self-sustaining Premium level will be required to resume paying premium at the current rates and retain the reduced MBP (if it has been reduced as explained above).

   c. As in Phase One, Opt-out Policyholders on premium waiver will not be subject to rate increases in Phase Two and will not be able to choose any other option.

9. Other provisions of the Plan not affected by these provisions would remain as applicable to the Opt-out Policies as to other policies. Additional details of the opt-out provisions will be specified depending on further discussions with other regulators and the Orders of the Court.

10. This approach is designed to defer to the issue-state for rate approval by making its decision the default option. It would reduce or eliminate the requirement that other policyholders subsidize the Opt-out Policies prospectively and provides Opt-out Policyholders benefits at

least equal to, and in many cases exceeding, what they would receive in liquidation. It would offer policyholders benefit downgrade options in lieu of the approved rate increases as well as a reduced paid-up policy option. In addition, to reduce the disadvantage of being excluded from the Plan, these policyholders would also be offered the option of retaining the current coverage if they are able and inclined to pay the required premium.

COMPARISON OF OPTIONS FOR OPT-IN AND OPT-OUT POLICYHOLDERS IN PHASE ONE

11. The options available to Opt-out policyholders differ in some respects from those available to Opt-in policyholders.

a. Option One for Opt-in policyholders is the same as Option B for Opt-out policyholders.

b. Opt-in policyholders do not have the equivalent of opt-out Option A - pay the approved rate and be downgraded to what that rate buys on an If Knew basis subject to the GA floor. That is because the "approved rate" for Opt-in policyholders would be the If Knew Premium, which would make Option A the same as Option D. The Opt-in policyholder option most similar to Option A for Opt-out policyholders is Opt-in Option Two, the Basic Policy Endorsement which, like Opt-out Option A, might entail both premium increases and benefit reductions. Note, however, that Option A does not exempt Opt-out policyholders from modifications in Phase Two, while Opt-in policyholders who elect Option Two in Phase One will not face additional rate increases or Benefit Reductions in Phase Two.

c. Opt-out policyholders do not have the equivalent of Opt-in Option Two, the Basic Policy Endorsements (which is the Default Option for premium-paying Opt-in policyholders) and enhanced Basic Policy Endorsements. The Basic Policy Endorsements consist of specific Policy Modifications intended to provide reasonable benefits and premiums that, if selected in Phase One, will be immune from changes in Phase Two of the Plan. Opt-in policyholders making this election will not face additional modifications in Phase Two of the Plan, except that they may be required to pay full premium rather than Differential Premium if a Premium Waiver becomes inactive.

d. Both Opt-in policyholders and Opt-out policyholders have an NFO option (Option Three for Opt-in policyholders and Option C for Opt-out policyholders); however, it is likely to be "richer" for Opt-in policyholders. For Opt-out policyholders, this is the only option that ensures that they will not face potential premium rate increases or benefit reductions in Phase Two.

e. Both groups have the same If Knew premium option – Option Four for Opt-in policyholders and Option D for Opt out policyholders. Note that Option Four in

Phase One for Opt-in policyholders is based on Phase One premium (the greater of the current premium and the If Knew premium) while Option D for Opt-out policyholders is based simply on if knew premium. However, they operate the same way because Opt-out policyholders with premium at or above If Knew premium will have no modifications, rate increases, or options. Thus, both Opt-in and Opt-out policyholders already paying at least If Knew premiums will be exempt from mandatory modifications. Although Opt-in policyholders with current premiums at or above If Knew premiums (and who therefore are not required to elect modifications under the Plan) can voluntarily select other options, Opt-out Policyholders with premiums at or above If Knew Premium will not have that option. They will simply retain their current premium and benefits.

f. For policyholders on premium waiver, the major difference is that Opt-out policyholders will not be required to pay Differential Premium, while Opt-in policyholders will be required to pay a Differential Premium if they elect to keep their current benefits. However, if the waived premium for an Opt-out Policy is below the If Knew level and the policy's current MPV is greater than the GA limit, the policy's MBP will be reduced to the longer of (1) what can be supported by the current premium (had it not been waived) on an If Knew basis, and (2) the MBP required to make the MPV no less than the GA limit. If the current MPV is lower than the GA limit, or if the waived premium is at or above the If Knew level, the MBP will be left unchanged.

W. DISCLAIMERS AND SOURCES OF INFORMATION

The discussion of the Rehabilitation Plan in this document describes how it is proposed to be implemented by the Rehabilitator. If the Plan is modified by the Court or pursuant to subsequent amendments proposed by the Rehabilitator, its implementation may differ materially from the description herein.

The Plan includes information concerning SHIP's history and current and projected financial condition. This information was prepared based on information available to SHIP and the Rehabilitator, including information provided by SHIP to the Rehabilitator or available in historical public filings, and on actuarial projections that inherently include a degree of uncertainty. The Rehabilitator has yet to conclude an investigation of all the reasons that led to the Company's distressed financial condition. Pursuant to her statutory ability to do so, the Rehabilitator has delegated broad responsibility to the SDR and references in the Plan to the Rehabilitator should be interpreted as including the SDR unless specified otherwise. The Rehabilitator and SHIP do not make (and hereby disclaim) any warranty, express or implied, as to the accuracy or completeness of the information contained in the Plan. In particular, events and forces beyond the control of the Rehabilitator and SHIP may alter the assumptions upon which the disclosures in the Plan are based. The Plan Document includes certain projections, but they cannot forecast and reflect fully any events that may occur subsequent to the date hereof. Such events may have a material impact on the information contained in the Plan Document and any recovery or benefits that may be received by

EXHIBIT C

SHIP
SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
(IN REHABILITATION)

September 30, 2021

Via U.S. Mail and Email

Opt-Out Election Notice for Senior Health Insurance Company of Pennsylvania (In Rehabilitation) - Deadline: November 15, 2021

Dear Commissioner:

This communication provides important information on a decision available to each state's Commissioner (or chief insurance regulator) affecting holders of long-term care insurance policies issued in their states by Senior Health Insurance Company of Pennsylvania ("SHIP") or its predecessors.

Background

As you are already aware, SHIP was placed in statutory rehabilitation on January 29, 2020, at the request of the Pennsylvania Insurance Commissioner, Jessica K. Altman (the "Commissioner"). On that day she appointed me Special Deputy Rehabilitator of SHIP. On April 22, 2020, the Commissioner as Rehabilitator filed a proposed Rehabilitation Plan with the Commonwealth Court of Pennsylvania ("Court"). Subsequently, on October 21, 2020, the Rehabilitator filed a proposed Amended Rehabilitation Plan and on May 3, 2021, she filed a proposed Second Amended Rehabilitation Plan ("Second Amended Plan"). A hearing on the Second Amended Plan was conducted by the Court the week of May 17, 2021. On August 25, 2021, the Court filed her Memorandum Opinion and Order approving the Plan. In accordance with its Order, an Approved Rehabilitation Plan (the "Approved

Plan" or "Plan") was filed with the Court on September 24, 2021. The Order approving the Plan and the Approved Plan can be found on the SHIP website ("Website"), www.shipltc.com/court-documents.

Issue-State Rate Approvals Introduction

The Approved Plan contains a section providing a rate approval alternative for states that object to the Rehabilitator and the Court modifying premium rates for SHIP long-term care insurance policies issued in those states, and which elect to make their own determinations as to such rate modification themselves. A state electing this alternative will be considered an Opt-out State. The process and additional information for the issue-state rate approval is provided in more detail in the Approved Plan beginning on page 108. **While this notice summarizes some aspects of that provision, the Plan and especially that section, must be read in its entirety to understand its requirements and consequences. In addition, we provide after this letter some frequently asked questions and their answers.**

The Opt-out deadline is November 15, 2021.

As described in that section of the Plan, the Rehabilitator has undertaken the development of a model that allows her to address each policy individually in a seriatim fashion. Most, if not all, material policyholder calculations under the Plan (including premium rate and benefit adjustments) are performed individually for each long-term care policy. This is a key component of the Plan's mechanism for eliminating discriminatory or inequitable premium rates and policyholder subsidization prospectively. In determining whether or not to "opt out" a state should carefully consider its ability to address the circumstances of each policy individually, as does the Rehabilitator under the Plan. As explained in the Plan, setting rates in cohorts or groups could work to the disadvantage of some policyholders.

Process to Opt-Out of the Plan

Every state in which there are long-term care insurance policies in force issued by SHIP or its predecessors has the opportunity to opt out of the rate approval provision of the Plan. States may, but are not required to, affirmatively opt into the Plan. States that wish to opt out of the Plan must make an Opt-out Election as described below.

The Opt-out Election must be signed and sworn by the Commissioner, Director, Superintendent, or other senior insurance regulatory official of the state. The communication must contain the following statement, also found on the attached Opt-out Form:

> *On behalf of the State [or Commonwealth] of [X], and in the exercise of my authority as [X's] senior insurance regulatory official I hereby elect to withdraw from the premium rate increase approval provisions of the Rehabilitation Plan for Senior Health Insurance Company of Pennsylvania (SHIP) all of the in force long-term care insurance policies currently held by SHIP and first issued by SHIP or its predecessors in [X]. I have read the Plan and understand the consequences of this election.*

As noted, November 15, 2021, is the Opt-out Deadline. All original signed and sworn Opt-out Elections must be received by the Rehabilitator at the following address by the Opt-out Deadline.

> Senior Health Insurance Company of Pennsylvania (In Rehabilitation)
> Attn: Administrator of State Opt-out Elections
> 550 Congressional Boulevard, Suite 200, Carmel, IN 46032

Alternatively, the Opt-out Election will be effective if an electronic form of the Opt-out Election is received by the Rehabilitator via email at rehabilitation@shipltc.com (or via facsimile at (317) 566-7588) on or before the Opt-out Deadline. The physical original signed and sworn Opt-out Election must be received by the Rehabilitator no later than ten days after the Opt-out Deadline, i.e., by November 25, 2021. **Every state that does not communicate to the Rehabilitator a proper election to opt out by the Opt-out Deadline will be deemed to have opted into the Plan. The Rehabilitator will not assert that submitting an Opt-out Election in accordance with the Plan constitutes an appearance in the Rehabilitation proceeding or submission to the Court's jurisdiction.**

The Rehabilitator will acknowledge every Opt-out Election in writing. An Opt-out Election sent in advance of the Opt-out Deadline may be canceled by the Opt-out State in a communication sent in the same manner as the Opt-out Election, received by the Rehabilitator no later than the Opt-out Deadline. It must contain the following language:

> *On behalf of State [or Commonwealth] of [X], and in the exercise of my authority as [X]'s senior insurance regulatory official, having first elected by communication dated [*Opt-out Election date*] to withdraw from the premium rate increase approval provisions of the Rehabilitation Plan for Senior Health Insurance Company of Pennsylvania (SHIP) as to all of the in force long-term care insurance policies currently held by SHIP and first issued by SHIP or its predecessors in [X], I hereby revoke the Opt-out Election. Accordingly, I request*

that all of the SHIP long-term care insurance policies issued in [X] be included in the premium rate increase approval provisions of SHIP's Rehabilitation Plan. I have read the Plan and understand the consequences of this revocation.

After the Opt-out Deadline, Opt-out Elections may only be revoked with the Rehabilitator's written consent. Generally, such consent will be provided unless the revocation will have an adverse effect on the Plan or opt-in policyholders.

After receiving an Opt-out Election, the Rehabilitator will file a premium rate application in the Opt-out state for all of the Opt-out Policies on an if knew premium basis (defined and explained in the Approved Plan). However, no rate increases will be sought for policyholders on premium waiver or, in Phase One, for those whose premium is at or above if knew premium.

If a state submits (and the Rehabilitator acknowledges) an Opt-out Election, and that state subsequently and timely approves the rate increases requested by the Rehabilitator in full for all Opt-out Policies, the state will be treated as if it had not opted out of the Plan. It will be deemed to be an Opt-in State, and its policyholders will be included in the Plan just as those whose policies were issued in states that did not opt out (Opt-in States).

Policyholder Data Available to Assist in Making Your Decision

A file of policyholder data has been prepared to assist in your decision about participation in the Plan's premium rate modification provisions. This policyholder file provides liabilities, premium, and Rehabilitation Plan coverage options information for individual policies in each state. Access to this file is available on the SHIP Rehabilitation Plan secure data site.

Please note that this policyholder file contains data as of July 31, 2021. This is the data the Rehabilitator will use in implementing the Plan. If you previously requested and reviewed policyholder files for your state as of June 30, 2021, or an earlier date, the July 31, 2021, policyholder file is intended to replace those earlier files.

Access to the SHIP Rehabilitation Plan Secure Data Site

In February 2021, information was provided to you regarding the creation of a SHIP Rehabilitation Plan secure data site. If you do not already have access to this site, please send an email requesting access to rehabilitation@shipltc.com and access will be granted. As the chief insurance regulator in your state,

you are authorized to have access to the secure data site which is being provided as a regulator-to-regulator confidential communication under the auspices of applicable NAIC confidentiality provisions. Please do not hesitate to contact us if you have any questions about these confidentiality provisions or about obtaining access to the secure data site.

Updated Information

SHIP's website will continue to be updated regularly with Court documents and related rehabilitation materials. You are encouraged to visit the website regularly for updated information.

The Rehabilitator, the Court, and other interested parties are aware that the effect of this Amended Plan may be substantial for some policyholders and creditors. Every reasonable effort has been made to design a plan that is consistent with the best interests of policyholders, consistent with applicable law, and in compliance with the orders of the Court.

We strongly encourage you to contact us if you have any questions about these matters. You can reach me at phcantilo@cb-firm.com and Robert L. Robinson, SHIP's chief rehabilitation officer, at rrobinson@shipltc.com and (609) 670-2367.

Thank you for your patience and cooperation during the rehabilitation process.

Sincerely yours,

Patrick H. Cantilo

Patrick H. Cantilo
Special Deputy Rehabilitator

Enclosures

SHIP
SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
(IN REHABILITATION)

Frequently Asked Questions about Issue-State Rate Approval Alternative ("Opt-Out Election")

Q1. What does opting out of the rate approval provisions of the Approved Plan mean for my policyholders?

If a state opts-out of the rate setting provisions of the Approved Plan, policyholders with SHIP long-term care insurance policies issued in that state will not be eligible to participate in the rate approval and certain other provisions of the Plan. Premium rates will be set by the Opt-out state and the Rehabilitator will adjust benefits accordingly to avoid requiring other policyholders to subsidize Opt-out policyholders. In other respects, those policies will be administered under the Plan. Opt-out policyholders will not have the same options as opt-in policyholders. In particular, they will not be able to select the basic policy endorsement, enhanced basic policy endorsement, or enhanced NFO. As explained in the Plan, under some circumstances Opt-out policyholders may end up paying a higher premium than they would have if the state had not opted out. Note also that, if after opting out a state approves in full the Rehabilitator's requested premium rate increases, the policies issued in that state will be treated as if the state had never opted out. See Q11, below.

Q2. How does a state opt-out of the Plan?

To opt out, the chief insurance regulator of a state must make an Opt-out Election using the attached form entitled "State Opt-out Election Form" or its own form containing the requisite provision, which will be signed and sworn by the chief insurance regulatory official of the state. The form must be mailed to the following address:

Senior Health Insurance Company of Pennsylvania (In Rehabilitation)
Attn: Administrator of State Opt-out Elections
550 Congressional Boulevard, Suite 200, Carmel, IN 46032

The form must be received by the Rehabilitator at the above address by the Opt-out Deadline, which is November 15, 2021. More detailed instructions can be found in the cover letter of this Notice and on pages 109 - 110 of the Approved Plan.

Q3. Will submitting an Opt-out Election subject a state to the jurisdiction of the rehabilitation court?

While the Rehabilitator obviously cannot predict what the Court will decide in cases that have not yet arisen, she hereby assures all the commissioners and chief insurance regulators that neither the Pennsylvania Insurance Commissioner, nor the Rehabilitator, will take the position with the Court that submitting an Opt-Out Election subjects a state to the jurisdiction of the Rehabilitation Court.

Q4. What happens when a state opts out of the Plan?

An Opt-out Election will be effective as to all the SHIP LTC policies issued in the Opt-out State. A state may not opt out as to only some of SHIP's policies issued in that state. The Rehabilitator will file a premium rate modification application in the Opt-out State and benefits will be adjusted depending on that state's decision in response to that application.

Additional details for the Premium Rate Increase Application begin on page 111 of the Approved Plan, including details of the treatment of opt-out policies in Phase One and Phase Two.

Q5. On what basis will the Rehabilitator file a rate modification application for Opt-out Policies?

The Rehabilitator's application will be on an if knew premium basis and submitted seriatim – policy-by-policy.

Q6. What will the Rehabilitator do if an Opt-out State rejects part or all of the requested premium rate modifications?

In that case, the Rehabilitator will adjust the affected premium rates to the amount approved by the Opt-out State. Depending on the option elected by the affected policyholder, benefits under the policy may be reduced to the amount that can be funded by the approved rate on an if knew basis. This is necessary to avoid forcing other policyholders to subsidize the Opt-out Policies prospectively. This matter is discussed in more detail in the Plan.

Q7. What will happen if an Opt-out State makes a rate decision for Opt-out Policies in groups rather than on a policy-by-policy basis?

In that case, the Rehabilitator will apply the new rates to the affected policies individually. Note that the result may be that some policyholders will get a larger rate increase than sought by the Rehabilitator without getting any additional benefits. For other policyholders this may result in an unintended mandatory downgrade. By way of illustration, assume that the Rehabilitator seeks a rate increase of 5% for Policyholder 1, 10% for Policyholder 2, and 15% for Policyholder 3. If the state approves a flat 10% increase for all three, Policyholder 1 will end up paying 5% more than he or she would have if the state had opted in and Policyholder 3 will face a 5% benefit reduction he or she would not have if the state had approved the 15% requested increase.

Q8. Will Opt-out Policies have the same options as Opt-in Policies?

No. While the Plan must be read in detail to understand this, in general three options available to Opt-in Policyholders will not be available to Opt-out Policyholders: (1) the basic policy endorsement, (2) the enhanced basic policy endorsement, and (3) the enhanced non-forfeiture option. These are described on pages 24, 48, 49 and 50 of the Plan. As noted above, if the state

approves the Rehabilitator's rate increase in full after opting out, the policyholders will be treated as if the state had not opted out and will have all the options available under the Plan.

Q9. How will states opting out affect the Plan?

It is difficult to predict future results but, in general, the Rehabilitator believes that states opting out is likely to help reduce SHIP's deficit more that states opting in. This is because it is anticipated that Opt-out States will approve lower rate increases than the Rehabilitator seeks. This will result in additional downgrades which reduce the deficit faster than additional premium. However, the Rehabilitator DOES NOT recommend that states opt out because that is generally expected to be disadvantageous to affected policyholders.

Q10. What policies will be affected by a state's opt-out decision?

The Opt-out Election only affects policies **issued** in the Opt-out State, not those **residing** in that state. On average, 15% of the policyholders reside in states other than the issue state. For some states, this percentage is as high as 40%. That means that the Opt-out State's rate decision will affect a significant number of policyholders residing in other states. Conversely, on average that rate decision will not affect 15% of SHIP's policyholders in the Opt-out State (because they were issued in other states), although this percentage is as high as 57% in some states.

Q11. What happens if a state that opts out of the Plan subsequently and timely approves the requested rate increases in full for all Opt-out Policies?

If a state submits and the Rehabilitator acknowledges an Opt-Out Election, then subsequently and timely approves the requested rate increases in full for all Opt-out Policies, it will be treated as if it had not opted out of the Plan. It will be deemed to be an Opt-in State, and for functional purposes its policyholders will be included in the Plan just as those whose policies were issued in states that did not opt out (Opt-in States). Additional information about the Premium Rate Increase Application following the receipt of a valid Opt-out Election can be found in the Approved Plan.

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)

This form must be received by the Opt-out Deadline – November 15, 2021

STATE OPT-OUT ELECTION FORM

Senior Health Insurance Company of Pennsylvania (In Rehabilitation)

If you desire to opt-out of the rate modification provisions of the Approved Plan, please fill in the blanks with the name of your state in the paragraph below, sign your name, and include your title and date in the blanks below the paragraph. The form must be notarized and received by the deadline.

> *On behalf of the State (or Commonwealth) of _____, and in the exercise of my authority as [_____'s] senior insurance regulatory official I hereby elect to withdraw from the premium rate increase approval provisions of the Rehabilitation Plan for Senior Health Insurance Company of Pennsylvania (SHIP) all of the in force long-term care insurance policies currently held by SHIP and first issued by SHIP or its predecessors in [_____]. I have read the Plan and understand the consequences of this election.*

Printed Name:_____

Signature:_____

Title:_____

Date:_____

State of _____

County of _____

BEFORE ME appeared on the ___day of _____, 2021 _____, known to me to be the person who signed the foregoing form and upon [his/her] oath stated that [he/she] executed the same for the purposes therein stated.

_____

Notary public in and for _____ [NOTARY SEAL]

My commission expires _____

This form should be returned to:

Senior Health Insurance Company of Pennsylvania (In Rehabilitation)
Attn: Administrator of State Opt-out Elections
550 Congressional Boulevard, Suite 200, Carmel, IN 46032